NHS
Yorkshire
Ambulance Service
NHS Trust

Meeting of the Board of Directors (in Public)

Agenda and Meeting Papers

Thursday 25th July, 2024

NHS Yorkshire Ambulance Service NHS Trust

Our Strategy 2024-29	
Our Purpose	To provide and co-ordinate safe, effective, responsive and patient-centred out-of-hospital emergency, urgent and non-emergency care, so all our patients can have the best possible experience and outcomes
Our Vision	Great Care Great People Great Partner
Our Values	Kindness Respect Teamwork Improvement
YAS Together	Care Lead Grow Excel Everyone
Our Bold Ambitions	
Our Patients	Our ambition is to deliver exceptional patient-centred out-of-hospital emergency, urgent and non-emergency care, which is safe, kind and responsive, seamlessly integrating services and utilising technology to deliver a high-quality patient experience
Our People	Our ambition is to be a diverse and inclusive organisation with a culture of continuous improvement, where everyone feels valued, included, proud to work and can thrive
Our Partners	Our ambition is to be a collaborative, integral and influential partner across a joined-up health and social care network that works preventatively, reduces inequality and improves population health outcomes, supporting all our communities
Our Planet and Pounds	Our ambition is to be a responsible and sustainable organisation in the use of our financial and physical resources, reducing our environmental impact and ensuring the most effective use of all our resource

NHS Yorkshire Ambulance Service NHS Trust

AGENDA		
Meeting:	**Board of Directors Meeting (held in Public)**	
Date: **Time:** **Venue:**	25 July 2024 1315 Springhill HQ: Kirkstall, Fountains and Rosedale	
Voting Directors	Martin Havenhand Tim Gilpin Anne Cooper Andrew Chang Amanda Moat Jeremy Pease Peter Reading Nick Smith Dave Green Kathryn Vause Julian Mark	Chair Non-Executive Director (Deputy Chair) Non-Executive Director (Senior Independent Director) Non-Executive Director Non-Executive Director Non-Executive Director Chief Executive Chief Operating Officer Director of Quality and Chief Paramedic Executive Director of Finance Executive Medical Director
Non-Voting Directors	Marc Thomas Mandy Wilcock	Deputy Chief Executive Director of People and Organisational Development
Contributing Directors	Adam Layland Jeevan Gill Rachel Gillott Carol Weir David O'Brien Sam Robinson	Director of Partnerships and Operations Director of Partnerships and Operations Director of Partnerships and Operations Director of Strategy, Planning and Performance Director of Corporate Services and Company Secretary Chief Digital Information Officer
In Attendance	Rebecca Randell Helen Edwards Odette Colgrave Jo Jennings	NeXT Director Head of Communications and Community Engagement Corporate Governance Manager Senior Executive Officer
Apologies:	Jeevan Gill	Director of Partnerships and Operations

No.	Description	Format	Lead	Time
1.	**OPENING BUSINESS**			
1.1	**Welcome and Apologies** (information)	Verbal	Martin Havenhand (Chair)	1315 - 1325
1.2	**Declaration of Interests** (assurance) *Any Board Member who is aware of a conflict of interest relating to any item on the agenda will be required to disclose it at this stage or when the conflict arises during consideration of the item.*	Attached		
1.3	**Minutes of Previous Meetings** (approve)			
1.3.1	Minutes of meeting held in Public on 30 May 2024	Attachment		
1.3.2	Minutes of meeting held in Public on 20 June 2024	Attachment		
1.4	**Matters Arising** (assurance) *Any Matters Arising in addition to items included on the agenda.*	Verbal		
1.5	**Action Log** (assurance) *To review open actions and agree closure of any completed actions.*	Attached		
1.6	**Patient Story** (information)	Presentation	Dave Green Executive Director of Quality and Chief Paramedic	1325 - 1335
1.7	**Chair's Report** (information)	Attached	Martin Havenhand (Chair)	1335 - 1340
1.8	**Chief Executive's Report** (information/assurance)	Attached	Peter Reading, Chief Executive	1340 - 1345
2.	**STRATEGY, PLANNING AND POLICY**			
2.1	**2024/25 Business Plan Priorities: Q1 Report** (assurance)	Attached	Carol Weir Director of Strategy, Planning and Performance	1345 - 1350

