AGENDA

NHS North West Ambulance Service NHS Trust

Board of Directors
Wednesday, 30th April 2025
9.45am – 11.30am
In the Oak Room, Ladybridge Hall, Trust Headquarters, Bolton

Item No	Agenda Item	Time	Purpose	Lead
INTRODUCTION				
BOD/2526/001	Apologies for Absence	09:45	Information	Chair
BOD/2526/002	Declarations of Interest		Decision	Chair
BOD/2526/003	Register of Interest		Assurance	Chair
GOVERNANCE AND RISK MANAGEMENT				
BOD/2526/004	Board Assurance Framework Q4 2024/25 Position	09:50	Decision	Director of Corporate Affairs
BOD/2526/005	Opening Position of the Board Assurance Framework 2025/26	10:00	Decision	Director of Corporate Affairs
BOD/2526/006	Annual Review of Core Governance Documents • Standing Orders and Reservation of Powers • Scheme of Delegation Review • Standing Financial Instructions	10:10	Decision	Director of Corporate Affairs / Director of Finance
BOD/2526/007	Code of Governance – Position of Compliance 2024/25	10:20	Assurance	Director of Corporate Affairs
BOD/2526/008	Non-Executive Terms of Office; Committee Membership 2025/26 and Non-Executive Champion roles	10:30	Assurance	Director of Corporate Affairs
BOD/2526/009	Board of Directors Cycle of Business 2025/26	10:40	Decision	Director of Corporate Affairs
BOD/2526/010	Board Assurance Committees Terms of Reference 2025/26	10:50	Decision	Director of Corporate Affairs
BOD/2526/011	Quality and Performance Committee Annual Report 2024/25	11:00	Assurance	Prof A Esmail, Chair, Quality and Performance Committee
BOD/2526/012	Resources Committee Annual Report 2024/25	11:10	Assurance	Dr D Hanley, Chair, Resources Committee
BOD/2526/013	Audit Committee Annual Report 2024/25	11:20	Assurance	Mr D Whatley, Chair, Audit Committee

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DATE AND TIME OF NEXT MEETING
9.45am on Wednesday, 28th May 2025 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	
Daniel	Ainsworth	Director of Operations	Partner is a Team Manager at NWAS in 111 service	N/A	N/A	√	N/A	Personal interest	Jul-24	Present	N/A
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.
			Interim Board Chair of MioCare which comprises a group of not for profit health and social care companies which are owned by Oldham Metropolitan Borough Council. I have held this position since mid 2024.		√			Position of Authority	Mid-2024	Present	
Alison	Chambers	Non-Executive Director	Self Employed, A&A Chambers Consulting Ltd	√				Self employment	Jan-23	Present	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	Present	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	Present	Withdrawal from the decision making process if the organisation(s) listed within the declaration were involved.
Salman	Desai	Chief Executive	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 in 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	Lay Representative Royal College of Physicians			√		Non Financial Professional Interest.	May-24	April 2025	No conflict.
			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

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	
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 financial 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-24	Feb-25	Declare an interest and withdraw from discussions as and when required.
			Son employed on NWAS admin bank contract			√		Non financial personal interest.	Aug-24	Sep-24	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	Non Executive Director	Trustee Pendle Education Trust		√				Mar-23	Present	Withdrawal from the decision making process if the organisations listed within the declarations were involved.
			Governor, Nelson and Colne College Group		√				Mar-23	Present	
			Independent Member of Audit Committee, Pendle Borough Council		√				Mar-23	Present	
			Wife is employed at Manchester Teaching Hospitals NHS FT as a Biochemist				√		Mar-23	Present	
Peter	White	Chairman	Chair of Lancashire Teaching Hospitals NHS Foundation Trust	√				Second Trust Chair Position in another NHS organisation	Aug-23	31-Dec-24	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
Carolyn	Wood	Director of Finance	Board Member - Association of Ambulance Chief Executives		√			Position of Authority	Nov-21	Present	No Conflict.
Elaine	Strachan-Hall	Interim Director of Quality and Improvement	Director of a family business Strachan Hall Associates Ltd set up to enable delivery of consultancy-like support to Healthcare organisations	√				Directorships, including non-executive directorships held in private companies or plc (with the exception of dormant companies);	Sep-13	Present	Informed and added to declaration of interest. No business with NWAS to be transacted through Strachan Hall Associates during employment
			Member of the Independent Reconfiguration Panel for the NHS and attend meetings every other month for which I am paid between £150 and £300 per meeting. Currently there have been no call in requests requiring additional work for some time	√				Any other relevant secondary employment	Jul-22	Present	Noted on CV and declared my employment with NWAS and will not take part in any work or discussion regarding services provided within the NWAS footprint
			Clinical associate (part time contractor) with KPMG since 2013 through which I support continuous improvement in healthcare	√				Any other relevant secondary employment	Mar-20	Present	Some ongoing activity to support clients may continue my agreed working hours with NWAS.
Daren	Mochrie	Chief Executive (Left the Trust 30/11/24)	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	Aug-24	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 (Left the Trust 31/03/2025)	Non Executive Director at AQUA - Improvement Agency based in the North West	√				Position of Authority	May-24	Present	All interactions will be discussed at one to ones and any conflicts or hospitality declared as appropriate.
			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.

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REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 30 April 2025
SUBJECT	Board Assurance Framework Q4 2024/25 Position
PRESENTED BY	Angela Wetton
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	☒	Cyber Security	☒	People	☒
	Financial/ Value for Money	☒	Reputation	☒	Innovation	☒		

ACTION REQUIRED	The Board of Directors is asked to: • Agree the decrease in score of SR01 from 20 to 15 • Agree the increase in score of SR06 from 10 to 15 • Approve the 2024/25 Q4 position of the Board Assurance Framework.	
EXECUTIVE SUMMARY	The proposed 2024/25 Q4 position of the BAF risks with associated CRR risks scored ≥15 can be viewed in Appendix 1. The BAF Heat Maps for 2024/25 year to date can be viewed in Appendix 2. As part of the Q4 review, the proposed changes to note are: • SR01 has decreased in risk score from 20 to 15. • SR06 has increased in risk score from 10 to 15. Actions to be carried forward into the BAF 2025/26 Opening Position are shown in italics.	
PREVIOUSLY CONSIDERED BY	Trust Management Committee & Audit Committee	
	Date	23rd April 2025 & 25th April 2025
	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.

2. RISK ASSURANCE PROCESS

The BAF and associated Corporate Risk Register (CRR) risks are reviewed via the Integrated Governance Structure, providing Board committees with the opportunity to identify where assurances support mitigation of risk, commission where appropriate additional assurances and identify any emerging risks that may require escalating via the 3A Reports. Risks identified on the CRR are aligned to the BAF risks and are included within the assurance reports and this supports the identification of any additional assurances that may need to be commissioned by the Chair.

To support the Q4 review of the BAF, the Head of Corporate Governance has collated evidenced based assurance information reported throughout the quarter onto the Assurance Map. The information has been identified through review of 3A Reports from both Groups and Board Committee meetings. The assurance mapping has been utilised to support and inform discussions with Executive Directors and assist with the population of the BAF risks.

3. REVIEW OF THE Q4 POSITION

Following review of each BAF risk, the proposed changes are proposed:

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

- Change in current risk score SR01 for Q4 from 20 to 15

Opening Score 01.04.2024	Q1 Risk Score	Q2 Risk Score	Q3 Risk Score	Q4 Risk Score	Exec Lead
15 5x3 CxL	**15** 5x3 CxL	**15** 5x3 CxL	**20** 5x4 CxL	**15** 5x3 CxL	**Dr C Grant**

The risk score has decreased because of the following rationale applied by the Executive Lead:

- Improved performance across ARP standards, particularly C2
- De-escalation to REAP Level 2 on 17 March 2025.
- Variation regionally in relation to handover delays causing inequitable care delivery
- Strong call pick-up performance

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

- Change in current risk score of SR06 for Q4 from 10 to 15

Opening Score 01.04.2024	Q1 Risk Score	Q2 Risk Score	Q3 Risk Score	Q4 Risk Score	Exec Lead
15 5x3 CxL	**15** 5x3 CxL	**15** 5x3 CxL	**10** 5x2 CxL	**15** 5x3 CxL	Dr E Strachan-Hall

The risk has increased in risk score because of the following rationale applied by the Executive Lead:

- Trust likely to be subject to additional scrutiny, because of changes to CQC framework and the external and political regulatory landscape

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 was reviewed as part of the BAF Review process.

5. ACTION REQUIRED

The Board of Directors is asked to:

- Agree the decrease in score of SR01 from20 to 15
- Agree the increase in score of SR06 from 10 to 15
- Approve the 2024/25 Q4 position of the Board Assurance Framework.

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BOARD ASSURANCE FRAMEWORK 2024/25

Proposed Q4 Position

Board of Directors – Part 1

30th April 2025

Q4 Position Reporting Timescales:

Trust Management Cttee:	23/04/2025
Audit Cttee:	25/04/2025
Quality & Performance Cttee:	28/04/2025
Board of Directors:	30/04/2025

BOARD ASSURANCE FRAMEWORK KEY

Risk Rating Matrix (Likelihood x Consequence)

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

Director Lead:	
CEO	Chief Executive
DoQII	Director of Quality, Innovation & Improvement
MD	Medical Director
DoF	Director of Finance
DoOps	Director of Operations
DoP	Director of People
DoSPT	Director of Strategy, Partnerships & Transformation
DoCA	Director of Corporate Affairs

Board Assurance Framework Legend					
BAF Risk	The title of the strategic risk that threatens the achievement of the aligned strategic priority				
Rationale for Current Risk Score	This narrative is updated on a quarterly basis and provides a summary of the information that has supported the assessment of the BAF risk				
Risk Appetite	The total amount of risk an organisation is prepared to accept in pursuit of its strategic objectives				
Controls	The measures in place to reduce the risk likelihood or risk consequence and assist secure delivery of the strategic priority				
Assurances	The measures in place to provide confirmation that the controls are working effectively in supporting the mitigation of the risk				
Evidence	This is the platform that reports the assurance				
Gaps in Controls	Areas that require attention to ensure that systems and processes are in place to mitigate the BAF risk				
Gaps in Assurance	Areas where there is limited or no assurance that processes and procedures are in place to support the mitigation of the BAF risk				
Required Action	Actions required to close the gap in control(s)/ assurance(s)				
Action Lead	The person responsible for completing the required action				
Target Completion	Deadline for completing the required action				
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

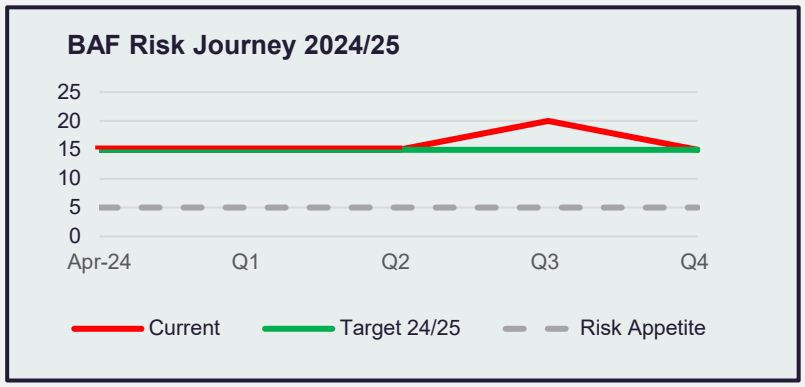
BAF Risk	Committee	Exec Lead	01.04.24	Q1	Q2	Q3	Q4	2024/25 Target	Risk Appetite Tolerance
SR01: There is a risk that the Trust does not provide high quality, inclusive care leading to avoidable harm, poorer patient outcomes and reduction in patient satisfaction	**Quality & Performance**	**MD**	**15** 5x3 C&L	**15** 5x3 CxL	**15** 5x3 CxL	**20** 5x4 CxL	**15** 5x3 CxL	**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	**16** 4x4 CxL	**16** 4x4 CxL	**12** 4x3 CxL	**12** 4x3 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**	**DoOps**	**15** 5x3 CxL	**15** 5x3 CxL	**15** 5x3 CxL	**15** 5x3 CxL	**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	**12** 4x3 CxL	**8** 4x2 CxL	**8** 4x2 CxL	**8** 4x2 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	**12** 4x3 CxL	**12** 4x3 CxL	**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**	**DoQ**	**15** 5x3 CxL	**15** 5x3 CxL	**15** 5x3 CxL	**10** 5x2 CxL	**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**	**DoSPT**	**8** 4x2 CxL	**8** 4x2 CxL	**8** 4x2 CxL	**8** 4x2 CxL	**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**	**DoQ/DoF**	**15** 5x3 CxL	**20** 5x4 CxL	**20** 5x4 CxL	**20** 5x4 CxL	**20** 5x4 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**	**DoSPT**	**10** 5x2 CxL	**10** 5x2 CxL	**10** 5x2 CxL	**10** 5x2 CxL	**10** 5x2 CxL	**10** 5x2 CxL	**6-12**
SR10: (**Sensitive Risk**):	**Resources**	**DoSPT**	**12** 4x3 CxL	**12** 4x3 CxL	**12** 4x3 CxL	**12** 4x3 CxL	**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	15	20	15	15	1-5
	5x3	5x3	5x3	5x4	5x3	5x3	
	CxL	CxL	CxL	CxL	CxL	CxL	
Risk Appetite	Exceeded	Exceeded	Exceeded	Exceeded	Exceeded	Exceeded	

RATIONALE FOR RISK SCORE: The risk score for the Q4 position of this BAF risk has decreased to 15. This is as a result of the improved position across all ARP standards, particularly C2 and de-escalation to REAP 2 on 17 March 2025. This year's C2 national target was to deliver 30 minutes which significantly exceeds ARP of 18 minutes. There is still significant regional variation in handover delays causing inequitable care delivery based on the geographical location of incidents and the predominant risk remains within the Cheshire and Mersey. All call performance remains consistently strong. Performance within 111 is now subject to withdrawal of national contingency support. Work on call before convey is ongoing across all 3 ICSs looking to drive improvements in See and Treat. All ACQIs remain above national average and work is ongoing to improve both hospital pre alerts and valuation of clinical decision support tools. The delivery of Duty of Candour and patient safety syllabus training continued to progress across the organisation, with plans to deliver a further cohort of accredited PSIRF training to selected roles. PSIRF priorities have been reviewed according to our risk profile and a new set of priorities will be in place for 25-26. The patient safety partner policy was approved in January 2025.

Projected Forecast Q1: Deteriorating / Stable / Improving

Rationale: Stable
The NHS will be out of winter period with improved hospital handover position and impact of weather/infectious diseases lessened.

CONTROLS	ASSURANCES	EVIDENCE
CLINICAL		
Clinical Audit	**Level 2:** Clinical Audit Tool (CAT) Outline Business Case	Reported to Trust Management Cttee TMC/2425/233 Reported to Board of Directors BoD/2425/69
QUALITY		
Progressing maturity of NHS Impact	Level 2: NHS IMPACT: Building NWAS Improvement Capability and Improvement Academy	Reported Trust Management Cttee TMC/2425/296
Patient Safety Strategy	**Level 2:** PSIRF Report Q2 24/25 **Level 2:** Proposed PSIRF Piorities and plan **Level 2:** Patient Safety Activity Q3 2024/25 **Level 2:** NHS Patient Safety Strategy Progress Update	Reported to Quality & Performance Cttee QPC/2425/083 Reported to Quality & Performance Cttee QPC/2425/084 Reported to Quality & Performance Cttee QPC/2425/107 Reported to Quality & Performance Cttee QPC/2425/108
Safety Education	**Level 2:** Patient Safety Activity Q3 2024/25 **Level 2:** NHS Patient Safety Strategy Progress Update	Reported to Quality & Performance Cttee QPC/2425/107 Reported to Quality & Performance Cttee QPC/2425/108
Variation in handover delays and process impacting patient safety	**Level 2:** Integrated Performance Report **Level 2:** Service Delivery Assurance Group 3A Report **Level 2:** Q&P Dashboard	Reported to Board of Directors BoD/2425/130 & BoD/2425/154 Reported to Trust Management Cttee TMC/2425/247 Reported to Quality & Performance Cttee QPC/2425/082
Implementation of Quality Strategy	**Level 2:** Annual Plan Assurance Q3 24/25	Reported to Resources Ctte RC/2425/125

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
QUALITY					
Local Quality Improvement Plans	*Service lines to develop local quality improvement plan focussed on safety, effectiveness and experience*	*Dr E Strachan-Hall / D Ainsworth*	*June 2025*	*Q&P Cttee*	*In Progress*
DIGITAL					
Insight and intelligence	*Integrated quality and performance reporting for service lines and sectors*	*Ms J Wharton*	*June 2025*	*TM Cttee*	*In Progress*

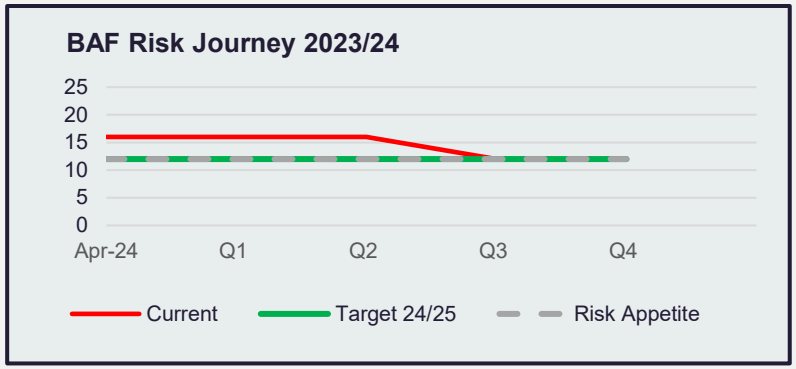
Operational Risks Scored 15+ Aligned to BAF Risk: SR01						
ERM ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
412	Operational/ Emergency Preparedness	There is a risk that, due to a lack of EPRR national occupational standards, training, exercising, and subsequent competency assurance, the EOC/ICC 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
507	Operational/ Emergency Preparedness	There is a risk that as a result of a major incident being declared, there are insufficient available resources to respond to the major incident which may lead to avoidable patient harm (quality outcomes).	20 High	15 High	⇩	5 Low
508	Operational/ Emergency Preparedness	There is a risk that as a result of a major incident being declared, there are insufficient available resources to respond to business as usual which may lead to avoidable patient harm (quality outcomes).	20 High	15 High	⇩	5 Low
440	Operational/ Operational Performance	There is a risk that due to NWAS clinicians receiving limited training in managing obstetric emergencies, there is a gap in knowledge and skills for clinicians to manage maternity and newborn care, potentially resulting in patient harm and non-compliance with MNSI safety recommendations.	20 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	16	16	12	12	12	6-12
	4x4	4x4	4x4	4x3	4x3	4x3	
	CxL	CxL	CxL	CxL	CxL	CxL	
Risk Appetite	Exceeded	Exceeded	Exceeded	Within	Exceeded	Within	

RATIONALE FOR CURRENT RISK SCORE:
At Q4 the risk score for the BAF risk remains at a score of 12. The actual year end financial position is better than the plan, and a significant proportion of the efficiency delivered, against the £15.5m target, is non-recurrent. The small shortfall on the delivery of recurrent efficiency (£0.3m) will be carried forward into the 2025/26 financial year.

Projected Forecast Q1:
Deteriorating
Stable
Improving

Rationale: Stable
With the improvement in Q3, the risk score will remain stable into Q4.