No.	Description	Format	Lead	Time
3.	**ASSURANCE**			
3.1	**Risk Report** (assurance)	Attached	David O'Brien Director of Corporate Services/ Company Secretary	1350 - 1355
3.2	**Board Assurance Framework** (assurance)	Attached	Director of Corporate Services/ Company Secretary	1355 - 1405
3.3	**Finance and Performance Committee Chair's Report** **(**assurance)	Attached	Amanda Moat Committee Chair	1405 - 1410
3.4	**Operational Assurance Report** (assurance)	Attached	Nick Smith Chief Operating Officer	1410 - 1420
3.5	**Finance Report** (assurance)	Attached	Kathryn Vause, Executive Director of Finance	1420 - 1430
3.6	**Quality Committee Chair's Report** (assurance)	Attached	Anne Cooper Committee Chair	1430 - 1435
3.7	**Quality and Clinical Highlight Report** (assurance)	Attached	Dave Green Executive Director of Quality and Chief Paramedic Julian Mark Executive Medical Director	1435 - 1445
3.8	**People Committee Chair's Report** **(**assurance)	Attached	Tim Gilpin Committee Chair	1445 - 1450
3.9	**People and Organisational Development Highlight Report** **(**assurance)	Attached	Mandy Wilcock Director of People and Organisational Development	1450 - 1455

No.	Description	Format	Lead	Time
3.10	**NHS Staff Survey** (assurance)	Attached	Mandy Wilcock Director of People and Organisational Development	1455 - 1505
3.11	**Audit and Risk Committee Chair's Report** (assurance)	Attached	Andrew Chang Committee Chair	1505 - 1510
4.	**ITEMS FOR APPROVAL**			
4.1	**Quality Improvement Enabling Plan** (approval)	Attached	Dave Green Executive Director of Quality and Chief Paramedic	1510 - 1520
5.	**PARTNERSHIP WORKING**			
5.1	**System Partnership Quarterly Update** (information / assurance)	Verbal	Adam Layland, Jeevan Gill, Rachel Gillott (Directors of Partnerships and Operations)	1520 - 1530
6.	**BOARD GOVERNANCE AND REGULATORY**			
6.1	**Corporate Governance Report** (information / assurance)	Attached	David O'Brien Director of Corporate Services/ Company Secretary	1530 - 1540
6.2	**Committee Annual Reports 2023-24** (assurance)	Attached	David O'Brien Director of Corporate Services/ Company Secretary Committee Chairs	
6.3	**Committees Terms of Reference 2024-25** (approve)	Attached	David O'Brien Director of Corporate Services/ Company Secretary	
6.4	**Governance Guide: Board of Directors** (information)	Attached	David O'Brien	

No.	Description	Format	Lead	Time
			Director of Corporate Services/ Company Secretary	
7.	**CLOSING BUSINESS**			
7.1	**Any Other Business**	Verbal	Martin Havenhand (Chair)	1540 - 1545
7.2	**Risks** *Any risks raised during the meeting that require consideration of adding to Risk Registers/Board Assurance Framework*	Verbal	Martin Havenhand (Chair)	
MEETING CLOSE 1545				
Date of next Board Meeting to be held in Public**: 26 September 2024**				

NHS Yorkshire Ambulance Service NHS Trust

Minutes of the Board of Directors Meeting (held in PUBLIC)

Thursday 30 May 2024 at 0930

Venue: Kirkstall, Fountains and Rosedale, SH1, Wakefield

Present:

Tim Gilpin	Non-Executive Director/ Deputy Chair
Anne Cooper	Non-Executive Director (Senior Independent Director)
Jeremy Pease	Non-Executive Director
Peter Reading	Chief Executive
Nick Smith	Chief Operating Officer
Dave Green	Executive Director of Quality and Chief Paramedic
Julian Mark	Executive Medical Director
Kathryn Vause	Executive Director of Finance

In Attendance:

Marc Thomas	Deputy Chief Executive
Mandy Wilcock	Director of People and Organisational Development
Adam Layland	Director of Partnerships and Operations
Rachel Gillott	Director of Partnerships and Operations
Carol Weir	Director of Strategy, Planning and Performance
Helen Edwards	Head of Communications and Community Engagement
Rebecca Randell	NExT Director
Lynsey Ryder	Head of Corporate Affairs
Odette Colgrave	Corporate Business Officer
Jo Jennings	Senior Executive Officer

Observers:

Peter Oakley	Business Development Director, CSS Europe Limited
Ciara Devlin	Regional Account Manager, Healthcare & Emergency Services, Zebra Technologies Europe Ltd
Andy Lee	Healthcare & Emergency Services, Zebra Technologies Europe Ltd

Apologies:

Martin Havenhand	Chair
Andrew Chang	Non-Executive Director
Amanda Moat	Non-Executive Director
David O'Brien	Director of Corporate Services and Company Secretary
Jeevan Gill	Director of Partnerships and Operations
Carole Hodgson-Mullings	Aspirant Non-Executive Director

BoD24/05/1	**Welcome and Apologies**
1.1	Tim Gilpin welcomed all to the Board.