CONTROLS	ASSURANCES	EVIDENCE
Financial Performance	**Level 2:** Finance Report Month 9 24/25 **Level 2:** Update on 2024/25 Forecast, Exit Run Rate and First Cut 2025/26 financial plans **Level 2:** Resources Committee 3A Report **Level 2:** Finance Report Month 10 24/25 **Level 2:** Finance Report Month 11 24/25 **Level 2:** Going Concern	Reported to Trust Management Cttee TMC/2425/221 & Resources Cttee RC/2425/092 Reported to Board of Directors PBM/2425/67 Reported to Board of Directors BoD/2425/134 Reported to Trust Management Cttee TMC/2425/258 Reported to Resources Cttee RC/2425/117 Reported to Board of Directors PBM/2425/80
2025/26 Financial Planning	**Level 2:** Update on Financial Planning for 2025/26 **Level 2:** Draft Financial Plan 2025/26 **Level 2:** Update on 2024/25 Forecast, Exit Run Rate and First Cut 2025/26 financial plans **Level 2:** Final 2025/26 Financial Plans	Reported to Trust Management Cttee TMC/2425/222 Reported to Resources Cttee RC/2425/095 Reported to Board of Directors PBM/2425/67 Reported to Resources Committee RC/2425/117 & Board of Directors PBM/2425/79

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
FINANCE					
2025/26 Financial Planning	Receipt of 2025/26 planning guidance from NHSE	Ms C Wood	January 2025	Resources Cttee	Completed

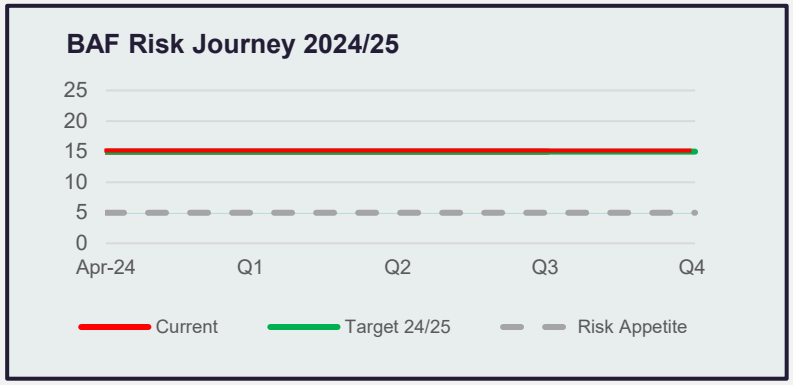
Operational Risks Scored 15+ Aligned to BAF Risk: SR02						
ERM ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
Commercially Sensitive Risk – FOI Act Section 43 – Commercial Interests						
317	Operational / People	**Sensitive Risk**	20 High	15 High	⇩	10 Moderate

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: DoOps

Risk Appetite Category: Quality Outcomes – Low



BAF RISK SCORE JOURNEY:

	01.04.24	Q1	Q2	Q3	Q4	24/25 Target	Risk Appetite
	15	15	15	15	15	15	1-5
	5x3	5x3	5x3	5x3	5x3	15x3	
	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 risk score of 15 primarily as a result of the delivery of the national ARP standards, which remained significantly challenged with C1 90th standard being met regionally. Hospital handover is 30 minutes with turnaround over 35 minutes, the more challenged area is Cheshire & Merseyside. The PTS contract award was not awarded, and the Trust remains on contract extension arrangements until 2026, whilst the Trust awaits commissioner advice regarding re-procurement. The PTS Improvement Group has agreed areas of priority and focus in order to address performance. 111 continued to perform well against contract KPIs and continued to deliver against the IUC Q4 trajectories.

Projected Forecast Q1:
Deteriorating
Stable
Improving

Rationale: Stable
Q4 commenced in a challenged position due to various critical incidents being declared across the systems however, seasonal variation has seen slight improvements in handover which have helped to improve performance which are expected to be maintained into Q1.

CONTROLS	ASSURANCES	EVIDENCE
Improve Hear and Treat Performance	**Level 2:** Q&P Dashboard **Level 2:** Integrated Performance Report **Level 2:** Service Delivery Assurance Group 3A Report	Reported to Quality & Performance Cttee QPC/2425/082 & QPC/2425/105 Reported to Board of Directors BoD/2425/130 & BoD/2425/154 Reported to Trust Management Cttee TMC/2425/247
Recruitment Plan Clinical Hub and Operational Staff (SR09)	**Level 2:** People and Culture Group 3A Report **Level 2:** Workforce Indicators Assurance Report **Level 2:** Integrated Performance Report	Reported to Trust Management Cttee TMC/2425/246 & TMC/2425/304 Reported to Resources Cttee RC/2425/101 & RC/2425/127 Reported to Board of Directors BoD/2425/130 & BoD/2425/154
Service Delivery Leadership Review (SR09)	**Level 2:** Board Assurance Framework Report **Level 2:** Culture Review – End of Year Update	Reported to Quality and Performance Cttee QPC/2425/081 Reported to Resources Cttee RC/2425/128

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Improve Hear and Treat Performance (Right Care Programme)	*Improve Hear and Treat Performance from 15% to 16.4%*	*Mr D Ainsworth*	*March 2026*	*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 D Ainsworth/ Mrs L Ward*	*March 2026*	*Q&P Cttee*	*In Progress*
ICC Integration and Restructure	*Delivery of Phase 3 of ICC Restructure*	*Mr D Ainsworth*	*June 2025*	*Q&P Ctte/Resources Cttee*	*In Progress*

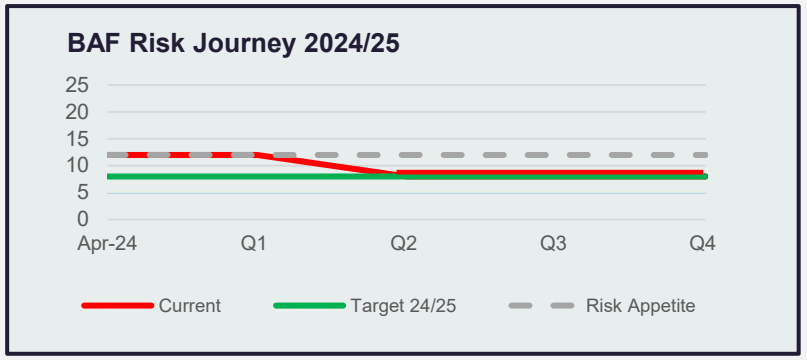
Operational Risks Scored 15+ Aligned to BAF Risk: SR03						
ERM ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
507	Operational/ Emergency Preparedness	There is a risk that as a result of a major incident being declared, there are insufficient available resources to respond to the major incident which may lead to avoidable patient harm (quality outcomes).	20 High	15 High	⇩	5 Low
508	Operational/ Emergency Preparedness	There is a risk that as a result of a major incident being declared, there are insufficient available resources to respond to business as usual which may lead to avoidable patient harm (quality outcomes).	20 High	15 High	⇩	5 Low

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	12	8	8	8	8	6-12
	4x3	4x3	4x2	4x2	4x2	4x2	
	CxL	CxL	CxL	CxL	CxL	CxL	
Risk Appetite	Within	Within	Within	Within		Below	Within

RATIONALE FOR CURRENT RISK SCORE: The Q4 position of this BAF risk has maintained a risk score of 8. Vacancy gaps are closing with PES and 111 both over-established at year end. Sickness absence remains above sector average, although an improving position and continues to impact on resource availability. On track to meet year end target improvement. Where vacancy gaps remain in EOC and PTS these are not impacting on the safety of service provision. Turnover improvement of 2.2% across the year. Previous areas of risk in 111 and EOC significantly improved across the year. Work to continue to improve retention in ICCs and PTS will translate into 2025/26 plans. The current score of 8 reflects the overall good position seen at the end of Q4 which indicates that safe staffing is being maintained. Where performance pressures have arisen as a result of system issues and not staff shortages.

Projected Forecast Q1:
Deteriorating
Stable
Improving

Rationale: Deteriorating
This BAF risk will merge with SR05 for 2025/26. The projected forecast is shown as deteriorating because 2025/26 will require additional UEC workforce growth leading to the implementation of challenging recruitment and training plans. As a result it would be normal practice for us to increase the level of risk at the start of the year until assurance is gained against delivery of those plans.

CONTROLS	ASSURANCES	EVIDENCE
Recruitment Plans	**Level 2:** Workforce Indicators Assurance Report **Level 2:** People and Culture Group 3A Report **Level 2:** International Recruitment Learning Review	Reported to Resources Cttee RC/2425/101 & RC/2425/127 Reported to Trust Management Committee TMC/2425/246 & 2425/304 Reported to Resources Cttee RC/2425/078
Retention Plans	**Level 2:** Workforce Indicators Assurance Report **Level 2:** People and Culture Group 3A Report	Reported to Resources Cttee RC/2425/101 & RC/2425/127 Reported to Trust Management Committee TMC/2425/246 & 2425/304
Attendance Improvement Teams – Improvement Plans	**Level 2:** Workforce Indicators Assurance Report **Level 2:** People and Culture Group 3A Report **Level 2:** Culture Review – End of Year Update	Reported to Resources Cttee RC/2425/077 Reported to Trust Management Cttee TMC/2425/195 Reported to Resources Cttee RC/2425/128
Flu Vaccination Programme	**Level 2:** Workforce Indicators Assurance Report	Reported to Resources Cttee RC/2425/101 & RC/2425/127

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Retention Plans	*Delivery of EOC Retention Plans*	*Ms L Ward*	*March 2026*	*Resources Cttee*	*Continuing*

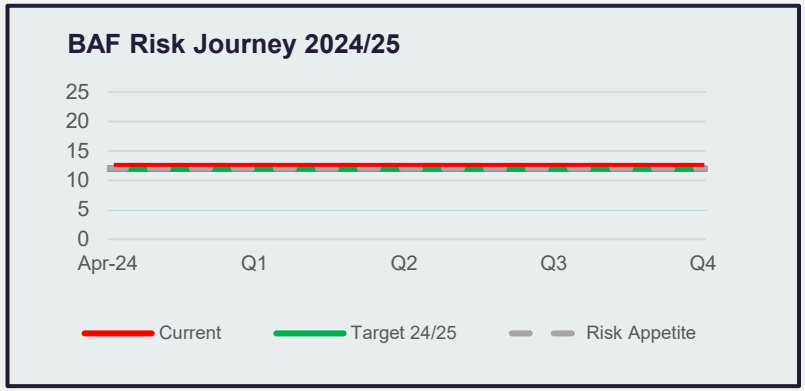
Operational Risks Scored 15+ Aligned to BAF Risk: SR04						
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
There are no operational risks scored 15+ aligned to this BAF risk						

BOARD ASSURANCE FRAMEWORK 2024/25

BAF RISK 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	12	12	12	12	6-12
	4x3	4x3	4x3	4x3	4x3	4x3	
	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 score of 12. Whilst 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 leadership review has been implemented and inductions delivered to all leaders; People Promise Manager has presented recommendations and workstreams for delivery have been mobilised, this work continues into 25/26; Disciplinary Policy evaluation and review complete; sexual safety campaign, partnership review continuing. Wellbeing Hub launched and revised induction launched incorporating senior leadership input with all new starters. Five culture focused leadership events held. 2024 staff survey response rate maintained at 48%, results indicate stable position with improvement across a number of areas acknowledged as one of best performing in NW. The current score of 12 reflects that retention and staff experience feedback is in an improving position. Gaps in assurance indicate the ongoing work in a number of areas. 25/26 BAF will indicate specified actions which will contribute to improving culture as reflected in the annual plan.

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
Culture Review	**Level 2:** Culture Review – End of Year Update	Reported to Resources Cttee RC/2425/128
People Promise Exemplar Programme	**Level 2:** People and Culture Group 3A Report **Level 2:** Culture Review – End of Year Update	Reported to Trust Management Cttee TMC/2425/304 Reported to Resources Cttee RC/2425/128
EDI Priorities	**Level 2:** Diversity & Inclusion 3A Report **Level 2:** Equality Delivery System Assessment 2024/25	Reported to Trust Management Cttee TMC/2425/272 Reported to Resources Cttee RC/2425/115
Wellbeing	**Level 2:** Culture Review – End of Year Update	Reported to Resources Cttee RC/2425/128
Sexual Safety Campaign	**Level 2:** Diversity and Inclusion Group 3A Report **Level 2:** Culture Review – End of Year Update	Reported to Trust Management Committee TMC/2425/272 Reported to Resources Cttee RC/2425/128
Service Delivery Leadership Review (SR09)	**Level 2:** Board Assurance Framework Report **Level 2:** Culture Review – End of Year Update	Reported to Quality and Performance Cttee QPC/2425/081 Reported to Resources Cttee RC/2425/128
Staff Survey	**Level 2:** Annual Staff Survey	Reported to Resources Cttee C/2425/114 and Board of Directors BoD/2425/152

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
EDI Priorities	Delivery of year 1 action of plan	Ms L Ward	2024/25	Resources Cttee	Complete
Partnership Agreement	*Implementation of revised Partnership Agreement*	*Ms L Ward*	*September 2026*	*Resources Cttee*	*In Progress*
Wellbeing	*Implementation of mental health improvement plans*	*Ms L Ward*	*March 2026*	*Resources Cttee*	*In Progress*

Leadership	Delivery of full Making a Difference Programme	Ms L Ward	March 2025	Resources Cttee	Complete
Sexual Safety	Process to support learner safety	Ms L Ward	March 2025	Resources Cttee	Complete
Culture Review *(Actions to continue from Annual Plan 25-26)*	*Deliver identified actions and support national work programme*	*Ms L Ward*	*2025/26*	*Resources Cttee*	*In Progress*
People Promise Exemplar Programme	*Deliver improvements in identified priority areas: flexible working; staff engagement*	*Ms L Ward*	*2025/26*	*Resources Cttee*	*In Progress*
Induction	Implement revised onboarding and induction	Ms L Ward	2024/25	Resources Cttee	Complete

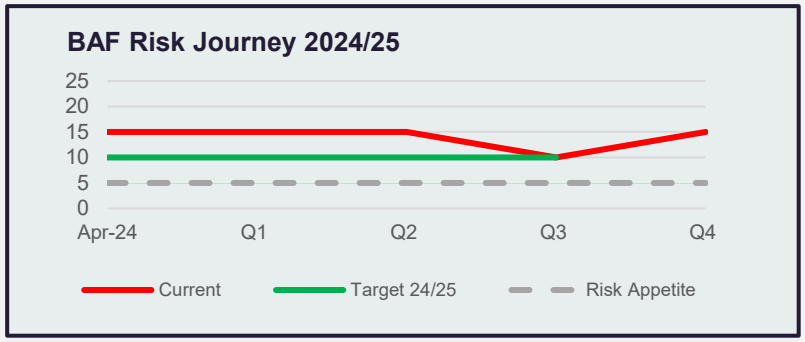
Operational Risks Scored 15+ Aligned to BAF Risk: SR05						
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
There are no operational risks scored 15+ aligned to this BAF risk						

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	15	15	10	15	10	1-5
	5x3	5x3	5x3	5x2	5x3	5x2	
	CxL	CxL	CxL	CxL	CxL	CxL	
Risk Appetite	Exceeded	Exceeded	Exceeded	Exceeded		Exceeded	Within

RATIONALE FOR CURRENT RISK SCORE: The risk score for the Q4 position of this BAF risk has increased to risk score of 15. Due to the changes with the CQC framework and the external and political regulatory landscape, the Trust is likely to be subject to additional scrutiny. Regular engagement meetings continue with the CQC relationship manager. Quality audits are now being undertaken with area assurance meetings offered with variation in engagement across the Trust. Mandatory training and appraisal compliance is achieving targets. An internal audit review took place during Q4 on the Patient Safety Incident Response Framework (PSIRF) and forms part of a regional audit. The risk associated with controlled drugs licensing remains at a risk score of 15.

Projected Forecast Q4: Deteriorating / Stable / Improving

Rationale: Deteriorating
The external and political regulatory landscape changes are likely to lead to additional scrutiny

CONTROLS	ASSURANCES	EVIDENCE
PEOPLE		
Appraisal and Mandatory Training Compliance 2024/25	**Level 2:** Integrated Performance Report **Level 2:** People and Culture Group 3A report **Level 2:** Workforce Indicators Report	Reported Board of Directors BoD/2425/101 & RC/2425/127 Reported to Trust Management Cttee TMC/2425/246 & 2425/304 Reported to Resources Cttee RC/2425/101 & RC/2425/127
QUALITY & SAFETY IMPROVEMENTS		
Duty of Candour	**Level 2:** Clinical and Quality 3A Report **Level 2:** Service Delivery Assurance Group	Reported to Trust Management Cttee TMC/2425/274 Reported to Trust Management Cttee TMC/2425/247
Medicines Management	**Level 2:** Medicines Management OBC **Level 2:** Medicines Management Report Q2 24/25 **Level 2:** Designated Body Controlled Drugs Accountable Officer (CDAO) Improvement Framework – Self Assessment Submission	Reported to Board of Directors PBM/2425/69 Reported to Quality & Performance Cttee QPC/2425/086 Reported to Quality & Performance Cttee QPC/2425/110 & Board of Directors BoD/2425/155
Information Governance	**Level 2:** Information Governance and Cyber Group 3A Report **Level 2:** Digital Strategy Update	Reported to Trust Management Cttee TMC/2425/302 Reported to Resources Cttee RC/2425/099 & RC/2425/126
Essential Checks	**Level 2:** Service Delivery Assurance Group 3A Report	Reported to Trust Management Cttee TMC/2425/197
Digital Clinical Safety (Creation of digital safety procedures)	**Level 2:** Information Governance & Cyber Group 3A Report	Reported to Trust Management Cttee TMC/2425/302

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
QUALITY & SAFETY IMPROVEMENTS					
Essential Checks	*Improve compliance of vehicle and equipment checks*	*Dr E Strachan-Hall / Mr D Ainsworth*	*March 2025*	*Q&P Cttee*	*Completed*
Digital Clinical Strategy	*Completion of digital clinical safety process on Electronic Patient Record*	*Ms J Wharton*	*June 2025*	*Q&P Cttee*	*In Progress*

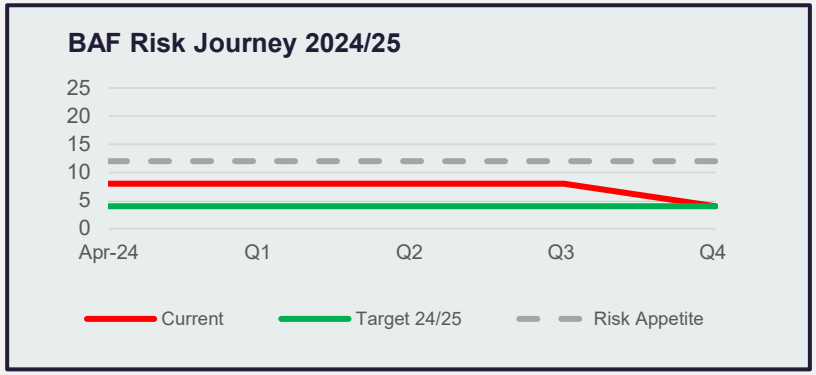
Operational Risks Scored 15+ Aligned to BAF Risk: SR06						
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
318	Operational/ Patient Safety	There is a risk that due to the variation in security provisions at ambulance bases where 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.	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: DoSPT

Risk Appetite Category: Reputation – Moderate



BAF RISK SCORE JOURNEY:

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

RATIONALE FOR CURRENT RISK SCORE: The risk score for Q4 position of this BAF risk has improved to a risk score 4. There is more evidence and assurance of engagement that is being undertaken across the areas including increased utilisation of the Knowledge Vault across all areas.

Projected Forecast Q4: Deteriorating / Stable / Improving

Rationale: Improving
The forecast for Q4 was projected to improve and will be taken forward into the opening position of the 25-26 Board Assurance Framework.

CONTROLS	ASSURANCES	EVIDENCE
Knowledge Vault	Level 2: Bi-annual Assurance Report: Stakeholder Engagement	Reported to Board of Directors: BOD/2425/159
External Engagement Assurance	Level 2:Bi-annual Assurance Report: Stakeholder Engagement	Reported to Board of Directors: BOD/2425/159

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
External Engagement Assurance	*Collate evidence of the impact of our stakeholder engagement*	*DoSP*	*July 2025*	*BoD*	*In Progress*

Operational Risks Scored 15+ Aligned to BAF Risk: SR07

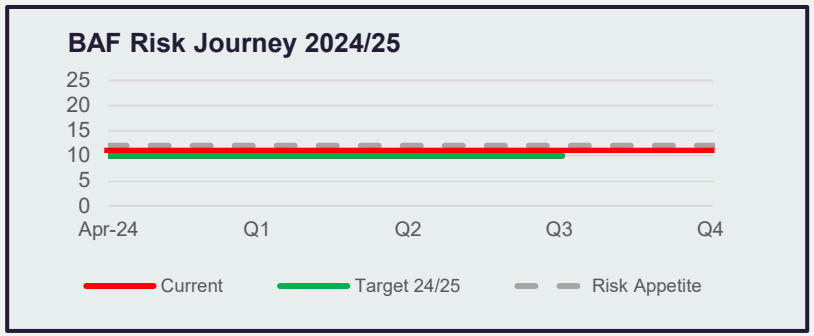
Datix ID	Directorate	Risk Description	Initial Score	Current Score	Trend Analysis	Target Score
There are no operational risks scored 15+ aligned to this BAF risk						

BOARD ASSURANCE FRAMEWORK 2024/25

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

Executive Director Lead: DoSPT

Risk Appetite Category: Reputation – Moderate



BAF RISK SCORE JOURNEY:

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

RATIONALE FOR CURRENT RISK SCORE: The risk score for the Q4 position of this BAF risk remains at a score of 10 due to hospital handover delays that continue 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. At the time of completion, performance is positive and at REAP 2, indicates demand performance reasonable very localised strike action that attracted media action however this was managed as business as usual.

Projected Forecast Q1:
Deteriorating
Stable
Improving

Rationale: Not Applicable
No strategic risk identified for 25/26.

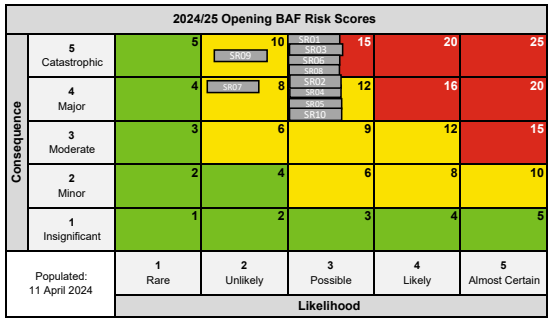
CONTROLS	ASSURANCES	EVIDENCE
Communications and Engagement Dashboard	**Level 2:** Q3 2024-25 Assurance	Reported to Board of Directors BoD/2425/135
Recruitment Plan Clinical Hub and Operational Staff (SR09)	**Level 2:** People and Culture 3A Report **Level 2:** Workforce Indicators Assurance Report **Level 2:** Integrated Performance Report	Reported to Trust Management Cttee TMC/2425/195 Reported to Resources Cttee RC/2425/077 Reported to Board of Directors BoD/2425/108
Service Delivery Leadership Review	**Level 2:** Board Assurance Framework Report **Level 2:** Culture Review – End of Year Update	Reported to Quality and Performance Cttee QPC/2425/081 Reported to Resources Cttee RC/2425/128

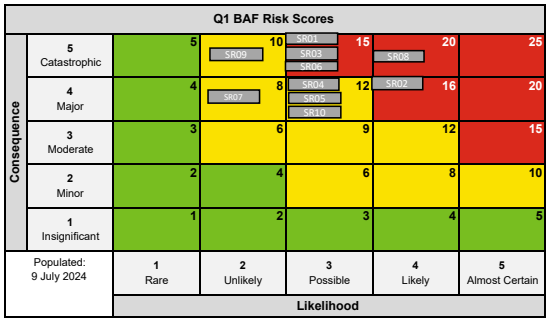
Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Recruitment Plan Clinical Hub and Operational Staff	*Robust recruitment plan to be delivered*	*Mr D Ainsworth/ Mrs L Ward*	*March 2026*	*Resources Cttee*	*In Progress*

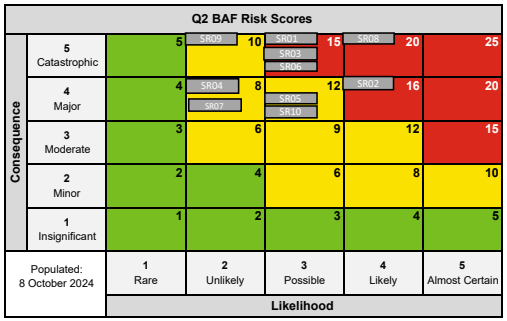
Operational Risks Scored 15+ Aligned to BAF Risk: SR09

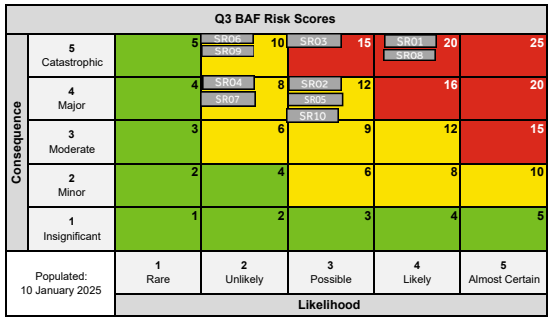
Datix ID	Directorate	Risk Description	Initial Score	Current Score	Trend Analysis	Target Score
There are no operational risks scored 15+ aligned to this BAF risk						

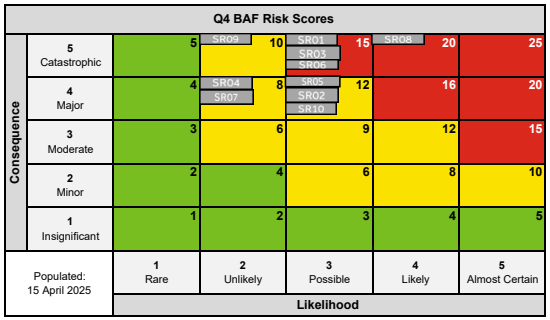
Appendix 2:
2024/25 Board Assurance Framework (BAF) Heat Maps
Q4 Position

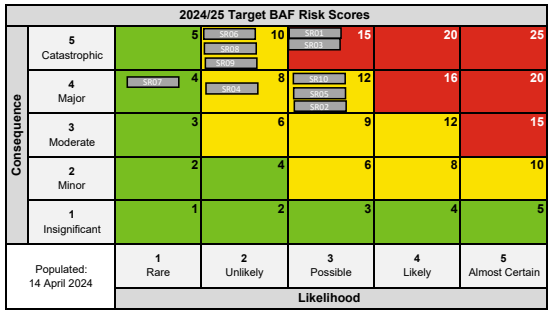


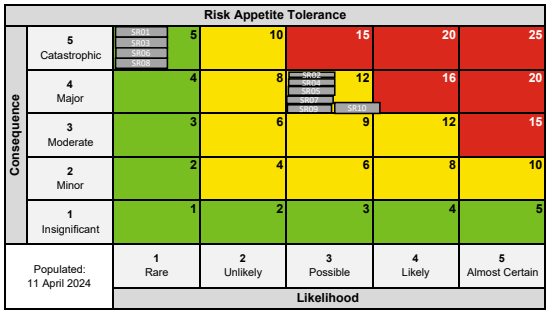












NHS
North West
Ambulance Service
NHS Trust

REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 30 April 2025
SUBJECT	Opening Position of the Board Assurance Framework 2025/26
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**	☒	**SR11**	☐

Risk Appetite Statement *(Decision Papers Only)*	Compliance/ Regulatory	☒	Quality Outcomes	☒	Cyber Security	☒	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 2025/26.
EXECUTIVE SUMMARY	The proposed 2025/26 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, with further detail and rationale provided in s2: • SR01 opening risk score of 15 • SR02 opening risk score of 16 • SR03 opening risk score of 12 • SR04 opening risk score of 15 • SR05 opening risk score of 12 • SR06 opening risk score of 15 • SR07 opening risk score of 12 • SR08 opening risk score of 20 • SR09 opening risk score of 15
PREVIOUSLY CONSIDERED BY	Trust Management Committee & Audit Committee
	Date: 23rd April 2025 & 25th April 2025
	Outcome: TMC recommended to Board for approval

1. BACKGROUND

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

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 achievement 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 2025/26 OPENING POSITION

The proposed 2025/26 strategic risks were approved at the March 2025 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.

The following proposed opening risk scores are as follows:

SR01: There is a risk that if the Trust does not provide the right care, at the right time, in the right place, this may lead to avoidable harm and/or poorer outcomes and experience for patients

Opening Score 01.04.2025	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:

- Delivery against ARP standards remains highly challenged.
- Expectation that C2 mean 28 minutes will be 2025-26 target against ARP 18 minutes.
- Significant NHS wide operational pressures leading to reconfigurations and unstable hospital handover performance

SR02: There is a risk that if the Trust does not achieve financial sustainability, its ability to deliver high quality (safe and effective) services will be affected

Opening Score 01.04.2025	Exec Director Lead
16 4x4 CxL	Ms C Wood Director of Finance

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

- Balanced draft financial plan submitted
- Risk within the plans as the full efficiency plans need developing to support delivery of £14.9m efficiency target.

SR03: There is a risk that if the Trust does not deliver against NHS net zero targets, it will impact on the Trust's ability to contribute towards environmental improvements and delivery of its Green Plan

Opening Score 01.04.2025	Exec Director Lead
12 3x4 CxL	Ms C Wood Director of Finance

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

- Refresh of Green Plan during Q1

SR04: There is a risk that if the Trust does not deliver improved sustained national and local operational performance standards across all services, patients may experience delayed care and/or suffer harm

Opening Score 01.04.2025	Exec Director Lead
15 5x3 CxL	Mr D Ainsworth Director of Operations

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

- Delivery of national ARP standards remain challenged, some improvement in handover and long waits.
- Sustained 111 performance
- Information awaited from ICBs relating to procurement of PTS contract

SR05: There is a risk that if the Trust does not create an inclusive environment and look after its people's wellbeing, safety and development, then it will be unable to attract, retain and maximise the potential of its workforce for the benefit of patients.

Opening Score 01.04.2025	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:

- Challenging requirements for growth; continued focus on recruitment, development and culture improvement.

SR06 There is a risk that a breach of legislative or regulatory standards could result in avoidable harm and/or regulatory action

Opening Score 01.04.2025	Exec Director Lead
15 5x3 CxL	Mrs A Wetton – Director of Corporate Affairs Dr E Strachan-Hall - Director of Quality

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

- Changes with the CQC framework
- Recent whistleblowing request
- External and political regulatory landscape and likelihood of Trust being subject to additional scrutiny

SR07: There is a risk that due to the geographical size of the Trust it will be unable to effectively engage with its numerous system partners which may impact on its ability to achieve the medium-long-term plan

Opening Score 01.04.2025	Exec Director Lead
12 4x3 CxL	Mrs A Ormerod Interim Deputy Director of Strategy, Integration & Partnerships

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

- Turbulence in the system partner environment (NHSE and ICBs)
- Horizon scanning across the system continues to detect early signs of development, potential threats and opportunities which are shared with internal stakeholders.
- Sector wide engagement with AACE and NAA to work collaboratively

SR08: There is a risk that if the Trust suffers a cyber incident, it could result in an inability to deliver a service and associated harm.

Opening Score 01.04.2025	Exec Director Lead
20 5x4 CxL	Ms C Wood Director of Finance

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

- Persistent threat of cyber-attacks, global unrest and continued attacks across the public sector.
- Recognise that any changes from DHSC and NHSE has the potential to impact on support.

SR09: There is a risk that the recent planned changes around the Board over the next 12 months could destabilise the organisation and impact delivery of strategic plans.

Opening Score 01.04.2025	Exec Director Lead
15 5x3 CxL	Mrs A Wetton, Director of Corporate Affairs Mr S Desai, Chief Executive

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

- New Chair expected to take up post during late Q1/early Q2
- 2x NED final Terms of Office end during 2025 calendar year
- New Director of Strategy and Partnerships following CEO appointment during Q4 2024/25
- New Director of Quality following the previous Director leaving the trust 31 March 2025.

4. 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.

5. ACTION REQUIRED

The Board of Directors is asked to:

- Approve the 2025/26 Opening Position of the BAF.

North West Ambulance Service NHS Trust

BOARD ASSURANCE FRAMEWORK
2025/26

Proposed Opening Position

Board of Directors – Part 1

30th April 2025

Opening Position Reporting Timescales:

Trust Management Cttee:	23/04/2025
Audit Cttee:	25/04/2025
Resources Cttee:	22/05/2025
Board of Directors:	28/05/2025
Quality & Performance Cttee:	30/06/2025

BOARD ASSURANCE FRAMEWORK KEY

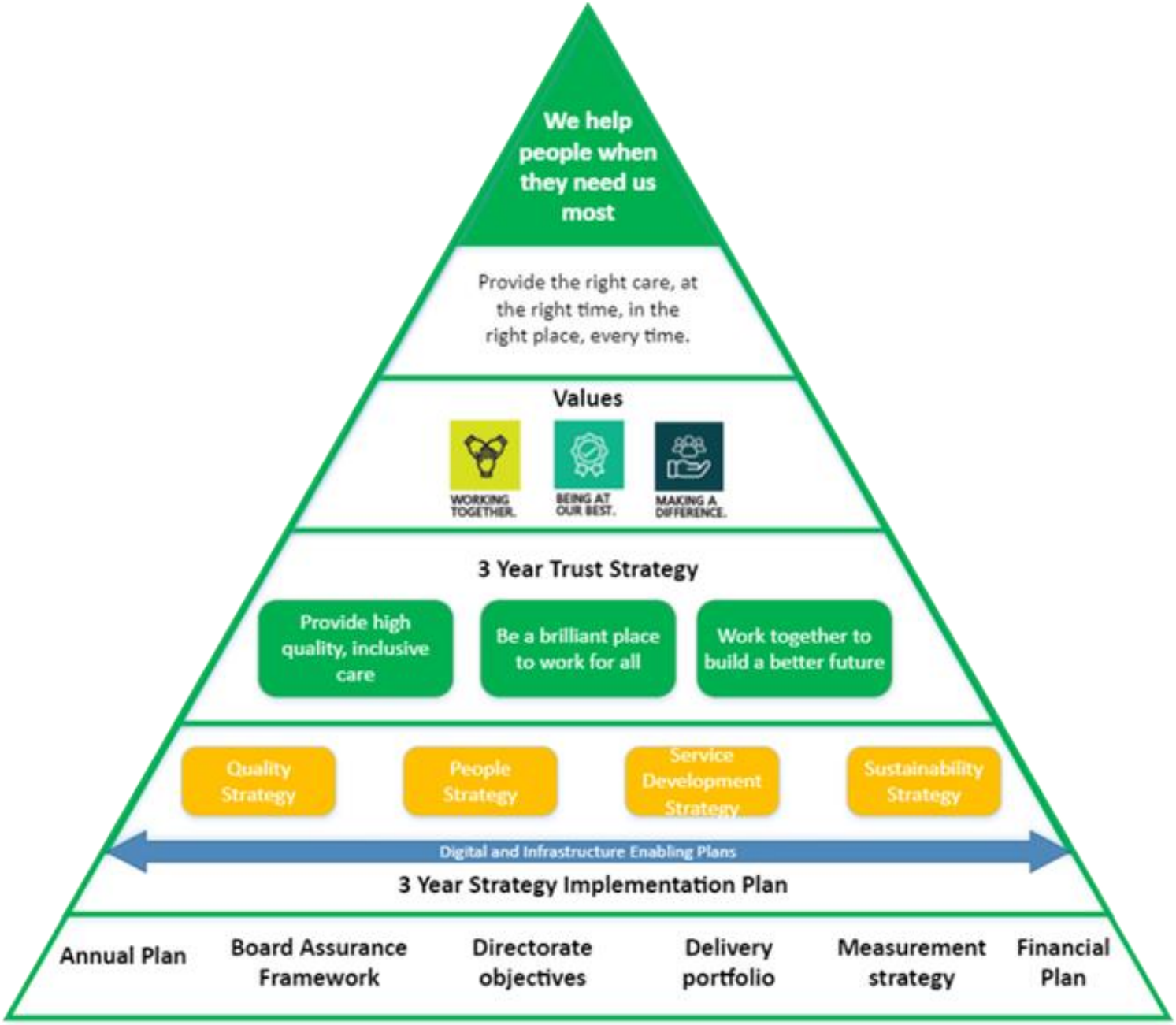
Risk Rating Matrix (Likelihood x Consequence)

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
DoQI	Director of Quality and Improvement
MD	Medical Director
DoF	Director of Finance
DoO	Director of Operations
DoP	Director of People
DoCA	Director of Corporate Affairs
DoSP	Director of Strategy & Partnerships

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

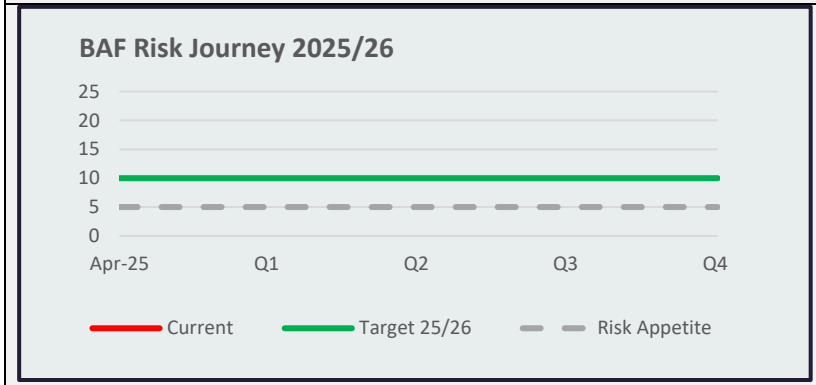
BOARD ASSURANCE FRAMEWORK DASHBOARD 2025/26

BAF Risk	Committee	Exec Lead	01.04.25	Q1	Q2	Q3	Q4	2025/26 Target	Risk Appetite Tolerance
SR01: There is a risk that if the Trust does not provide the right care, at the right time, in the right place, this may lead to avoidable harm and/or poorer outcomes and experience for patients	**Quality & Performance**	**MD**	**15** 5x3 CxL					**10** 5x2 CxL	**1-5**
SR02: There is a risk that if the Trust does not achieve financial sustainability, its ability to deliver high quality (safe and effective) services will be affected	**Resources**	**DoF**	**16** 4x4 CxL					**12** 4x3 CxL	**6-12**
SR03: There is a risk that if the Trust does not deliver against NHS net zero targets, it will impact on the Trust's ability to contribute towards environmental improvements and delivery of its Green Plan	**Resources**	**DoF**	**12** 3x4 CxL					**9** 3x3 CxL	**6-12**
SR04: There is a risk that if the Trust does not deliver improved sustained national and local operational performance standards across all services, patients may experience delayed care and/or suffer harm	**Quality & Performance**	**DoO**	**15** 5x3 CxL					**15** 5x3 CxL	**1-5**
SR05: There is a risk that if the Trust does not create an inclusive environment and look after its people's wellbeing, safety and development, then it will be unable to attract, retain and maximise the potential of its workforce for the benefit of patients.	**Resources**	**DoP**	**12** 4x3 CxL					**12** 4x3 CxL	**6-12**
SR06 There is a risk that a breach of legislative or regulatory standards could result in avoidable harm and/or regulatory action	**Quality & Performance**	**DoQ/DoCA**	**15** 5x3 CxL					**10** 5x2 CxL	**1-5**
SR07: There is a risk that due to the geographical size of the Trust it will be unable to effectively engage with its numerous system partners which may impact on its ability to achieve the medium-long-term plan	**Resources**	**DoSP**	**12** 4x3 CxL					**12** 4x3 CxL	**6-12**
SR08: There is a risk that if the Trust suffers a cyber incident, it could result in an inability to deliver a service and associated harm.	**Resources**	**DoF**	**20** 5x4 CxL					**15** 5x3 CxL	**1-5**
SR09: There is a risk that the recent planned changes around the Board over the next 12 months could destabilise the organisation and impact delivery of strategic plans.	**Board**	**CE/ DoCA**	**15** 5x3 CxL					**5** 5x1 CxL	**1-5**
SR10: Sensitive Risk:	**Resources**	**DoSP**	**12** 4x3 CxL					**12** 4x3 CxL	**6-12**
SR11: Sensitive Risk:	**Resources**	**DoF**	**16** 4x4 CxL					**8** 4x2 CxL	**6-12**

BOARD ASSURANCE FRAMEWORK 2025/26

BAF RISK SR01:
There is a risk that if the Trust does not provide the right care, at the right time, in the right place, this may lead to avoidable harm and/or poorer outcomes and experience for patients

Executive Director Lead:	MD
Strategic Aim:	Provide high quality inclusive care
Risk Appetite Category:	Quality Outcomes – Low



BAF RISK SCORE JOURNEY:

	01.04.25	Q1	Q2	Q3	Q4	25/26 Target	Risk Appetite
	15					10	1-5
	5x3					5x2	
	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 is a risk score of 15. Delivery against statutory ARP remains highly challenged with an expectation that C2 mean of approximately 28 minutes will be this year's target against ARP of 18 minutes. Significant NHS wide operational pressures likely to see significant reconfigurations and unstable hospital handover performance. Demand across 111 and 999 service lines may rise as a result of these wider regional pressures.

Projected Forecast Q1: Deteriorating / Stable / Improving

Rationale: Stable
The NHS will be out of winter period with improved hospital handover position and impact of weather/infectious diseases lessened.

CONTROLS →	ASSURANCES →	EVIDENCE

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
CLINICAL					
Deliver Right Care Programme	Quality Impovement Academy – Cohort 1: Evaluate outcomes to adopt learning across NWAS	Dr C Grant / D Ainsworth	June 2025	TM Cttee	In Progress
Improve the input, analysis and utilisation of data which provides intelligence on population health and health inequalities	Develop Phase 2 of population health dashbaord.	Dr C Grant / J Wharton	September 2025	TM Cttee	In Progress
	Use current data to identify improvement initiatives to improve equity of access, experience and outcomes for patients.	Dr C Grant	September 2025	TM Cttee	In Progress
	Produce stakeholder engagement map of current public health, population health and anchor groups/networks across the regions	Dr C Grant	September 2025	TM Cttee	In Progress
QUALITY					
Focus on delivering national and local priorities in line with PSIRF	Establish improvement plans associated with local and national priorities	Dr E Strachan-Hall	December 2025	Q&P Cttee	In Progress
Delivery of improvement against local PSIRF priority (mental capacity)	Delivery of improvement against local PSIRF priority (mental capacity)	Dr E Strachan-Hall	March 2026	Q&P Cttee	In Progress
Delays in responding to patients in mental health crisis	Training needs analysis Mental health	Dr E Strachan-Hall	October 2025	Q&P Cttee	In Progress
	Mental Health Oversight Group to be established	Dr E Strachan-Hall	April 2025	TM Cttee	In Progress
	Mental health strategic plan implementation	Dr E Strachan-Hall	October 2025	Q&P Cttee	In Progress

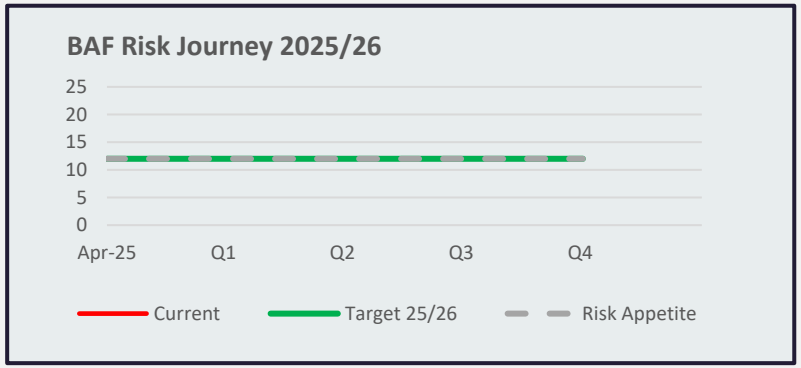
Local Quality Improvement Plans	Service lines to develop local quality improvement plan focussed on safety, effectiveness and experience	Dr E Strachan-Hall / D Ainsworth	June 2025	Q&P Cttee	In Progress
DIGITAL					
Insight and Intelligence	*Integrated quality and performance reporting for service lines and sectors*	*Ms J Wharton*	*June 2025*	*TM 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 EPRR national occupational standards, training, exercising, and subsequent competency assurance, the EOC/ICC 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
507	Operational/ Emergency Preparedness	There is a risk that as a result of a major incident being declared, there are insufficient available resources to respond to the major incident which may lead to avoidable patient harm (quality outcomes).	20 High	15 High	⇩	5 Low
508	Operational/ Emergency Preparedness	There is a risk that as a result of a major incident being declared, there are insufficient available resources to respond to business as usual which may lead to avoidable patient harm (quality outcomes).	20 High	15 High	⇩	5 Low
440	Operational/ Operational Performance	There is a risk that due to NWAS clinicians receiving limited training in managing obstetric emergencies, there is a gap in knowledge and skills for clinicians to manage maternity and newborn care, potentially resulting in patient harm and non-compliance with MNSI safety recommendations.	20 High	15 High	⇩	5 Low

BOARD ASSURANCE FRAMEWORK 2025/26

BAF RISK SR02:
There is a risk that if the Trust does not achieve financial sustainability, its ability to deliver high quality (safe and effective) services will be affected

Executive Director Lead:	DoF
Strategic Aim:	Work together to shape a better future
Risk Appetite Category:	Finance/ VfM – Moderate



BAF RISK SCORE JOURNEY:

	01.04.25	Q1	Q2	Q3	Q4	25/26 Target	Risk Appetite
	16					12	6-12
	4x4					4x3	
	CxL	CxL	CxL	CxL	CxL	CxL	
Risk Appetite						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 the full efficiency plans are yet to be fully developed to support delivery of the £14.9m efficiency target.

Projected Forecast Q1: Deteriorating / Stable / Improving

Rationale: Stable
Improvement in the development and delivery of efficiency plans will support a reduction in the risk score. Monthly forecasting will continue from month 1 reporting to the ICB.

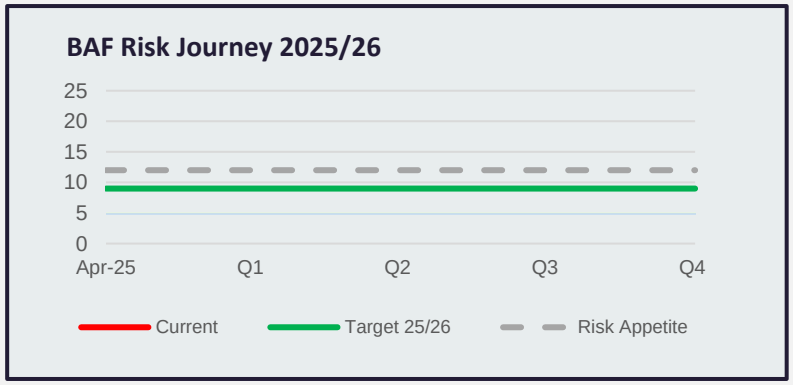
CONTROLS →	ASSURANCES →	EVIDENCE

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
FINANCE					
Final 2025/26 financial plans	Final 2025/26 financial plan	Ms C Wood	May 2025	Resources Cttee / BoD	Not Commenced
2026/27 Financial Planning	Receipt of 2026/27 planning guidance from NHSE	Ms C Wood	January 2026	Resources Cttee	Not Commenced
	Draft 2026/27 Financial Plan (Revenue & Capital)	Ms C Wood	March 2027	Resources Cttee / BoD	Not Commenced
	Approval of 2026/27 Financial Plans by Resources Cttee & BoD	Ms C Wood	March 2027	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**
Commercially Sensitive Risk – FOI Act Section 43 – Commercial Interests						
317	Operational / People	**Sensitive Risk**	20 High	15 High	⇩	10 Moderate

BOARD ASSURANCE FRAMEWORK 2025/26

BAF RISK SR03: There is a risk that if the Trust does not deliver against NHS net zero targets, it will impact on the Trust's ability to contribute towards environmental improvements and delivery of its Green Plan	**Executive Director Lead:**	DoF
	Strategic Aims:	Work together to shape a better future
	Risk Appetite Category:	Finance/ VfM – Moderate



BAF RISK SCORE JOURNEY:

	01.04.25	Q1	Q2	Q3	Q4	25/26 Target	Risk Appetite
	12					9	6-12
	3x4					3x3	
	CxL	CxL	CxL	CxL	CxL	CxL	
Risk Appetite	Within					Within	Within

RATIONALE FOR CURRENT RISK SCORE: The risk score for the opening position is 12.

Projected Forecast Q1: Deteriorating
Stable
Improving

Rationale: Stable
No significant changes are expected over the course of the first quarter.

CONTROLS →	ASSURANCES →	EVIDENCE

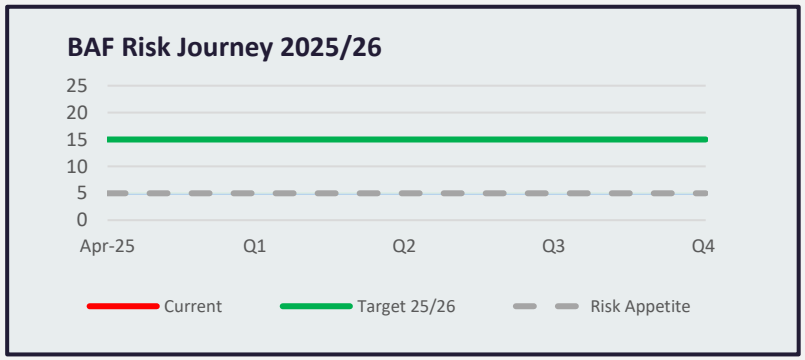
Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Refreshed Green Plan following publication of guidance in February 2025	Approval of Green Plan by Board of Directors	C Wood	May 2025	BoD	In Progress

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 2025/26

BAF RISK SR04:
There is a risk that if the Trust does not deliver improved sustained national and local operational performance standards across all services, patients may experience delayed care and/or suffer harm

Executive Director Lead:	DoO
Strategic Aim:	Provide high quality inclusive care
Risk Appetite Category:	Quality Outcomes – Low



BAF RISK SCORE JOURNEY:

	01.04.25	Q1	Q2	Q3	Q4	25/26 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 this BAF risk is 15 primarily as a result of the Q4 closing position i.e. although there are some improvements in handover and with long waits, national ARP standards remain challenged. 111 performance is expected to be sustained. The Trust awaits information from ICBs in respect of their intention for procurement of the PTS contract(s).

Projected Forecast Q1: Deteriorating / Stable / Improving

Rationale: Stable
Seasonal variation has seen slight improvements in handover which have helped to improve performance which are expected to be maintained into Q1.

CONTROLS →	ASSURANCES →	EVIDENCE

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Recruitment Plan Clinical Hub and Operational Staff	*Robust recruitment plan to be delivered to maximise resources to the most efficient level*	*Mr D Ainsworth / Mrs L Ward*	*March 2026*	*Q&P Cttee*	*In Progress*
ICC Integration Restructure	*Delivery of Phase 3 of ICC Restructure*	*Mr D Ainsworth*	*June 2025*	*Q&P Cttee / Resources Cttee*	*In Progress*
Review current care delivery model	Create a current state map of flow through the organisation from the patient perspective	Mr D Ainsworth	September 2025	*Q&P Cttee / Resources Cttee*	*In Progress*
Improve patient outcomes	Generate ideas for change utilising best practice and national learning/priorities	Mr D Ainsworth	December 2025	*Q&P Cttee / Resources Cttee*	*In Progress*
Develop long term roadmap to deliver initiatives	Highlight short-term initiatives and create a plan	Mr D Ainsworth	March 2026	*Q&P Cttee / Resources Cttee*	*In Progress*
Right Care Programme of Work	Implement and embed workstreams within the Right Care Porgramme	Mr D Ainsworth	March 2026	*Q&P Cttee / Resources Cttee*	*In Progress*
Deliver PTS Improvement Programme	Deliver workforce and operational delivery workstreams	Mr D Ainsworth	March 2026	*Q&P Cttee / Resources Cttee*	*In Progress*
Delivery of UEC Plan 25-26	Agreement of funding with NHSE	Mr D Ainsworth	June 2025	TM 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**
507	Operational/ Emergency Preparedness	There is a risk that as a result of a major incident being declared, there are insufficient available resources to respond to the major incident which may lead to avoidable patient harm (quality outcomes).	20 High	15 High	⇩	5 Low
508	Operational/ Emergency Preparedness	There is a risk that as a result of a major incident being declared, there are insufficient available resources to respond to business as usual which may lead to avoidable patient harm (quality outcomes).	20 High	15 High	⇩	5 Low

BOARD ASSURANCE FRAMEWORK 2025/26

BAF RISK SR05:
There is a risk that if the Trust does not create an inclusive environment and look after its people's wellbeing, safety and development, then it will be unable to attract, retain and maximise the potential of its workforce for the benefit of patients.

Executive Director Lead:	DoP
Strategic Aim:	Be a brilliant place to work for all
Risk Appetite Category:	People - Moderate

BAF RISK SCORE JOURNEY:

	01.04.25	Q1	Q2	Q3	Q4	25/26 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. This BAF is a merger of the safe staffing and culture risks on the 24/25 BAF. Overall there are challenging requirements for continued growth this year which will require continued focus on recruitment, development and culture improvement. Whilst there are clear plans in place to continue deliver improvements, these will take time to deliver a step change.

Projected Forecast Q1: **Deteriorating**
Stable
Improving

Rationale: **Stable**
Expected to remain stable with continuing incremental improvements.

CONTROLS →	ASSURANCES →	EVIDENCE

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
EDI Priorities	Delivery of agreed 25/26 workforce related actions	Ms L Ward	March 2026	Resources Committee	In Progress
Sexual Safety	Delivery of planned work programme	Ms L Ward	March 2026	Resources Committee	In Progress
Partnership Agreement	*Implementation of revised Partnership Agreement*	*Ms L Ward*	*September 2026*	*Resources Cttee*	*In Progress*
Wellbeing	*Implementation of mental health improvement plans*	*Ms L Ward*	*March 2026*	*Resources Cttee*	*In Progress*
Learner safety	Progress implementation of Safe Learning Environment Charter	Ms L Ward	March 2026	Resources Committee	Not Commenced
People Promise Exemplar Programme	*Deliver improvements in identified priority areas: flexible working; staff engagement*	*Ms L Ward*	*2025/26*	*Resources Cttee*	*In Progress*
Vacancy position	Delivery 2025/26 recruitment and training plan	Ms L Ward	March 2026	Resources Committee	In Progress
Leadership	Continue to enhance compassionate leadership in support of culture change	Ms L Ward	March 2026	Resources Committee	In Progress
Attendance	Deliver continued improvement in attendance	Ms L Ward	March 2026	Resources Committee	In Progress
Retention Plans	*Delivery of EOC Retention Plans*	*Ms L Ward*	*March 2026*	*Resources Cttee*	In Progress

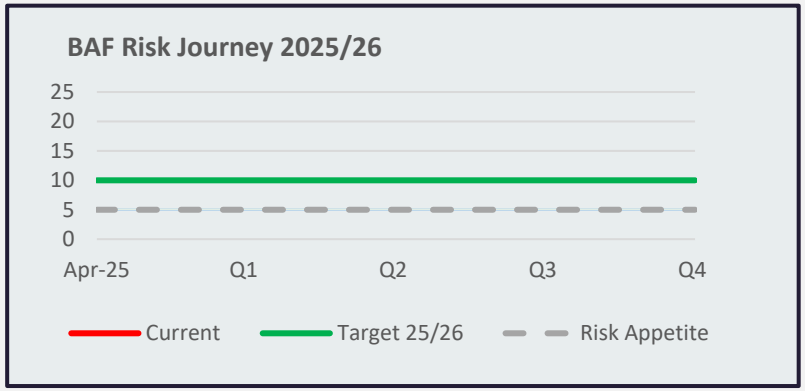
Operational Risks Scored 15+ Aligned to BAF Risk: SR05

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 2025/26

BAF RISK SR06:
There is a risk that a breach of legislative or regulatory standards could result in avoidable harm and/or regulatory action

Executive Director Lead:	DoQ/DoCA
Strategic Aims:	Provide high quality inclusive care Be a brilliant place to work for all Work together to shape a better future
Risk Appetite Category:	Compliance & Regulatory – Low



BAF RISK SCORE JOURNEY:

	01.04.25	Q1	Q2	Q3	Q4	25/26 Target	Risk Appetite
	15					10	1-5
	5x3					5x2	
	CxL	CxL	CxL	CxL	CxL	CxL	
Risk Appetite	Exceeded						Low

RATIONALE FOR CURRENT RISK SCORE: The risk score for the opening position of this BAF risk is 15 due to the changes with the CQC framework and recent whistleblowing request and the external and political regulatory landscape, the Trust is likely to be subject to additional scrutiny. Regular engagement meetings need to be established with the Interim Director of Quality with the CQC relationship manager.

Projected Forecast Q1: Deteriorating
Stable
Improving

Rationale: Deteriorating
The external and political regulatory landscape changes are likely to lead to additional scrutiny

CONTROLS →	ASSURANCES →	EVIDENCE

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
QUALITY & SAFETY IMPROVEMENTS					
Continue to strengthen our delivery against the CQC assessment framework and well-led in readiness for future inspection	Developmental well-led review	Dr E Strachan-Hall	September 2025	Q&P Cttee	In Progress
	Development programme for new board and senior leaders to familiarise with CQC assessment framework	Dr E Strachan-Hall	July 2025	Q&P Cttee	In Progress
	Desktop exercises for mock CQC inspection for senior leaders & leadership teams	Dr E Strachan-Hall	September 2025	Q&P Cttee	Not commenced
	Review and amend quality assurance visits aligned with new Chief Executive Officer (CEO) accountability reviews	Dr E Strachan-Hall	March 2026	Q&P Cttee	Not commenced
Essential Checks	*Review process and assurance of vehicle and equipment checks and components of actions submitted to CQC*	*Dr E Strachan-Hall*	*June 2025*	*TM Cttee*	*In Progress*
Improve the processes associated with medicines management including controlled drugs	Procure medicines management system	Dr C Grant	September 2025	Resources Cttee	In Progress
	Implement medicines management system	Dr C Grant	March 2026	TM Cttee	Not Commenced

Clinical Audit	Procure clinical audit tool	Dr C Grant	July 2025	Resources Cttee	In Progress
	Implement clinical audit tool	Dr C Grant	March 2026	TM Cttee	Not Commenced
Digital Clinical Strategy	*Completion of digital clinical safety process on Electronic Patient Record*	*Ms J Wharton*	*June 2025*	*Q&P Cttee*	*In Progress*
PEOPLE					
Appraisal Compliance 2024/25	Achieve 85% compliance	Ms L Ward	May 2025	Resources Cttee	Complete
Appraisal Compliance 2025/26	Achieve 85% compliance	Ms L Ward	March 2026	Resources Cttee	In Progress
Mandatory Training Compliance 2025/26	Achieve 85% compliance	Ms L Ward	March 2026	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.	15 High	15 High	⇔	5 Low

BOARD ASSURANCE FRAMEWORK 2025/26

BAF RISK SR07:
There is a risk that due to the geographical size of the Trust it will be unable to effectively engage with its numerous system partners which may impact on its ability to achieve the medium-long-term plan.

Executive Director Lead:	DoSP
Strategic Aims:	Work together to shape a better future
Risk Appetite Category:	Reputation – Moderate

BAF RISK SCORE JOURNEY:

	01.04.25	Q1	Q2	Q3	Q4	25/26 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 due to turbulence in the system partner environment, particularly NHSE and ICBs. Horizon scanning across the system continues to detect early signs of important developments and potential threats and opportunities and shared across internal stakeholders. Sector-wide engagement with AACE forums and the NAA ensure we are working collaboratively with other Ambulance trusts and aligned with AACE vision.

Projected Forecast Q1: Deteriorating / Stable / Improving

Rationale: Stable
Due to the geographical size of the trust, it is challenging to effectively engage with external partners. The trusts Partnerships and Integration Managers are in place and liaise with operational, clinical and directorate teams to ensure the right representation at strategic and critical meetings across the footprint and also ensuring that this engagement is evidenced and assured.

CONTROLS →	ASSURANCES →	EVIDENCE

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Development of Trust Strategy	Community and Enagement work stream is part of Strategy Develoment work programme.	Mrs A Ormerod	2025/26	TM Cttee	In Progress
Horizon scanning - emergent priorities	Review impact and communicate with system partners, agree any impact to existing plans.	Mrs A Ormerod	2025/26	TM Cttee	In Progress
Publication of NHS 10 year plan including underpinning policy/guidance documents to provide clarity on the wider national/regional direction of travel.	Update SWOT and PESTLE and review plans to ensure relevance.	Mrs A Ormerod	Q2	TM 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 2025/26

BAF RISK SR09:
There is a risk that the recent planned changes around the Board over the next 12 months could destabilise the organisation and impact delivery of strategic plans.

Executive Director Lead:	CE / DoCA
Strategic Aims:	Provide high quality inclusive care Be a brilliant place to work for all Work together to shape a better future
Risk Appetite Category:	Regulatory - Low

BAF RISK SCORE JOURNEY:

	01.04.25	Q1	Q2	Q3	Q4	25/26 Target	Risk Appetite
	15					5	1-5
	5x3					5x1	
	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 a risk score of 15.

- New Chair expected to take up post during late Q1/early Q2
- 2x NED final Terms of Office end during 2025 calendar year
- New Director of Strategy and Partnerships following CEO appointment during Q4 2024/25
- New Director of Quality following the previous Director leaving the trust 31 March 2025.

Projected Forecast Q1: Deteriorating
Stable
Improving

Rationale: Stable/Improving
Likely to improve due to recruitment processes that are ongoing.

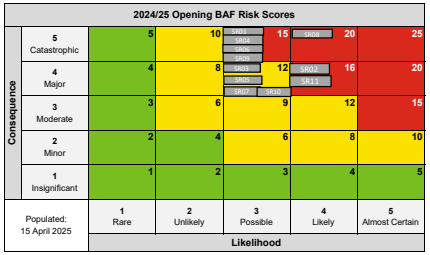
CONTROLS →	ASSURANCES →	EVIDENCE

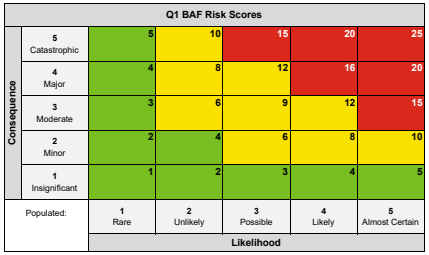
Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Recruitment to vacant Director posts	Appoint Director of Quality and Improvement	Mr S Desai	June 2025	Nom & Rem Cttee	In Progress
	Appoint to Director of Strategy and Partnerships	Mr S Desai	April 2025	Nom & Rem Cttee	In Progress
Recruitment of Chair	NHSE to appoint Chair	n/a	April 2025	n/a	In Progress
Recruitment of 2x Non-Executive Directors	New Chair and NHSE to appoint	tbc	End Nov 2025	n/a	Not Commenced

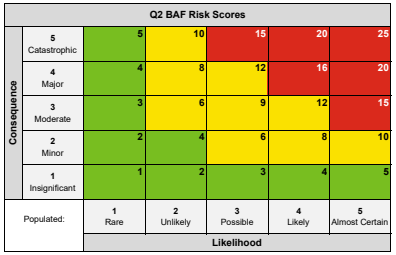
Operational Risks Scored 15+ Aligned to BAF Risk: SR09						
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
There are no operational risks scored 15+ aligned to this BAF risk						

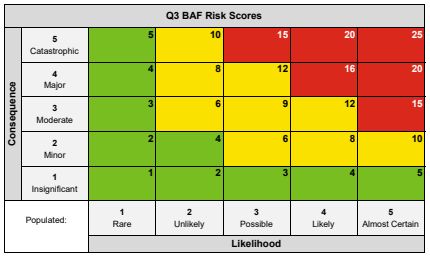
Appendix 2:
2025/26 Board Assurance Framework (BAF) Heat Maps
Opening Position

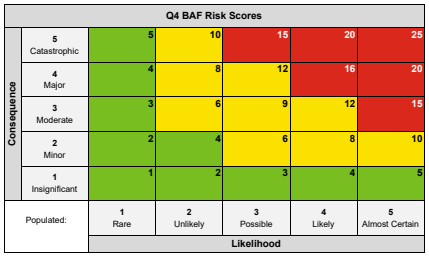
NHS North West Ambulance Service NHS Trust

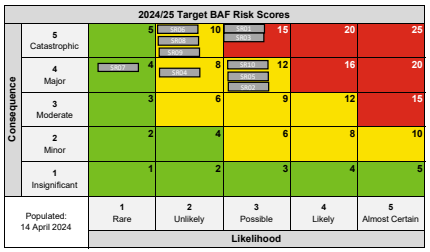


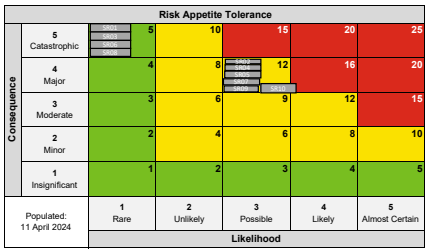












SR07

NHS
North West Ambulance Service
NHS Trust

REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 30 April 2025
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**	☒	**SR11** ☒

Risk Appetite Statement *(Decision Papers Only)*	Compliance/ Regulatory	☒	Quality Outcomes	☒	Cyber Security	☒	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 The Scheme of Delegation has been redesigned to focus on matters delegated from the Standing Orders and Standing Financial Instructions.	
PREVIOUSLY CONSIDERED BY	Audit Committee	
	Date	Friday, 25 April 2025
	Outcome	Awaited

1. BACKGROUND

As per the Standing Orders, the Trust's core governance documents are subject to annual review. These documents are attached within the appendices for approval by the Board of Directors.

2. REVIEW OUTCOMES

The core governance documents are:

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

The Scheme of Delegation has been redesigned to focus on matters delegated from the Standing Orders and Standing Financial Instructions.

All changes can be identified within the Appendices as tracked changes.

3. RISK 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. EQUALITY/ SUSTAINABILITY IMPACTS

None identified.

5. 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	24 April 2024
22	Change in Voting Rights and Board Membership	31 July 2024
23	Annual Review, March 2025	

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 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 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 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 lead to good governance and ~~that will~~ ensure that decision-making is informed by intelligent information. Integrated governance better enables the Board to take a holistic view of the organisation and its capacity to meet its legal and statutory requirements and clinical, quality and financial objectives.

2. The Board of Directors: Composition of Membership, Tenure and Role of Members

2.1 Composition of the Board of Directors

2.1.1 In accordance with the Establishment Order 2006 No 1662 and Membership and Procedure Regulations 1990 (as amended) the voting membership of the Board of Directors shall comprise the Chair and five Non-Executive Directors, together with up to five Executive Directors. At least half of the membership of the Trust Board, excluding the Chair, shall be independent Non-Executive Directors.

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

- one appointee nominated to be the Deputy or Vice-Chair
- one appointee nominated to be the Senior Independent Director
- up to three non-voting Associate Non-Executive Directors

The Voting Executive Directors shall include:

- Chief Executive
- Executive Director of Operations
- ~~Executive Director of Quality, Innovation and Improvement~~
- Executive Director of Finance
- Executive Medical Director
- Executive Director of People

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

- ~~Deputy Chief Executive/~~Executive Director of Strategy and ~~,~~ Partnerships ~~and Transformation~~
- Executive Director of Quality and Improvement~~People~~
- Executive 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 for Health and Social Care.

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 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 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 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 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 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.

5.2.2 There may be instances where it is deemed critical for the Board of Directors to make a decision outside the time frames of a formal meeting. Such decisions should be agreed electronically (via email circulation) and the formal decision reported to the next formal meeting of the Board of Directors for formal ratification. A minimum quorum must be achieved for decisions reached outside formal meetings, wherever possible, the full Board of Director membership must reach any decision being made outside the meeting. The list of members involved must be reported to the next Board of Directors meeting alongside the formal ratification of the decision.

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, 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 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.

~~3.1.4~~3.1.5 Ratify any decisions taken by the Board of Directors outside the timeframes of a normal meeting, in accordance with SO5.2.

~~3.1.5~~3.1.6 Approval of a scheme of delegation of powers from the Board to committees and officers.

~~3.1.6~~3.1.7 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~~3.1.8 Require and receive the declaration of officers' interests that may conflict with those of the Trust.

~~3.1.8~~3.1.9 Approve arrangements for dealing and responding to complaints.

~~3.1.9~~3.1.10 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~~3.1.11 Confirm the recommendations of the Trust's committees where the committees do not have executive powers.

~~3.1.11~~3.1.12 Approve arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust.

~~3.1.12~~3.1.13 Establish terms of reference and reporting arrangements for all committees and sub-committees that are established by the Board.

~~3.1.13~~3.1.14 Receive reports on instances of use of the seal.

~~3.1.14~~3.1.15 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.

~~3.2.1~~3.2.2 Agree and oversee the approach to disciplining directors who are in breach of statutory requirements of the Trust's Standing Orders.

~~3.2.2~~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 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 however the Board shall maintain responsibility for approving the following policies:

- Policy on 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 Investigation Policy
- 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.

Powers Delegated in Standing Orders

North West Ambulance Service NHS Trust

S/O Ref	Delegated Matter	Delegated To
SO 1.2	Final authority in the interpretation of Standing Orders	Chair (As advised by Chief Executive and Director of Corporate Affairs)
SO 1	Advice on the interpretation or application of the Scheme of Reservation and Delegation of Powers	Director of Corporate Affairs
SO 2.5.1	Responsibility for the overall performance of the executive functions of the Trust in line with the requirements of the Accountable Officer Memorandum for Trust Chief Executives.	Chief Executive
SO 2.5.1	Responsibility for the provision of financial advice to the Trust and supervision of financial controls and accounting systems and discharge of obligations under relevant Financial Directions.	Director of Finance
SO 3.2.4	Public to be informed of the Board of Directors agenda at least three days before the meeting.	Director of Corporate Affairs
SO 3.6	Responsibility for deciding whether a vote is required and what form this will take.	Chair
SO 3.14	Review each decision to suspend Standing Orders	Audit Committee
SO 4	Board of Director approval to establish and disestablish Committees of the Trust	Director of Corporate Affairs
SO 4.8	Advise the Board of Directors on the selection and appointment of the External Auditor	Audit Panel
SO 5.2	Use of emergency powers relating to the authorities retained by the Board of Directors	Chair & Chief Executive acting jointly (following consultation with 2 NEDs & 2 Voting Executive Directors)
SO5	Preparation of a schedule for Decisions Reserved to the Board of Directors and Scheme of Delegation	Director of Corporate Affairs
SO 6	Establish Register of Interests for publication on Trust website	Director of Corporate Affairs
SO 7	Compliance with Standards of Business Conduct: Policy on Managing Conflicts of Interest, Gifts and Hospitality and Sponsorship.	Director of Corporate Affairs
SO 8	The Common Seal of the Trust shall be kept in a secure place.	Director of Corporate Affairs
SO 8	Authorise use of Common Seal	Chief Executive, Director of Finance Director of Corporate Affairs (or their designated deputies)
SO 9	Approval of Partnership Arrangements – Memorandum of Understanding	Trust Management Committee

North West Ambulance Service NHS Trust

SFI REF	DELEGATED MATTER	DELEGATED TO
SFI 2	**AUDIT**	
SFI 2	Responsibility to ensure adequate internal and external audit services are provided involving Audit Committee in the selection process	Director of Finance
SFI 3	**INCOME, BUSINESS PLANNING, BUDGETS, BUDGETARY CONTROL AND MONITORING**	
SFI 3.1.1	Compilation and submission of annual plan taking into account financial targets and forecast limits of available resources	Chief Executive
SFI 3.1.2	Preparation and submission of income and expenditure budgets for approval by Board of Directors prior to start of financial year	Director of Finance
SFI 3.1.3	Monitor financial performance against budget and plan and advise Board of Directors	Director of Finance
SFI 3.1.4	Provision of information to enable budgets to be compiled	Budget Holders
SFI 3.1.5	Budget holders to sign up to allocated budgets at the commencement of each financial year	Director of Finance See Annex 1
SFI 3.1.6	Provision of adequate training to all budget holders relating to financial management within the NHS	Director of Finance
SFI 3.2.1	Responsibility for the delegation of the management of budget to permit the performance of a defined range of activities.	Chief Executive
SFI 3.3.1	Devise and maintain systems of budgetary control	Director of Finance
SFI 4	**ANNUAL REPORT & ACCOUNTS**	
SFI 4.1.1	Preparation and submission of financial reports in accordance with the accounting policies, guidance and timetable prescribed by the Department of Health and Social Care.	Director of Finance
SFI 4.1.1	Preparation and publication of Annual Report a public meeting.	Chief Executive
SFI 5	**BANK AND GOVERNMENT SERVICE ACCOUNTS**	
SFI 5.1.2	Responsibility for managing Trust banking arrangements following approval by Board of Directors	Director of Finance
SFI 5.2.1	Opening of bank accounts	Director of Finance
SFI 6	**INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGORTIABLE INSTRUMENTS**	
SFI 6.1 & 6.1.3	Design, maintain and ensure compliance with income and expenditure systems for prompt banking of all monies	Director of Finance
SFI 6.1.4	Responsibility for ensuring appropriate arrangements are in place for authorisation of contracts of service provision through NHS or non NHS income activities	Chief Executive
SFI 6.2.2	Approval and regular review of the level of all fees and charges, other than those determined by the DHSC or by statute	Director of Finance

SFI REF	DELEGATED MATTER	DELEGATED TO
SFI 6.3.1	Responsibility for debt recovery and associated procedures	Director of Finance
SFI 6.4	Security of cash, cheques and other negotiable instructions	Director of Finance
SFI 7	**NHS SERVICE AGREEMENTS FOR PROVISION OF SERVICES**	
SFI 7.1	Responsibility for ensuring the Trust enters into suitable service level agreements (SLA) or contracts with service commissioners for the provision of NHS services.	Chief Executive as Accountable Officer See Annex 1
SFI 8	**TERMS OF SERVICE, ALLOWANCES AND PAYMENT OF MEMBERS OF THE BOARD AND EMPLOYEES (Annex 1)**	
SFI 8.1.2	Board of Directors to be advised in respect of the Chief Executive, Executive Directors and Very Senior Managers.	Nominations & Remuneration Committee
SFI 8.4	Responsibility for processing payroll	Director of People
SFI 8.5	Authority to issue, variate and terminate contracts of employment in a form approved by the Board of Directors	Director of People
SFI 9	**NON-PAY EXPENDITURE**	
SFI 9.1.1	Level of non-pay expenditure to be prepared on an annual basis for approval by Board of Directors	Director of Finance
SFI 9.1.1	Responsibility to determine level of delegation to budget managers	Chief Executive
SFI 9.1.2	Agree and maintain a list of managers authorised to place requisitions for the supply of goods and services	Director of Finance
SFI 10	**EXTERNAL BORROWING AND INVESTMENTS**	
SFI 10.1.3	Preparation of detailed procedural instructions concerning applications for loans and overdrafts.	Director of Finance
SFI 10.1.5	Authorisation of short-term borrowing with the authority of two members of an authorised panel and advise next meeting of the Board.	Chief Executive or Director of Finance
SFI 10.2.2	Responsibility for detailed procedural instructions on the operation of investment accounts and the records to be maintained.	Director of Finance
SFI 11	**CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSETS REGISTERS AND SECURITY OF ASSETS**	
	Preparation of Capital Programme for approval by the Board of Directors	Director of Finance
SFI 11	Maintenance of asset registers as specified in the Capital Accounting Manual issued by the Department of Health and Social Care.	Director of Finance
SFI 11.4.2	Approval of Asset control procedures (including fixed assets, cash, cheques and negotiable instruments and donated assets).	Director of Finance
SFI 13	**DISPOSALS AND CONDEMNATIONS, INSURANCE LOSSES AND SPECIAL PAYMENTS**	
SFI 13.1	Detailed procedures for disposal of assets including condemnations	Director of Finance See Annex 1

SFI REF	DELEGATED MATTER	DELEGATED TO
SFI 13.2	Preparation of losses and special payments procedure	Director of Finance
SFI 13.2.2	Preparation of fraud response plan setting out action to be taken	Director of Finance
SFI 13.2.4	Approval to write off losses and special payments in accordance with the Scheme of Delegated Financial limits	See delegated financial limits within SFIs
SFI 13.2.7	Maintenance of Losses and Special Payments Register recording write off action.	Director of Finance
13.2.7	Reporting of all losses and special payments to the Audit Committee	Director of Finance
SFI 14	**INFORMATION TECHNOLOGY**	
14.1	Responsibility for accuracy and security of the computerised financial data of the Trust.	Director of Finance
14.1.3	Responsibility for publishing and maintenance of a Freedom of Information (FOI) Publication Scheme, or adoption of a model publication scheme approved by the Information Commissioner.	Director of Strategy & Partnerships
14.5	Responsibility to undertake risk assessments to ensure risks to the Trust's financial systems from the use of IT are effectively, identified, considered and appropriate action taken to mitigate or control risk.	Director of Finance
16	**FUNDS HELD ON TRUST**	
16.1.1	Corporate Trustee for the management of funds held in Trust	Director of Finance
16.1.6	Responsibility for maintenance of accounts and records for Trust funds	Director of Finance
16.1.7	Responsibility for day to day management and operation of the charity.	Director of Strategy & Partnerships
SFI 16	Delegation of Charitable Funds Expenditure	Director of Finance (See Annex 1)
SFI 16	Charitable Funds Annual Accounts	Director of Finance
SFI 17	**TENDERING AND CONTRACT PROCEDURE**	
SFI 17	Approval of competitive tendering awards and appoint of tender evaluation panel	See Annex 1
SFI 17	Waiver of Standing Financial Instructions	Director of Corporate Affairs, Director of Finance, Chief Executive (or their designated deputies)
SFI 17.3.4	Reporting of waivers to Audit Committee	Director of Corporate Affairs
SFI 18	**GIFTS AND HOSPITALITY**	
SFI 18.1.1	To ensure staff are aware of the Trust policy on acceptance on gifts and other benefits in kind through Standards of Business Conduct Policy: Policy on Managing Conflicts, Gifts and Hospitality and Sponsorship.	Director of Corporate Affairs
SFI 19	**RETENTION OF DOCUMENTS**	
SFI 19	Compliance with Records Management – NHS Code of Practice	Chief Executive and SIRO

SFI REF	DELEGATED MATTER	DELEGATED TO
	Compliance with Access to Health Records	Medical Director acting as Caldicott Guardian
	Compliance with Data Protection and Freedom of Information Acts	Director of Strategy & Partnerships in conjunction with SIRO
SFI 20	**RISK MANAGEMENT**	
SFI 20	Responsibility for programme of risk management	Director of Corporate Affairs
SFI 20	Annual Governance Statement	Chief Executive

Powers Delegated in Standing Financial Instructions

Annex A

Authorisation of Purchase Requisitions (Revenue and Capital)	
>£1,000,000	Board of Directors
Up to £999,999	Chief Executive
Up to £249,999	Director of Finance
Up to £99,999	Voting Director
Up to £49,999	Non-Voting Director including Area Directors & Director of Integrated Contact Centres
Refer to SFIs for all other levels.	

Requirement to obtain Quotes and Tenders (Revenue and Capital)		
Value Range (Inc VAT)	**Requirement**	**Contract awarded by**
Up to £11,999	Budget holder discretion	N/A
£12,000 to £29,999	Minimum of 3 formal written quotations	Director
£30,000 to FTS Threshold	Minimum of 3 formal tenders	<£1m Director of Finance
Above FTS Threshold	FTS process must be followed and must be published on Find a Tender Portal	<£1m Director of Finance >£1m Board of Directors
Refer to Annex A of SFIs for further details		

Cabinet Office Spend Control >£20m
Refer to Annex A of SFIs for details

Contract and Service Level Agreement Sign Off		
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-£11,999 (annual aggregated value)	N/A	Director of Finance
£12,000 to £29,999	Director of Finance, Delegated to Head of Procurement if contract award decision ratified.	Director of Finance
£30,000 to Procurement Act threshold.	<£1m Director of Finance	<£1m Director of Finance
Above Procurement Act threshold	<£1m Director of Finance >£1m Board of Directors	<£1m Director of Finance >£1m Board of Directors

Authorisation of Charitable Funds Expenditure	
Head of Charity	Up to £999
Deputy Director of Finance Head of Technical Accounts Director of Strategy & Partnerships	From £1,000 to £2,499
Director of Finance or Chief Executive	£2,500 to £49,000
Charitable Fund Committee or Board of Directors on behalf of Corporate Trustee	>£50,000

Condemnation and Disposal of Assets	
Post holder	**Authorisation limits (including VAT)**
Relevant Executive Director and relevant Service Line Head of Finance	Where the net book value is up to £2,499 (subject to informal quotations for disposal)
Director of Finance	Where the net book value is between £2,500 and £24,999, (subject to competitive quotations for disposal)
Trust Management Committee	£25,000 to £249,999 (Subject to formal tender action to disposal)
Board of Directors	Where the net book value is >£250,000, (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).
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).
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	
Postholder	**Authorisation limits (including VAT)**
Director of Finance	Up to £250,000
Chief Executive	Over £250,000
Deputisation: Postholders with delegated powers are able to assign their powers to a nominated deputy (agreed by relevant Line Director) in the event of planned absences. For unplanned absences, a similar procedure should be followed although a memorandum would be prepared by the absent post holder's Line Manager.	

Remuneration and Conditions of Service	
Very Senior Manager (VSM) Pay arrangements - Authorisation of all pay, benefits and grading issues for Directors subject to VSM pay arrangement and NHS England (NHSE) approval - Recommendation of non-contractual termination payments to the NHSE and Treasury for approval - Approval of costs incurred in relation to Directors subject to VSM 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 - Recommendation contractual terminations to the NHSE where costs exceed £100,000	Nominations and Remuneration Committee
- Jointly approve business cases for redundancy/premature retirement applications where ethe cost does not exceed £50,000	Director of People and Director of Finance

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	24 April 2024
20	Annual Review, April 2025	

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~~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.

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~~all 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, the Annual Governance Statement and supporting assurance processes, together with any accompanying audit statement, prior to endorsement by the Board of Directors; and
f. review the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the organisation's activities (both clinical and non-clinical) that supports the achievement of the organisation's objectives.

2.1.2 The Board of Directors shall satisfy itself that at least one member of the Audit Committee has recent and relevant financial experience.

2.1.3 Where the Audit Committee considers there is evidence of *ultra vires* transactions in, evidence of improper acts, or if there are other important matters that the Committee wish to raise, the Chair of the Audit Committee should raise the matter at a full meeting of the Board of Directors (to the Director of Finance in the first instance).

2.1.4 It is the responsibility of the Director of Finance to ensure adequate internal and external audit services are provided and the Audit Committee shall be involved in the selection process when an audit service provider is changed.

2.2 Director of Finance

2.2.1 The Director of Finance is responsible for:

a. ensuring there are arrangements to review, evaluate and report on the effectiveness of internal control, including the establishment of an effective internal audit function and the coordination of other assurance arrangements;
b. ensuring that the internal audit is adequate and meets the NHS mandatory audit standards;

c. deciding at what stage to involve the police in cases of fraud, misappropriation and other irregularities, including theft not involving fraud or corruption; and
d. ensuring that an annual internal audit report is prepared for the consideration of the Audit Committee and the Board of Directors. The report must cover:

I. a clear opinion on the effectiveness of internal controls in accordance with current assurance framework guidance issued by the Department of Health and Social Care, including for example, compliance with control criteria and standards;
II. major internal financial control weaknesses discovered;
III. progress on the implementation of internal audit recommendations;
IV. progress against plan over the previous year;
V. strategic audit plan; and
VI. a detailed plan for the coming year.

2.2.2 The Director of Finance or designated auditors are entitled, without necessarily giving prior notice, to require and receive:

a. access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;
b. access at all reasonable times to any land, premises, members of the Board of Directors or employee of the Trust;
c. the production of any cash, stores or other property of the Trust under a member of the Board of Directors or employee's control; and
d. explanations concerning any matter under investigation.

2.3 Internal audit

2.3.1 The NHS Trust Accounting Officer Memorandum requires the Trust to have an internal audit function.

2.3.2 Role of Internal Audit:

The role of internal audit embraces two key areas:

- the provision of an independent and objective opinion to the Accountable Officer, the Board of Directors and the Audit Committee on the degree to which risk management, control and governance support the achievement of the organisation's agreed objectives; and
- the provision of an independent and objective consultancy service specifically to help line management improve the organisation's risk management, control and governance arrangements.

Internal audit will review, appraise and report upon:

a. the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;
b. the adequacy and application of financial and other related management controls;
c. the suitability of financial and other related management data;

d. the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

   I. fraud and other offences
   II. waste, extravagance or inefficient administration
   III. poor value for money or other causes

e. Internal Audit shall also independently verify the Assurance Statements in accordance with guidance from the Department of Health and Social Care (DHSC).

2.3.3 Whenever any matter arises which involves, or is thought to involve, irregularities, including theft, concerning cash, stores or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Director of Finance must be notified immediately.

2.3.4 The Head of Internal Audit will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chair and Chief Executive of the Trust.

2.3.5 The Head of Internal Audit shall be accountable to the Director of Finance. The reporting system for internal audit shall be agreed between the Director of Finance, the Audit Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Internal Audit Manual. The reporting system shall be reviewed at least every three years. Where, in exceptional circumstances, the use of normal reporting channels is thought to limit the objectivity of the audit, the Head of Internal Audit shall have access to report directly to the Chair or a non-executive member of the Trust's Audit Committee.

2.3.6 Managers in receipt of audit reports referred to them have a duty to take appropriate remedial action within the agreed timescales specified within the report. The Director of Finance shall identify a formal review process, including Audit Committee oversight, to monitor the extent of compliance with audit recommendations. Where appropriate, when remedial action has failed to take place within a reasonable period, the matter shall be reported to the Director of Finance.

2.4 External audit

2.4.1 The External Auditor is appointed by the Trust and the service provided is paid for by the Trust. The Audit Committee must ensure a cost-efficient service. If there are any problems relating to the service provided by the External Auditor, these should be raised with the Director of Finance in the first instance who will seek to resolve issues with the senior representative of the External Audit provider.

2.4.2 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 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 Resources Committee/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 Resources Committee/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 pProductivity and eEfficiency 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 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 reportsto date showing variance to plans; income and expenditure run-rates; and 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 and delivered;
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. (T(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 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 non NHS income activities.

6.1.5 The Scheme of Delegation for the authorisation of income contracts is outlined in the Schedule of Delegated Limits (Annex 1 of these SFIs).

6.2 Fees and charges other than Trust contract

6.2.1 The Trust shall follow the Department of Health and Social Care's advice in the 'Costing Manual' in setting prices for NHS service agreements.

6.2.2 The Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health and Social Care or by statute. Independent professional advice on matters of valuation shall be taken as necessary. Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered the guidance in the Department of Health and Social Care's Commercial Sponsorship – Ethical standards in the NHS shall be followed.

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

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 sService ~~Level Agreements (SLA) or~~ contracts with theservice ~~service~~ commissioners for the provision of NHS services.

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

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

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

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

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

8.1 Remuneration Committee

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

8.1.2 The Committee will:

a) advise the Board of Directors about appropriate remuneration and terms of service for the Chief Executive, Executive Directors and other Very Senior Managers in conjunction with NHSE where required ensuring that officers are fairly rewarded for their individual contribution to the Trust – having proper regard the Trust's circumstances and performance and to the provisions of any national arrangements for such staff:

- approve all aspects of salary (including any performance related elements, bonuses)
- provisions for other benefits, including pensions and cars
- arrangements for termination of employment and other contractual terms.

8.1.3 The Committee shall report in writing to the Board of Directors the basis for its recommendations. The Board of Directors shall use the report as the basis for their decisions but remain accountable for taking decisions on the remuneration and terms of service of executive directors. Minutes of the Board of Directors meetings should record all decisions.

8.1.4 The Board of Directors will approve proposals presented by the Chief Executive for setting of remuneration and conditions of service for those employees not covered by the Committee.

8.1.5 The Trust will pay allowances to the Chair and non-officer members of the Board in accordance with instructions issued by the Secretary of State for Health and Social Care.

8.2 Funded establishment

8.2.1 The workforce plans are incorporated within the annual pay budget and form the funded establishment.

8.2.2 The funded establishment of any department may not be varied without the approval of the Chief Executive or individual nominated within the relevant section of the Scheme of Delegation. The Finance Department are responsible for verifying that funding is available.

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 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 must be 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 guidance, 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 purchase 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 purchase order and clearly marked 'Confirmation Order';
h. orders are not split or otherwise placed in a manner devised ~~so as to~~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~~. Requisitions and ~~P~~payments must be authorised in accordance with the delegated limits set for non-pay expenditure.

~~m.~~n. Orders are not required to be raised for council rates and fuel and payments must be authorised in accordance with the delegated limits set for non-pay expenditure.

~~n.~~

o. Purchases by credit cards are restricted in value and by type of purchase in accordance with instructions issued by the Director of Finance.

p. Credit card purchase records are maintained in a form as determined by the Director of Finance.

q. 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 borrowing must be with the authority of two members of an authorised panel, one of which must be the Chief Executive or the Director of Finance. The Board must be made aware of all short-term borrowings at the next Board meeting.

10.1.6 All long-term borrowing must be consistent with the plans outlined in the current LTFM and be approved by the Board of Directors.

10.2 Investments

10.2.1 Temporary cash surpluses must be held only in such public or private sector investments as notified by the Secretary of State 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 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*trusts and HM Treasury Green Book 5 Case Model, identifying the following:

I. Business Justification Case/ Strategic Outline Case for Change for investments 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 potential benefits, risks and financial costs to determine and the option with the highest net present societal benefit to cost ratio.

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 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~~cost-effective practice;
IV. following guidance issued by the NHS Resolution relating to clinical negligence;
V. maintaining Care Quality Commission registration standards; and
VI. implementing an effective system of Clinical Governance.

13.3.3 The Director of Corporate Affairs is responsible for clinical negligence, for managing the claims process and informing the Board of Directors of any major developments on claims related issues.

14. Information technology

14.1 Responsibilities and duties of the Director of Finance

14.1.1 The Director of Finance, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:

a. devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which they are responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998 and the Computer Misuse Act 1990;
b. ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness and timeliness of the data, as well as the efficient and effective operation of the system;
c. ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;
d. ensure that adequate controls exist to maintain the security, privacy, accuracy and completeness of financial data sent via transmission networks; and
e. ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as they may consider necessary are being carried out.

14.1.2 The Director of Finance shall satisfy themselves that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy will be obtained from them prior to implementation.

14.1.3 The Director of Strategy and 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 Strategy and Partnerships~~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 the~~of~~ Director of Strategy and Partnerships~~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 Strategy and Partnerships~~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~~ Strategy & Partnerships 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 Cabinet Office, with the support of NHSE, have introduced a spend control authorisation process for all none pay expenditure projects with a primary contract value of ~~>=+~~ £20m, excluding VAT and any potential extension periods. This process is mandatory and sits outside all other Trust, ICS, NHSE or Central Government approval governance.

17.1.4 The Trust should have policies and procedures in place for the control of all tendering activity.

17.2 Public Procurement Legislation~~Public Contracts directives~~ governs~~ing~~ all public procurement

17.2.1 The latest ~~P~~procurement l~~L~~egislation ~~Public Contracts Directives~~ promulgated by the Department of Health and Social Care (DHSC) prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in the Standing Orders and Standing Financial Instructions. Procedure notes detailing thresholds and the differing procedures adopted must be maintained within the Trust.

17.3 Formal competitive tendering

17.3.1 The Trust shall ensure that competitive tenders are invited for:

- the supply of goods, materials and manufactured articles;
- the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the DHSC); and
- the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens) and for disposals.

For tenders for the supply of healthcare these Standing Financial Instructions shall apply as far as they are applicable to the tendering procedure.

17.3.2 Formal tendering procedures are not required where:

a. the estimated expenditure or income does not, or is not reasonably expected to, exceed the limit set in the Schedule of Financial Delegated Limits (this figure to be reviewed annually); or

b. the supply is proposed under special arrangements negotiated by the Department of Health and Social Care or other public sector representatives (for example Association of Ambulance Chief Executives (AACE)) in which event the said special arrangements must be complied with; or

c. regarding disposals as set out in Standing Financial Instruction 'Disposals and Condemnations'.

17.3.2 Formal tendering procedures may be waived in the following circumstances:

- in very exceptional circumstances where the Chief Executive decides that formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures and the circumstances are detailed in an appropriate Trust record; or
- where the requirement is covered by an existing contract;
- where the timescale genuinely precludes competitive tendering but failure to plan the work properly would not be regarded as a justification for a single tender; or
- where specialist expertise is required and is available from only one source (also includes memberships/subscriptions/licences); or
- when the task is essential to complete the project and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate; or
- there is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering; or
- for the provision of legal advice and services providing that any legal firm or partnership commissioned by the Trust is regulated by the Law Society for England and Wales for the conduct of their business (or by the Bar Council for England and Wales in relation to the obtaining of Counsel's opinion) and are generally recognised as having sufficient expertise in the area of work for which they are commissioned; or
- where allowed and provided for in the NHS Trust Capital Accounting Manual; or
- Single source supplier – one accredited supplier for service; or
- Single source supplier – goods compatible with existing equipment and are essential to complete a project. In addition, engagement with an alternative provider for the additional work would be impractical; or
- Single source supplier – Original Equipment Manufacture's maintenance provision for existing equipment. Engagement with an alternative provider for the additional work would be impractical; or
- Where it was necessary to obtain goods/services without raising a Purchase Order in advance and a retrospective order is required; or
- Where the principal contractor or a key sub-contractor has gone into liquidation, administration or bankruptcy and is unable to complete a current project or commence a scheme which has just been awarded; or
- request approval for accepting a quotation/tender which is not the lowest as evaluations have shown that the clinical and operational benefits outweigh the financial savings of the lowest cost option.

17.3.3 The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.

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, generally electronically via the Trusts preferred electronic tendering portal.
III. Every tender for goods, materials, services or disposals shall embody such of the latest ~~NHS~~ Standard Contract Conditions as are applicable; and
~~IV.~~ Every tender for building or engineering works shall comply with the specific national guidance relating to estates and construction. ~~, such as the NHS Estatecode documents.~~

17.4.2 Receipt and safe custody of tenders

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

I. As soon as practicable after the date and time stated as being the latest time for the receipt of 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 Trust's tendering portal will hold a full electronic record of all the tenders received in accordance with agreed system parameters.
III. A register of tenders will be held in the Procurement Department.
IV. 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

II. 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.

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 ~~Mmost Aadvantageous Ttender~~~~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. All awards for goods, services and works must comply with the process set out in the tender documentation.~~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.~~a. ~~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.~~II. 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.~~III. 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.~~IV. 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. National Procurement Legislation~~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 England's ~~NHS Digital~~ Records Management Code of Practice for Health and Social Care 2021~~16~~.

19.3 Types of record covered by the Code of Practice

19.3.1 The guidelines apply to NHS and adult social care 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~~ digital or paper ~~based~~)
- Records of patients treated on behalf of the NHS in the private healthcare sector
- Records of private patients treated on NHS premises~~seen on NHS premises~~
- Records created by providers contracted to deliver NHS services (eg GP services)
- Adult service user records who receive social care support
- Jointly held records
- Records held as part of a Connecting Care Records programme
- Records held by local authorities such as public health records, contraceptive and sexual health service records
- Staff records
- Complaints records
- Corporate records – administrative records relating to all functions of the organisation
- Health and care records
- ~~Registers:~~ birth, death, Accident and E~~e~~mergency, theatre, minor operations~~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
- Secondary uses records (records that relate to uses beyond individual care eg records used for service management, planning and research
- Photographs, slides and other images
- Microform (microfiche or microfilm~~i.e. fiche / film~~)
- Physical records (records made of physical material such as plaster, gypsum and alginate moulds)
- 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
- Metadata added to, or automatically created by, digital systems when in use (content of little value if not accompany by metadata)
- 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, including Director of ICC	5	Up to £49,999
A4C Band 8d/9	6	Up to £24,999
A4C Band 8c	7	Up to £14,999
A4C Band 8b	8	Up to £9,999
A4C Band 8a	9	Up to £7,499
A4C band 6/7	10	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 Assistant	Up to £999
Procurement Officer	Up to £2,499
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~~ £11,999 (annual aggregated value)	At budget holder discretion	N/A	**N/A**	**N/A**
£~~10,000~~ 12,000 to £29,999	Minimum of 3 formal written quotations **OR** must be published on the Central Digital Platform. All appropriate notifications must be published.	Lead Procurement Manager	Appropriate Service Line Finance Lead	Director
£30,000 to Procurement Act 2023 threshold	Minimum of 3 formal tenders*	Lead Procurement Manager	Evaluation Panel (must include a Finance member)	≤£1m delegated to the Executive Director of Finance, if the recommendation is endorsed by the Head of Procurement
Above Procurement Act threshold	~~FTS~~ Compliant process must be followed*	Lead Procurement Manager	Evaluation Panel (must include a Finance member)	≤£1m delegated to the Executive Director of Finance, if the recommendation is endorsed by the Head of Procurement. >£1m Board of Directors

* To be published on the Central Digital Platform, with all appropriate notifications published.~~Find a Tender Portal~~

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

Cabinet Office Spend Control =+ £20m Projects

Activity	Who	When	Action	Timescale
Identify Project with potential Spend ≥=+£20m (ex VAT)	Senior Responsible Officer	As soon as possible minimum of 24 months before project go live **Before any tendering activity**	Notify Head of Procurement	
Notify NHSE Spend Controls Team	Head of Procurement/ Senior Responsible Officer	As above	Enter project onto Trust Pipeline	1 week
Project Assurance Review	NHSE Spend Control Team/ Cabinet Office	As above	Decide whether project is: **Assured** or **Controlled**	1-2 months
Assured Project	NWAS Senior Responsible Officer and Head of Procurement	As above	No further requirements from NHSE Spend Control Team/ Cabinet office. Follow standard tender processes and Trust and other external approval governance (as applicable). Award Business, via standard processes.	Circa 6 months
Controlled Project – OBC Production	NWAS Senior Responsible Officer and Head of Procurement	As Above	Produce, Present & Submit a pre procurement Outline Business Case (OBC) to NHSE Spend Control Team and NHSE Commercial Assurance Panel (CAP).	6 weeks
Controlled Project – OBC Review/ Approval	NHSE Spend Control Team/ Cabinet Office	As above	Review and approve continuation to procurement phase.	2 months on receipt of completed and accepted OBC
Controlled Project – Procurement Phase	NWAS Senior Responsible Officer and Head of Procurement	Following approval by NHSE Spend Control Team/ Cabinet Office	Follow standard tender processes and Trust/ other external approval governance (as applicable). **Final Trust approval must be subject to NHSE Spend Control/ Cabinet Office approval.** Produce, Present & Submit a post procurement Full Business Case (FBC)	6-8 months

			to NHSE Spend Control Team and NHSE Commercial Assurance Panel (CAP).	
Controlled Project – FBC	NHSE Spend Control Team/ Cabinet Office	Following completed tender process and approval by internal governance	Review and approve continuation to procurement phase.	2 months on receipt of complete and accepted FBC
Controlled Project – Contract Award	Head of Procurement	Following approval by NHSE Spend Control Team/ Cabinet Office/ internal governance	Follow standard contract award processes.	2-3 weeks.

Note failure to comply with this process will result in the Cabinet Office referring the Trust to the National Audit Office.

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-£11,999 (annual aggregated value)	**N/A**	Executive Director of Finance
£12,000 to £29,999	Executive Director of Finance, Delegated to Head of Procurement if contract award decision ratified.	Executive Director of Finance
£30,000 to Procurement Act 2023 threshold	≤£1m delegated to the Executive Director of Finance, if the recommendation is endorsed by the Head of Procurement	≤£1m delegated to the Executive Director of Finance, if the recommendation is endorsed by the Head of Procurement
Above Procurement Act threshold	≤£1m delegated to the Executive Director of Finance, if the recommendation is endorsed by the Head of Procurement. >£1m Board of Directors	≤£1m: delegated to the Executive Director of Finance, if the recommendation is endorsed by the Head of Procurement. >£1m Board of Directors

Authorisation of Charitable Funds expenditure

Post holder	Authorisation limits (including VAT)
Head of Charity	0 to £999
Deputy Director of Finance or Head of Technical Accounts or Director of Strategy and Partnerships~~Corporate Affairs~~	~~0~~£1,000 to £2,499
Director of Finance or Chief Executive	£2,500 to £4950,999~~000~~
Charitable Funds Committee or Board of Directors on behalf of Corporate Trustee	≥~~>~~£50,0001~~~~

Condemnation and Disposal of Assets

Post holder	Authorisation limits (including VAT)
Relevant Executive Director and relevant Service Line Head of Finance	Where the net book value is up to £2,499 (subject to informal quotations for disposal)
Director of Finance	Where the net book value is between £2,500 and £24,999, (subject to competitive quotations for disposal)
Trust Management Committee	£25,000 to £249,999 (Subject to formal tender action to disposal)
Board of Directors	Where the net book value is ≥~~=>~~£250,000, (subject to formal tender action for disposal)

Losses, write off and compensation

Board of Directors	Write-off individual non-NHS debts in excess of £10,000. Ex-gratia payments for loss of personal effects above £10,000 (up to a maximum of £50,000). Losses (including cash) due to theft, fraud, overpayment and others in excess of £10,000 (up to a maximum of £50,000). Fruitless payments (including abandoned capital schemes) in excess of £10,000 (up to a maximum of £250,000). Damage to buildings, fittings furniture & equipment and loss of equipment and property in stores and in use to culpable causes (e.g. fraud, theft, arson) or other in excess of £10,000 (up to a maximum of £50,000). ~~Personal injury claims involving negligence where legal advice has been obtained and guidance applied in excess of £50,000 (up to a maximum of £1m).~~ ~~Clinical negligence claims where legal advice has been obtained and guidance applied in excess of £50,000 (up to a maximum of £1m).~~
Chief Executive	Ex-gratia payments for loss of personal effects between £5,000 and £10,000. Losses (including cash) due to theft, fraud, overpayment & others between £5,000 and £10,000. Fruitless payments (including abandoned capital schemes) between £5,000 and £10,000. Damage to buildings, fittings furniture & equipment and loss of equipment and property in stores and in use to culpable causes (e.g. fraud, theft, arson) or other between £5,000 and £10,000.
Director of Finance	Write-off individual non-NHS debts up to £10,000. Ex-gratia payments for loss of personal effects between £500 and £5,000. Losses (including cash) due to theft, fraud, overpayment and others up to £5,000. Fruitless payments (including abandoned capital schemes) up to £5,000. Damage to buildings, fittings furniture & equipment and loss of equipment and property in stores and in use to culpable causes (e.g. fraud, theft, arson) or other up to £5,000. Compensation payments made under legal obligation (no limit).

	~~Personal injury claims involving negligence where legal advice has been obtained and guidance applied up to £50,000.~~ ~~Clinical negligence claims where legal advice has been obtained and guidance applied up to £50,000.~~
Head of Technical Accounts	Write-off individual non-NHS debts between £11 and £100
Financial Services Manager	Write-off individual non-NHS debts up to £10

Authorisation of Income Contracts/New Service Initiatives

Post holder	**Authorisation limits (including VAT)**
Director of Finance	Up to £250,000
Chief Executive	Over £250,000

Deputisation

Post holders with delegated powers are able to assign their powers to a nominated deputy (agreed by the relevant Line Director) in the event of planned absences. Such assignment to be documented in a memorandum to the nominated deputy setting out precisely what authority is being assigned to.

In the event of unplanned absences, a similar procedure is to be followed although the memorandum would be prepared by the absent post holder's Line Manager.

NHS
North West
Ambulance Service
NHS Trust

REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 30 April 2025
SUBJECT	NHS England NHS Provider Code of Governance: Disclosure of Corporate Governance Arrangements 2024/25
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**	☒	**SR11**	☒

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

ACTION REQUIRED	The Board of Directors is asked to: • Note and agree the declaration of compliance • Note the two actions required during Q1 2025/26	
EXECUTIVE SUMMARY	Following review of the Trust's position during 2024/25, 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. It should be noted two actions are required to be undertaken during 2025/26: 1. B.2.5: Statement of Responsibilities to be updated to reflect new Chair and Chief Executive. 2. C.4.5: Formal evaluation of the Board of Directors to be undertaken during Q1 2025/26. All clauses not applicable to the Trust have been highlighted in grey for ease.	
PREVIOUSLY CONSIDERED BY	Audit Committee	
	Date	Friday, 25 April 2025
	Outcome	Recommended to Board of Directors

1. BACKGROUND

The NHS Provider Code of Governance (NHS Code) provides an overarching framework for the application of effective corporate governance processes. The NHS Code reflects 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 2024/25

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 2024/25.

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

It should be noted two actions are required to be undertaken during 2025/26:

1. B.2.5: Statement of Responsibilities to be updated to reflect new Chair and Chief Executive.
2. C.4.5: Formal evaluation of the Board of Directors to be undertaken during Q1 2025/26.

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

3. RISK 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'. It should be noted that licence conditions within the 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 and agree the declaration of compliance.
- Note the two actions required during Q1 2025/26

DISCLOSURE OF CORPORATE GOVERNANCE ARRANGEMENTS FOR 2024/25

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. In November 2024, the Board of Directors agreed to extend the Trust Strategy for a further year due to the Government's pledge to reform the NHS and current development of the 10-year-plan by Lord Darzi. Four supporting strategies exist that outline how the Trust intends to achieve the strategic aims and objectives and aid the annual planning process. These strategies will also be updated to reflect the Trust's new strategy from 1st April 2026.	• Our Strategy 2022-2025 • Annual Plan • Board Minutes • Quality Strategy • Service Development Strategy • Sustainability Strategy • People Strategy	√
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	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	• IPR • Planning process • Financial report includes efficiency updates • Trust Strategy • Quality Strategy	√

SECTION A: BOARD LEADERSHIP AND PURPOSE				
CODE PROVISION		**TRUST POSITION**	**Evidence**	**Comply?**
	performance in these areas against regulatory and contractual obligations, and approved plans and objectives, including those agreed through place-based partnerships and provider collaboratives.	and South Cumbria Integrated Care System. The Trust continues to meet its duty under the NHS Act (2006) to deliver a balanced financial performance. 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 as per the Single Oversight Framework and provides data on current and historical performance relating to quality, clinical effectiveness, finance, operational performance and organisational health. It also includes information 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 has a 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.	• Service Development Strategy • Sustainability Strategy • People Strategy • Board Assurance Framework • Quality Account • Annual Plan • ICS Operational Planning Submissions	
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 is aligned to the NHSE Single Oversight Framework and 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-	• IPR • Committee ToR • Minutes of Board • Minutes of Committees • Meeting Schedule • Chair's Assurance Reports to Board • Internal Audit Plan	√

SECTION A: BOARD LEADERSHIP AND PURPOSE				
CODE PROVISION		**TRUST POSITION**	**Evidence**	**Comply?**
		Executive Directors, improve executive oversight and assurance and, where possible, to remove any duplication of reporting through the governance structure. Each committee and Executive-led Group 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 are approved by the Board of Directors. The Trust Management Committee approves the Terms of Reference for Executive-led Groups. The Executive led Groups support the Audit, Resources and Quality and Performance Committees that are in place. A programme of internal audits is agreed with MIAA to focus on high-risk areas as identified within the Board Assurance Framework and/or Corporate Risk Register (risks ≥ 15).	• Internal Audit reports • Audit Committee minutes	
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 Clinical and Quality Group is chaired by the Medical Director, who is a member of the Quality and Performance Committee and accountable for clinical governance. Assurance from the Clinical and Quality Group is provided to the Trust Management Committee via an Escalation & Assurance report using the 3A format (Alert, Advise, Assure, including the key risks discussed/identified during the meeting). The work programmes of the Clinical and Quality Group and Quality and Performance Committee are aligned to allow streamlined reporting and provision of assurance around clinical governance. The Quality and Performance	• Quality Strategy • Clinical Audit reports • Minutes of Quality and Performance Committee • Quality and Performance Committee Workplan • Clinical and Quality Group minutes • Clinical and Quality Group Workplan • Clinical and Quality 3A Reports • Quality and Performance Committee 3A Report • IPR to Board of Directors	√

DISCLOSURE OF CORPORATE GOVERNANCE ARRANGEMENTS FOR 2024/25

SECTION A: BOARD LEADERSHIP AND PURPOSE				
CODE PROVISION		**TRUST POSITION**	**Evidence**	**Comply?**
		Committee meets bi-monthly (alternate months to Board Meetings) and provides assurance to the Board of Directors via a 3A report. 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 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 3A Report from the Quality and Performance Committee is submitted to every meeting.	• Quality Account • Audit Committee Minutes • Internal Audit Reports	
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 NED 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 other members of the public and patient stories are shared to improve and promote understanding of patient and staff centred issues, including improvements made to prevent issues from recurring. The Board Development Sessions involve key strategic stakeholders, both internal and external.	• Board Agendas • Board Minutes • Board Development Sessions • Non-Executive Directors attendance at community events	√

SECTION A: BOARD LEADERSHIP AND PURPOSE				
CODE PROVISION		**TRUST POSITION**	**Evidence**	**Comply?**
		Board members attend Ambulance Awareness and community events throughout the calendar year. Members of the PPP, patients, staff and members of the public are invited to these events. 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.		
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 receives annual and bi-annual assurance reports relating to the FTSU arrangements in place, detailing themes and trends 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. During 24/25, the Trust appointed two Freedom to Speak Up Guardians. The Guardians support staff to raise concerns (anonymously if preferred) and progress concerns towards resolution and where necessary refer concern raisers into the human resources team.	• Freedom to Speak Up Policy • Board Agenda • Board Minutes • Board work plan	√
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 should 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	The role of Senior Independent Director and the Director of Corporate Affairs support the escalation of concerns	• Board of Directors Standing Orders	√

SECTION A: BOARD LEADERSHIP AND PURPOSE				
CODE PROVISION		**TRUST POSITION**	**Evidence**	**Comply?**
	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.	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 has been included into the Board of Directors Standing Orders.	• Board minutes	

DISCLOSURE OF CORPORATE GOVERNANCE ARRANGEMENTS FOR 2024/25

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 at the start of the financial year – this is linked to regulatory reporting cycles and the Board Assurance Framework. 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 - People - 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 • Board Minutes	√
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.	• 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?**
		Agendas and accompanying papers are made available five days prior to Board or Committee 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, both from NEDs to execs and from execs to execs. Board Development sessions have previously focussed 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 commissioned from Chairs of Board Assurance Committees.	• Board minutes. • Board action log. • Committee 3A 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. His final term of office was due to end 31st January 2025 however an extension period was granted by NHSE until July 2025 to provide stability to the Board of Directors whilst senior leadership appointments are made, including recruitment of a Chair. The roles of the Chair and Chief Executive are documented within the Statement of Responsibilities approved by the Board of Directors in September 2023. This document will be refreshed during 2025/26	• 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?**
		following appointment of a new Chair and Chief Executive. 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 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. All non-executives are limited to 2x 3 years terms of office and only in exceptional circumstances would an extension to the six-year period be sought by the Trust and this would be subject to support from the Lancashire & S Cumbria ICB Chair and the NW Regional NHSE Director prior to submitting the request to NHSE for approval.	• 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-	The Board reviews Committee membership on an annual basis and where appropriate, membership is refreshed.	• Report to Board 24th April 2024: Non-Executive Terms of Office; Committee Membership 24/25 and Non-Executive Champion Roles	√

SECTION B DIVISION OF RESPONSIBILITIES				
CODE PROVISION		**TRUST POSITION**	**Evidence**	**Comply?**
	executive directors with a range of skill sets, backgrounds and lived experience.		• Board minutes	
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 consists of four independent Non-Executive Directors. The Director of Finance, Director of Corporate Affairs, Internal Audit, 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.	• Nominations & Remuneration Committee Terms of Reference • Audit Committee Terms of Reference • 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	√

DISCLOSURE OF CORPORATE GOVERNANCE ARRANGEMENTS FOR 2024/25

SECTION B DIVISION OF RESPONSIBILITIES				
CODE PROVISION		**TRUST POSITION**	**Evidence**	**Comply?**
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	√
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 considered in relation to any Board level appointments during the year. The Declaration of Interest process requires all Directors to declare their outside interests. The Standards of Business Conduct policy deals with outside employment and no outside employment can be sought without prior agreement from the Board, delegated to the Chief Executive for executive directors. The Board Register of Interest is a standard agenda item at each Board of Directors meeting.	• Standards of Business Conduct Policy: Declaration of Interest, Gifts and Hospitality and Sponsorship • Board Register of Interests • Board of Director Meeting papers • Board minutes	√
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 of the company secretary, however, as per the Code of Governance, removal of the company secretary would be a matter for the whole board.	• 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	The integrated governance structure facilitates assurance reporting on clinical, quality, patient safety to and from the Board.	• Integrated Governance Structure.	√

SECTION B DIVISION OF RESPONSIBILITIES				
CODE PROVISION		**TRUST POSITION**	**Evidence**	**Comply?**
	and standards of clinical governance set out by DHSC, NHS England, the CQC and other relevant NHS bodies.	The Quality and Performance Committee has a comprehensive Work Plan which includes statutory and regulatory reporting requirements. Executive Directors responsible for clinical governance and workforce are commissioned to provide assurance to the Board Assurance Committees. In addition, they seek assurance through the Executive led Groups: Clinical and Quality Group and People and Culture Group and provide assurance to the Trust Management Committee via a 3A report. NED briefings include updates on regulatory reporting requirements and the Trust's Research and Development Annual Report 2024/25 includes key successes in education, training, and research.	• Board Assurance Committee Work Plans. • Group work plans. • 3A Reports • NED briefings. • Research and Development Annual Report 2024/25.	
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 responsibilities of the chief executive as the accounting officer.	The Board of Directors function as a unitary board and all Directors are clear on their joint responsibilities for every board decision taken. 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.	• Board of Director minutes. • Chief Executive Updates. • 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	All board members are aware of their responsibilities to provide constructive challenge, which is welcomed and effectively facilitated by the Chair. Previous Board development sessions have focused on Board cohesion and constructive challenge. During 24/25 the Board attended sessions in relation to • Strategy Deliverables 24/25	• Board of Directors minutes • Terms of Reference • Committee Minutes • Board of Directors Action Logs. • Committee work plans.	√

SECTION B DIVISION OF RESPONSIBILITIES				
CODE PROVISION		**TRUST POSITION**	**Evidence**	**Comply?**
	and other information, and make sure that financial and clinical quality controls, and systems of risk management and governance, are robust and implemented.	• CQC Single Assessment Framework • NARU – Directors Responsibilities under the Civil Contingencies Act (CCA) 2004 • EPRR Self Assessment • Cyber Security • Patient Safety • NCSC Cyber Security Board Training • Annual Plan 250-26 • Financial Planning Board members have also been provided with the opportunity to engage and provide input into the risk appetite statement and Board Assurance Framework. 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. 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	• Committee 3A Reports to Board • Board Development Programme • Internal Audit Plan • Board Assurance Framework • Risk Appetite Statement	

SECTION B DIVISION OF RESPONSIBILITIES				
CODE PROVISION		**TRUST POSITION**	**Evidence**	**Comply?**
		account on progress made to mitigate the risks during the quarter. The Audit Committee, through the work of internal audit, receive the assurance outcomes from reviews set out within the Internal Audit Plan and track the progress of recommendations. Where internal audit reviews receive no or 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 3A 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 2024/25

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 been	Not applicable		

SECTION C: COMPOSITION, SUCCESSION AND EVALUTION				
CODE PROVISION		**TRUST POSITION**	**Evidence**	**Comply?**
	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. Internal Audit undertook a review of the Trust's Fit and Proper Persons Test arrangements during 2024/25 which received high assurance. 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 was due to end in January 2025. An extension period has been agreed by NHSE until July 2025 to provide stability to the Board of Directors whilst senior leadership appointments are made, including recruitment of a new Chair	• 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	Not applicable		

SECTION C: BOARD APPOINTMENTS				
CODE PROVISION				
	election. This should include prior 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 were approved by the Board of Directors in April 2024. Formal evaluation of the Board of Directors will be undertaken during Q1 2025/26. 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 is included with the Committee Annual Report to the Board of Directors. Executive led Groups are subject to the same annual evaluation and the outcome of the evaluations and revised Terms of Reference will be reported to the Trust Management Committee for approval. 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 utilised as part of executive appraisals.	• 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	• Appraisal Documentation • Committee Minutes • Committee ToR	√

SECTION C: BOARD APPOINTMENTS				
CODE PROVISION				
		appraisals is reported to the Nominations and Remuneration Committee on an annual basis.		
C.4.8	Led by the chair, foundation trust councils of governors should periodically assess their collective performance and 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	Not applicable		

SECTION C: BOARD APPOINTMENTS				
CODE PROVISION				
	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.			
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	• NARC ToR • NARC Minutes	√

SECTION C: BOARD APPOINTMENTS				
CODE PROVISION				
		consideration the changing landscape of the NHS and skills and experience required for the future.		
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 their 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 programme 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 individual 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,	A Board Development plan is drafted each year that provides additional training/education for all Board members on a variety of topics. Board Development Sessions have previously included sessions relating to EDI Priorities and the NW BAME Assembly Anti Racist Framework.	• Board Development Programme • Mandatory Training records • NED Training/Event Register	√

SECTION C: DEVELOPMENT, INFORMATION AND SUPPORT				
CODE PROVISION				
	knowledge and capabilities. Where directors or, for foundation trusts, governors are involved in recruitment, they should receive appropriate training including on equality diversity and inclusion, including unconscious bias.	The Trust does not have a council of governors. Executive Directors have attended the Trust's Unconscious Bias leadership module as part of their mandatory training requirements. All Board Directors have the opportunity to attend external development sessions to continually enhance their skills and knowledge.		
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 on a regular basis, 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 and local staff forums which gives an opportunity to meet and interact with both members of staff and members of our communities.	• Reservations of Powers to the Board • Standing Orders • Standing Financial Instructions • Policy Management Framework	√
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 programme 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. Introduction meetings between all Board colleagues are arranged upon commencing with the Trust and time is spent in operational services such as Integrated Contact Centres, 111, PTS, Paramedic	• Chair/NED Induction • Board Development Programme • Mandatory Training • NED Training/Event Register	√

SECTION C: DEVELOPMENT, INFORMATION AND SUPPORT				
CODE PROVISION				
		Emergency Service and other service line visits. Longer standing NEDs provide mentoring to new NEDs during their first year of office to assist with carrying out their and understanding the organisation. For anyone who is in their first NED/Chair or Executive role in the NHS, attendance at one of the national induction/development sessions is mandatory during their first 3-6 months in role. The Trust does not have a council of governors.		
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 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.	• Appraisal documentation. • Board Development Programme	√
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.	• Board paper front Cover • Board Cycle of Business • Board minutes • Committee ToR	√

SECTION C: DEVELOPMENT, INFORMATION AND SUPPORT				
CODE PROVISION				
		Should any additional reporting be required this can be commissioned. 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.		
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 integrated governance structure has been designed to allow information to flow effectively from Executive led Groups to the Committees of the Board which include the Trust Management Committee. During 2024/25 this was facilitated through a n Escalation & Assurance Report, which is used as a mechanism to provide key areas of escalation from Chairs of the Groups and Committees. It focuses on areas of alert, advise and assure, including the key risks discussed/identified during the meeting. The Audit Committee also receives the 3A Reports from the Quality and Performance Committee and Resources Committee as part of its remit to seek and triangulate assurance on the overall system of control. C.5.4 details the arrangements to facilitate induction and any professional development identified by the Chair or Chief Executive.	• Committee Chairs Assurance Reports • Board minutes • Audit Committee minutes • Chair/NED induction programme.	√
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	The Board of Directors, all committees and Groups have an annual cycle of business to ensure that all key information/data is seen in the appropriate forum at the appropriate time. The members of the meetings agree these annual business cycles and ensure that all the required information is mapped across the year. Further	• Board paper front Cover • Cycle of Business • Board minutes • Committee Terms of Reference	√

SECTION C: DEVELOPMENT, INFORMATION AND SUPPORT				
CODE PROVISION				
	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.	assurance can be sought, and the business cycle document is dynamic throughout the year as it is reviewed 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.		
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, non-executives may reasonably decide that external assurance is appropriate.	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. For complex or high-risk issues, non-executives are able to seek external assurance through using internal audit review or another external body.	• Board minutes • Committee minutes	√
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 be sought if deemed appropriate by all members. Information relating to the availability of independent external sources of advice is 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	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	• Board/Committee Structure • Terms of Reference	√

SECTION C: DEVELOPMENT, INFORMATION AND SUPPORT				
CODE PROVISION				
	sufficient resources to undertake its duties with such arrangements agreed in advance.	meets with Committee Chairs to provide a brief overview of the meeting agenda and to highlight areas where further assurance may be required.		
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 (financial).	• 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 foundation trust's plans, and explain the reasons for any not being included.	Not applicable		
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 2024/25

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-Executive Director 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 2024/25, 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 2020	• 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.	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. The Standing Financial Instructions have been updated (s2.4.2) 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	√

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 remuneration, especially for directors close to retirement.	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 in place at the time. 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	√

DISCLOSURE OF CORPORATE GOVERNANCE ARRANGEMENTS FOR 2024/25

SECTION E: REMUNERATION				
CODE PROVISION		**TRUST POSITION**	**Evidence**	**Comply?**
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 director's requirement for compensation to be reduced. Since 2019, new director appointments have reflected a 'claw back' agreement subject to achieving performance criteria. 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 2024/25.	• NARC Minutes	√
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	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	• NARC Terms of Reference • Annual Report	√

SECTION E: REMUNERATION				
CODE PROVISION		**TRUST POSITION**	**Evidence**	**Comply?**
	for this purpose and this should normally include the first layer of management below board level.	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.		

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REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 30 April 2025
SUBJECT	Non-Executive Terms of Office; Committee Membership 2025/26 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**	☒	**SR11**	☒

Risk Appetite Statement *(Decision Papers Only)*	Compliance/ Regulatory	☐	Quality Outcomes	☐	Cyber Security	☐	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 2025/6. • 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 2025/26 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

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 2025/26.

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 be extended.

Terms of Office wef 1st April 2025 are shown below:

Non-Executive Directors	
Name	**Term of Office**
Peter White (Chairman)	Extended to 31 July 2025 (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	Extended to 30 November 2025 (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	25/03/24 – 24/03/26

3. COMMITTEE MEMBERSHIP

As a result of the Chairman's annual review of Committee membership, the Non-Executive Director membership for 2025/26 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	Alison Chambers
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 2025/26.
- The Non-Executive Director Champion Roles

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REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 30 April 2025
SUBJECT	Board of Directors Cycle of Business 2025/26
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**	☒	**SR11**	☒

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

ACTION REQUIRED	The Board of Directors is asked to: • Approve the Annual Cycle of Business for 2025/26 outlined within 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 2025/26 outlined within Appendix 1.

Board of Directors
Work Programme 2025/26

NHS North West Ambulance Service NHS Trust

	Date of meeting	30.04.25	28.05.25	18.06.25	30.07.25	24.09.25	26.11.25	28.01.26	25.03.26
	Report Deadline	**23.04.25**	**21.05.25**	**11.06.25**	**23.07.25**	**17.09.25**	**19.11.25**	**21.01.26**	**18.03.26**
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 & Partnerships)			√		√	√	√	√	√
Agenda Item	**Strategy**								
Chairman & Non Executive Directors Update			√		√	√	√	√	√
Chief Executive's Report			√		√	√	√	√	√
Agenda Item	**Governance and Risk Management**								
3A Report - Audit Committee (NED Chair)			√		√		√	√	
3A Report - Trust Management Committee (CEO)			√		√	√	√	√	√
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 - TBC									
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)		√						
NHS Provider Code of Governance – Position of Compliance	√							
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)								√
Proposed Strategic Risks 26/27 (Director of Corporate Affairs)								√
Health, Safety, Security and Fire Annual Report (Director of Corporate Affairs)			√					
3A Report - Charitable Funds Committee (NED Chair)		√		√		√		√
Agenda Item	**Quality, Patient Safety, Effectiveness and Experience**							
3A 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 & Improvement)								
Safeguarding				√				√
IPC Report & IPC BAF				√				√
Senior Information Risk Owner Annual Report				√				
Complaints Annual Report (Director of Corporate Affairs)		√		√				
Quality Account (Director of Quality & Improvement)			√	√				
CQC Update: As required (Director of Quality & Improvement)								
Emergency, Preparedness, Resilience and Response (EPRR) Bi Annual Assurance (Director of Operations)					√ (anticipated outcome of the self assessment)			√ (confirmed position post ICB sign off)
Operational, Performance and Use of Resources								

Agenda Item								
3A Report - Resources Committee (NED Chair)		√		√	√	√	√	√
3A Report - Charitable Funds Committee (NED Chair)		√		√		√		√
Integrated Performance Report (Director of Quality & Improvement)		√		√	√	√	√	√
Winter Plan (Director of Operations)						√		
Equality, Diversity and Inclusion (Director of People)		Annual Report		EDI Regulatory reports, WRES, WDES, Gender Pay				
Approach to Planning (Director of Strategy & Partnerships)	**To be confirmed on an annual basis**							
Strategy and Planning								
Agenda Item								
Communications Update (Director of Strategy & Partnerships)		Q4		√		√	√	
Bi Annual Assurance Report - Stakeholder Engagement (Director of Strategy & Partnerships)				√			√	
Estates and Fleet Strategic Plan Roadmap (Director of Finance)								√ (annual review)
Consent Agenda								
Agenda Item								
Policies and Strategies: As required								

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REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 30 April 2025
SUBJECT	Board Assurance Committee Terms of Reference 2025/26
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**	☒	**SR11**	☒

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

ACTION REQUIRED	The Board of Directors is asked to: • Approve the Terms of Reference for all Board Assurance Committees.
EXECUTIVE SUMMARY	An annual review of the Terms of Reference has been undertaken, and any changes have been made in conjunction with the Executive Leads and Non-Executive Committee Chairs. The Audit Committee ToR have been drafted in line with the latest HFMA Audit Committee guide/handbook. 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	Executive Leads and Committee Chairs
	Date
	Outcome

TERMS OF REFERENCE

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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 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.

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 COMMITTEE

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 Global Internal Audit Standards (GIAS)~~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:

- ❖ considering 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
- ❖ 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:

- ❖ 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 of the 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 Trust's 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
- ❖ the policies and procedures for all work related to counter fraud, bribery and corruption 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 governance, risk management and assurance of the organisation. These 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 and Resources Committee) to understand processes and to provide relevant assurance to the Committee's own scope of work. However, these Committees must not assume the Committee's role.

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 and escalation report which ~~are~~ reported through to the Audit Committee. The committee will also seek assurance through this report in relation to the ~~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.

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)~~., as may be appropriate to the understanding of the overall arrangements.~~

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.

Review

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 North West Ambulance Service NHS Trust

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.
- Director of Finance
- Director of Corporate Affairs
- Director of Operations~~Chief Operating Officer/Deputy Chief Executive~~
- Director of People

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:

- Head of Technical Accounts
- Head of Charity
- Fundraising Manager

- Head of Communications
- Area Director (Cumbria and Lancashire)

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 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 COMMITTEE

The overall remit of the Committee is to:

i. ensure the stewardship and effective management of funds which have been donated, bequeathed and given to the North West Ambulance Service NHS Trust Charitable Fund for charitable purposes;

ii. co-ordinate the provision of assurance to the corporate trustee of the funds, that the funds are accounted for, deployed and where appropriate, invested in line with legal and statutory requirements;

iii. consider and recommend the annual accounts for charitable funds for submission to and approval by the Board of Directors, acting as trustee of the funds;

iv. satisfy itself that an appropriate control environment is maintained to manage the key risks faced by the charity and to ensure compliance with Charity Law and Charity Commission regulations

Duties and responsibilities of the Committee shall be:

Governance, Risk Management and Internal Control

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~~will:

- 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 and approve ~~expenditure~~ requests for use of charitable funds over £50,001 (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.

Meeting frequency
The Group will meet on a bi-monthly 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 COMMITTEE

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.
- 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 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 and Improvement~~, Innovation, and Improvement~~
- Medical Director
- Director of Operations~~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
- Deputy Director of Corporate Affairs

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 and improvement~~, 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 action notes within 48 hours of the meeting.

2. REMIT OF THE COMMITTEE

The Committee will:

Quality:

- Gain assurance 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.
- Gain assurance that the registration criteria of the Care Quality Commission continue to be met by reviewing 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.
- Gain assurance that the Trust has appropriate processes in place that safeguard children and vulnerable adults.
- Gain assurance through review of the routine Legal and Clinical Governance reports that the Trust incorporates the recommendations from external bodies, ~~(eg the Kirkup Maternity Review)~~ as well as those made internally, (eg in connection with ~~serious incident~~patient safety reports and adverse incident reports) into practice and has mechanisms to monitor their delivery.

- Gain assurance 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.
- Gain assurance that actions for improvement identified in Patient Safety incident reports, e.g. reports from HM Coroner, Learning from Deaths and other similar documents are addressed.
- ~~Ensure implementation of the Patient Safety Incident Response Framework (PSIRF)~~
- Gain assurance 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.
- Gain assurance that the Trust has a robust process in place to assess, mitigate and monitor the quality and/or safety impact of proposals for efficiency 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;~~
- Gain assurance 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, oversee 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).
- Gain assurance that 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

- ~~Gain assurance on any fluctuations in 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 Quality & Performance domain of the Integrated ~~Quality and~~ Performance report ahead of the Trust Board and seek assurance of the actions in place to deliver against the targets and any mitigation where performance is not on track
- 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 the EPRR annual self assessment framework ~~Emergency Preparedness Resilience and Response plan and performance~~(prior to submission and post submission)
- Review ~~of~~ the operational plans such as the Winter Plan, ~~&~~ Adverse Weather Plan and Incident R~~r~~esponse Plan
- 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 to the Board of Directors that the ~~relating to all aspects of~~ 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 shall also seek assurance in relation to the strategic planning framework and delivery against the Trust's strategic aims and objectives. ~~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 and, ~~-~~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
- 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, and Fleet strategic plans
  - People Strategy
  - Procurement compliance
  - 3 Year Implementation Roadmap
  - Long Term Financial Model
  - Financial Plan
  - Operational 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 Annual~~Business~~ Plan).

- Monitor the ongoing financial performance of the Trust, the financial forecast, and the key financial risks.
- Monitor delivery of the cCapital eExpenditure programmes and seek assurance on the preparation of comprehensive programmes for subsequent years.
- Recommend the cCapital eExpenditure programme to the Board of Directors for approval and review cCapital and rRevenue investment proposals over £1,000,000 and recommend to the Board of Directors for approval.
- 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 reduction strategy 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 ~~recommendation to~~recommendation to 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 workforce plans.
- 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 education, apprenticeship delivery and leadership development ~~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.

- Provide assurance on the Trust's progress in developing an inclusive culture in line with the recommendations of the ambulance culture review.

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

North West Ambulance Service NHS Trust

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 and Improvement~~, Innovation and Improvement~~
- Director of Operations
- Director of Finance
- Medical Director
- Director of People
- Director of Corporate Affairs
- Director of Strategy and Partnerships
- 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 action notes 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, that have not been identified as a corporate project, ~~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
  - Service Delivery Assurance Group
  - Planning Group

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REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 30 April 2025
SUBJECT	Quality and Performance Committee Annual Report 2024/25
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**	☐	**SR11**	☐

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

ACTION REQUIRED	The Board of Directors is asked to: • Review the Quality and Performance Committee Annual Report for 2024/25. • Note the amendments to the Committee Terms of Reference for 2025/26 presented under separate cover for Board approval.
EXECUTIVE SUMMARY	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 2024 to 31st March 2025 and to set out how it has met its terms of reference and priorities. The Terms of Reference have been reviewed and the following amendments have been made: • Amendments to titles within Membership section • Removal of historical references within the Remit section • Clarification around the Patient Safety items • Removal of duplication points • Clarification regarding Integrated Performance Report item within the Committee's remit • Clarification regarding operational items within Remit referring to EPRR and operational plans

	The committee effectiveness review highlighted high satisfaction with committee effectiveness and identified the group has met its remit and functions. However, key improvements have been identified for focus during 2025/26: • Enhanced focus of debates to ensure the discussion does not wonder from the point thus impacting on the timing of other agenda items • Improvements to quality papers on key topics with greater scrutiny and assurances.	
PREVIOUSLY CONSIDERED BY	Quality and Performance Committee	
	Date	Monday, 28 April 2025
	Outcome	Awaited

1. BACKGROUND

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 2024 to 31st March 2025 and to set out how it has met its terms of reference and priorities.

2. ROLE OF QUALITY AND PERFORMANCE COMMITTEE

The Quality and Performance Committee has been established as a formal committee of the Board of Directors.

The purpose of the Committee is to provide 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.

3. COMMITTEE MEMBERSHIP AND ATTENDANCE

Meetings of the Committee have been held as scheduled in the corporate calendar and there have been no instances where a quorum was not present.

4. QUALITY AND PERFORMANCE COMMITTEE SELF ASSESSMENT

The current Terms of Reference have been reviewed by the Executive Leads and the Chair of the Quality and Performance Committee. The Board should note that during 2024/25 all functions set out within the Terms of Reference have been discharged.

On review of the ToR, the reporting process will be strengthened for CQC reporting and QIA process reporting for 2025/26.

Leadership and meetings

Feedback from the effectiveness survey indicated a high level of satisfaction with the effectiveness of the Committee and its leadership.

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 progress made at bi-monthly meetings. Robust discussions and challenge regarding the risks aligned to the Committee were held and triangulated with the content of Integrated Performance Reports.

Integrated Performance Report and Quality Dashboard

The Committee has received the IPR Dashboard reports at each meeting. 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.

3A Reports

The 3A Report (Alert, Advise and Assure) is a mechanism for the Committee to escalate and report matters to the Board of Directors following each Committee meeting.

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).

The Committee received and recommended to the Board approval of Proposed PSIRF Priorities and Plan.

Mental Health, Disability and Autism Learning

The Committee received focused reports on Mental Health and Learning Disability and Autism.

Medicines Management including Controlled Drugs

The Committee has received regular quarterly reports as well as the annual report and the Designated Body Controlled Drugs Accountable Officer (CDAO) Improvement Framework - Self-Assessment Submission.

IPC and Safeguarding

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

EPRR and Adverse Weather Plans

The Committee has received regular submissions, those included EPRR Annual Assurance Report and Strategic Winter Plan.

Clinical Audit Plans

The Committee has received regular updates against Clinical Audit Plan.

5. COMMITTEE IMPROVEMENTS FOR 2025/26

The 2024/25 annual effectiveness review highlighted the following areas for improvement during 2025/26:

- Enhanced focus of debates to ensure the discussion does not wander from the point thus impacting on the timing of other agenda items
- Improvements to quality papers on key topics with greater scrutiny and assurances.

6. TERMS OF REFERENCE

The terms of reference have been reviewed by the Executive Leads, Committee Chair and received at the Committee meeting on 28th April 2025. The refreshed Terms of Reference are presented to the Board of Directors for approval as a separate agenda item.

7. EQUALITY/SUSTAINABILITY IMPACTS

None identified.

8. ACTION REQUIRED

The Board of Directors is asked to:

- Review the Quality and Performance Committee Annual Report for 2024/25.
- Note the amendments to the Committee Terms of Reference for 2025/26 presented under separate cover for Board approval.

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REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 30 April 2025
SUBJECT	Resources Committee Annual Report 2024/25
PRESENTED BY	Dr D Hanley, Chair of the Resources Committee
PURPOSE	Assurance

LINK TO STRATEGY	People Strategy									
	Sustainability Strategy									
BOARD ASSURANCE FRAMEWORK (BAF)	**SR01**	☐	**SR02**	☒	**SR03**	☐	**SR04**	☐	**SR05**	☒
	SR06	☐	**SR07**	☒	**SR08**	☒	**SR09**	☐	**SR10**	☒	**SR11**	☒

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

ACTION REQUIRED	The Board of Directors is asked to: • Review the Resources Committee Annual Report for 2024/25. • Note the amendments to the Committee Terms of Reference for 2025/26 presented under separate cover for Board approval.
EXECUTIVE SUMMARY	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 2024 to 31st March 2025 and to set out how it has met its terms of reference and priorities. The Terms of Reference have been reviewed and the following amendments have been made: • Removal of reference to assurance regarding corporate projects, as this was identified as historical item from the old Finance and Investment Committee (2016). • Removal of reference to assurance regarding volunteers as this is reported through the Service Delivery Assurance Group (SDAG). • Removal of reference to revalidation. • Addition of reference to strategy and planning processes. • Addition of reference to culture review.

	The committee effectiveness review highlighted high satisfaction with committee effectiveness and identified the group has met its remit and functions. However, key improvements have been identified for focus during 2025/26: • Rotation of the agenda items for a balanced timing of items and allowing sufficient time for deep dives. • Additional financial update in light of the enhanced grip and control measures – additional item was added to Work Plan.	
PREVIOUSLY CONSIDERED BY	Resources Committee	
	Date	Friday, 21 March 2025
	Outcome	Recommend to BoD for approval

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 2024 to 31st March 2025 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 provide assurance to 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 shall also seek assurance in relation to the strategic planning framework and delivery against the Trust's strategic aims and objectives.

3. COMMITTEE MEMBERSHIP AND ATTENDANCE

Meetings of the Committee have been held as scheduled in the corporate calendar, except for the July meeting, which was cancelled due to annual leave commitments with items redirected to Board (People Strategy refresh, EDI priorities and Annual Plan) and other items deferred to the September meeting. 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 2024/25 all functions set out within the Terms of Reference have been discharged.

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

- Effective deep dives - sharing of issues and challenges such as the BME access to disciplinary processes enabled honest and open debate and surfaced new ideas to explore using the breadth of experience available through the committee. Deep dives have allowed time to focus on specific topics.
- Financial updates have provided assurance regarding achievement of key financial duties.
- Enhanced digital updates have provided better insight on digital performance and risk.

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:

- The Committee works very effectively.
- There is appropriate questioning on areas that require it during the meeting, and reasonable asks to bring back additional/deep dive where more information and assurance is required.

- Action has been taken to address areas of knowledge deficit around digital via updates and deep dives.

Finance

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 were 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.

The committee received regular updates regarding procurement process and compliance with statutory requirements.

Regular updates were presented to the committee in relation to sustainability, with the progress against the Green Plan and the environmental aspects of the Sustainability Strategy.

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 Interim Deputy Director of Strategy, Partnerships and Transformation and annual plans, supported by quarterly assurance reports. The committee also received and recommended to the BoD the strategy development options and annual plans for 2025-26.

Workforce

The committee has received regular updates on the key workforce performance indicators, as well as Deep Dives and a wide range of other items covering the following areas:

- Annual staff Survey Results
- Health & Wellbeing
- Culture review
- Violence Prevention and Reduction
- Recruitment
- Flu campaign

EDI

The committee has received the Equality, Diversity and Inclusion Annual Report 2023/24, Equality Delivery System Assessment 2024/25 and recommended to the Board the approval of the Anti-racism Statement.

Digital

The committee received regular digital updates against strategic plans as well as other specific digital items.

5. COMMITTEE IMPROVEMENTS FOR 2025/26

The 2024/25 annual effectiveness review highlighted the following areas for improvement during 2025/26:

- Rotation of the agenda items for a balanced timing of items and allowing sufficient time for deep dives.
- Additional financial update in light of the enhanced grip and control measures – additional item was added to Work Plan to address this suggestion.

6. TERMS OF REFERENCE

The terms of reference have been reviewed by the Resources Committee at the meeting held on 21st March 2025 and are presented to the Board of Directors for approval as a separate agenda item.

7. EQUALITY/SUSTAINABILITY IMPACTS

None identified.

8. ACTION REQUIRED

The Board of Directors is asked to:

- Review the Resources Committee Annual Report for 2024/25.
- Note the amendments to the Committee Terms of Reference for 2025/26 presented under separate cover for Board approval.

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REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 30 April 2025
SUBJECT	Audit Committee Annual Report 2024/25
PRESENTED BY	Mr D Whatley, Chair of Audit Committee
PURPOSE	Assurance

LINK TO STRATEGY	All Strategies										
BOARD ASSURANCE FRAMEWORK (BAF)	**SR01**	☐	**SR02**	☒	**SR03**	☐	**SR04**	☐	**SR05**	☐	
	SR06	☒	**SR07**	☐	**SR08**	☐	**SR09**	☐	**SR10**	☐	**SR11**	☐

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

ACTION REQUIRED	The Board of Directors is asked to: • Note the Audit Committee Annual Report 2024/25.	
EXECUTIVE SUMMARY	The Audit Committee Annual Report provides information on how the Audit Committee met its Terms of Reference during the 2024/25 financial year.	
PREVIOUSLY CONSIDERED BY	Audit Committee	
	Date	Friday, 25 April 2025
	Outcome	Approved

Audit Committee Annual Report 2024/25

Introduction

This report provides information on the how the Audit Committee has met its Terms of Reference during the 2024/25 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 2024 to 31 March 2025.

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 Forvis Mazars (External Auditors), MIAA (Internal Audit and Counter-Fraud Services), Director of Finance and Director of Corporate Affairs.

The Committee Terms of Reference were reviewed against the template Terms of Reference provided within the HFMA Audit Committee Handbook released in March 2024 and approved by the Audit Committee on 19th April 2024.

Committee Members and Attendance

During 2024/25 the Audit Committee consisted of the following members:

Committee Member		Attendance
Mr D Whatley	Non-Executive Director (Chair)	6/6
Dr A Chambers	Non-Executive Director	5/6
Prof A Esmail	Non-Executive Director	5/6
Mrs C Butterworth	Non-Executive Director	6/6

The Committee met on the following occasions during 2024/25:

19th April 2024
17th May 2024
19th June 2024
19th July 2024
18th October 2024
17th January 2025

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.

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 Annual Risk Management report provided assurance on the adequacy and effectiveness of risk management arrangements in place during 2023/24. During the year, MIAA reviewed the Trust's core risk management controls which provided an outcome of High Assurance.

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 2024/25 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.

Bi-Annual Self-Certification of NHS Provider Licence

In line with the revised Terms of Reference and updated HFMA Audit Committee Handbook, the Committee received annual self-certification that provided assurance the organisation was compliant with the conditions of its NHS Provider Licence during 2023/24. A further report was received at its meeting on 18th October 2024 to confirm bi-annual compliance.

NHS Provider Code of Governance

The annual declaration of compliance was received against the NHS Provider Code of Governance for 2023/24 which confirmed compliance with all relevant clauses.

Management Reports

Core Governance documents: The received the outcome of the annual reviews of the Trust's core governance documents; Standing Orders and Reservations of Power to the Board of Directors; Scheme of Delegation and Standing Financial Instructions (SFIs)which were recommended for approval by the Board of Directors.

Quarterly Waiver Reports: In accordance with Section 17.3.4 of the SFIs *'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'*, the Committee reviewed the waiver register on a quarterly basis.

Information Governance: Information Governance (IG) is the framework for handling information in a secure and confidential manner that allows organisations and individuals to manage patient, personal and sensitive information legally, securely, efficiently and effectively in order to deliver the best possible healthcare and services. During the year, the Trust's Senior Information Risk Officer (SIRO) provided a summary of the Trust's information governance framework for the 2023/24 financial year. The Committee took assurance that there are appropriate controls in place to maintain security of information.

Clinical Governance: The committee received the chair's 3A reports from the Quality and Performance Committee following presentation to the Board of Directors to consider 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 Executive Director or Senior Manager to meetings. During the reporting period there were no limited assurance reports issued.

The committee considered all critical and high-risk 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:

High Assurance Opinions	**Substantial Assurance Opinions**	**Moderate Assurance Opinions**
Fit & Proper Persons	Data Security & Protection Toolkit	EPRR
Key Financial Transactional Processing Controls	Complaints	Cyber Assessment Framework Baseline / Gap Analysis Review
Risk Management – Core Controls	Safeguarding	E-Timesheets
Review of HFMA Improving NHS Financial Sustainability Checklist	Access to Health Records	
	Management of Controlled Drugs	
	Environmental Sustainability	
	PSIRF	
	EDI	
0 No Assurance Opinions	**0 Limited 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.

In September 2024, the NHS Data Security Protection Toolkit (DSPT) transitioned from using the NDGs 10 data security standards to the National Cyber Security Centre's Cyber Assessment Framework (CAF) as its assessment mechanism. MIAA undertook a baseline review/gap analysis against the Cyber Assessment Framework that was aligned with the 2024/25 Data Security and Protection Toolkit submission. The review identified good levels of compliance from which an improvement plan was identified in order to meet the assessment framework. The Committee has continued to track actions through MIAAs follow up report.

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 2024/25, the Head of Internal Audit overall opinion for the period 1 April 2024 to 31 March 2025 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

Forvis Mazars were the External Auditors to the Trust for the 2024/25 financial year and will report on the Annual Report and Financial Statements. The audit for the financial year 2024/25 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 18 June 2025, 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, the Committee undertook a review of its effectiveness against two checklists provided within the HFMA Audit Committee handbook, facilitated by MIAA. These checklist aid facilitation of the Committee effectiveness in relation to 1) testing the committee processes and 2) to test its effectiveness against a number of themes; focus, team working, effectiveness, engagement and leadership. Whilst the outcome was positive, there were a small number of areas that required review with Executive Leads. An action plan was developed by the Chair of the Committee and presented to the Committee on 18th October 2024.

Members of the Audit Committee met privately with external auditors in April 2024 and internal auditors in July 2024. Meetings for 2025 have been scheduled.

The revised Terms of Reference will be submitted to the Board of Directors on 30th April 2025 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 25th April 2025

APPENDIX 1 - REPORTS TO THE AUDIT COMMITTEE DURING 2024/25

Management Reports
Quarterly Board Assurance Framework Reports
Opening Position of the Board Assurance Framework 2024/25
Risk Management Policy
Quarterly Losses and Compensation Reports
Estates Evaluation Report
Accounting Policies for 2023/24
Annual Review of Core Governance Documents
Audit Committee Annual Report 2023/24
Audit Committee Terms of Reference
Declarations of Interest, Gifts & Hospitality Annual Report 2023/24
Standards of Business Conduct: Policy on Register of Interests, Gifts and Hospitality and Sponsorship
Bi Annual Compliance Against Provider Licence
NHS Code Disclosure of Corporate Governance Arrangements
Quarterly Waiver of Standing Orders Reports
Committee Self-Assessment and Action Plan
3A Reports from Quality and Performance Committee and Resources Committee
Draft and Audited Accounts 2023/24
Draft Annual Governance Statement 2023/24
Annual Report 2023/24 including Annual Governance Statement
Management Letter of Representation
SIRO Annual Report
Annual Risk Management Report 2023/24
Reports produced by Mazars, External Auditors
Audit Progress and Technical Updates
Audit Completion Report
Auditor's Annual Report
Reports produced by MIAA
Internal Audit Progress Reports
Internal Audit Work Plan 2024/25
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 2023/24 including Self Review Toolkit (SRT) Ratings
Anti-Fraud Annual Work Plan 2024/25
Anti Fraud, Bribery and Corruption Policy