1.2 Apologies were received from Martin Havenhand, Andrew Chang, Amanda Moat, David O'Brien, Jeevan Gill and Carole Hodgson-Mullings.

1.3 The meeting was quorate.

BoD24/05/2 **Declaration of Interests**

2.1 No declarations of interest were reported. If any declarations of interest did arise during the meeting these would be considered at that time.

BoD24/05/3 **Minutes of Previous Meeting**

3.1 The minutes of the meeting of the Board of Directors held in public on 25 April 2024 were approved as an accurate record subject to the following amendments:

- To add three additional attendees, Odette Colgrave, Jo Jennings and Helen Greer-Waring.
- 19.2 Adam Layland reported that there is a high prevalence of smoking in South Yorkshire, and this is a priority for the ICB, and he sought assurance regarding how the plan will encourage staff to adopt healthier lifestyles. Mussarat Suleman confirmed that the Trust had been working on smoking cessation with a public health consultant and will be running a national 'Stop and Swap' pilot scheme.
- 15 – Mandy Wilcock wanted to add in respect of the 6-month post meeting for the Sexual Safety Charter, the Trust will be introducing a professional panel to review more serious and complex cases.
- 10.5 it was Rachel Gillott who sought clarity not Amanda Moat.

3.2 There were no matters arising.

BoD24/05/4 **Action Log**

4.1 All completed actions to be closed.

BoD24/05/5 **Patient Story**

5.1 Dave Green introduced a patient story about Trust Board Homelessness and Rough Sleepers review with Healthwatch Kingston upon Hull. This includes a wider project outlining experiences of rough sleepers when accessing emergency services. YAS in particular wanted to improve what they can offer to these vulnerable people. 70 homeless people had been spoken to with weekly visits to the breakfast club and hostels. Healthwatch Hull staff have also liaised with YAS front line paramedics, call centre staff, 111 and Patient Transport Services.

5.2 If patients are not registered with a GP and have no fixed abode this can cause challenges for the management team and crews on where to pick them up and where to drop them off in a safe place. YAS has developed a Standard Operations Procedure (SOP) on how to process patients with no fixed abode.

5.3 A steering group has now been set up and will involve Communications for wider shared learning. Helen Edwards agreed to take an action to raise the profile with all ICBs to build a multi-agency response. Helen also confirmed Jeevan Gill has alerted the ICB with this report. Peter Reading also suggested

to take the report to AACE. Rachel Gillott will also provide contact details for the West Yorkshire BEVAN healthcare organisation.

Action: Helen Edwards

5.4 Anne Cooper advised there is a well-established group in Leeds for rough sleepers and if we could establish common principles that work for them. Dave Green agreed to be the lead on behalf of the Board.

5.5 **Resolved**
The Board noted the patient story.

BoD24/05/6 **Chairs Report**

6.1 Tim Gilpin drew particular attention to the General Election which is not too far away and as a public organisation the Trust is now in the purdah period. The Trust needs to avoid any activities that could call its political impartiality into question and ensure public resources are not used for party-political purposes.

6.2 **Resolved**
The Board noted the update.

BoD24/05/7 **Chief Executive's Report**

7.1 Peter Reading presented the Chief Executive's report and drew attention to the following key matters:

- Section 2.2 provides the link to the full report outlined in the patient story.
- Hidden disabilities sunflower network
- The Trust's Business Intelligence (BI) team has been shortlisted at this year's HSJ Digital Awards for Place-Based Population Health Management Analytics Tool for Ambulance and Integrated and Urgent Care.
- Community engagement and installation of Public Access defibrillators in Bradford
- Planting of 100 trees and 50 plants at Fairfield.

7.2 **Resolved**
The Board noted the report.

BoD24/05/8 **Trust Priorities 2024-25**

8.1 Peter Reading presented the Trust Priorities 2024-25 and confirmed the wording had not changed since the previous Trust Executive Meeting. The Board is asked to approve the nine priorities to make a commitment to the Trust's patients, staff and stakeholders and to deliver these in 2024-25.

8.2 While the main efforts of the Trust will be focused on these nine 9 Trust Priorities, the Trust will also continue to support work in other important areas. These priorities have been presented to the Executive Leadership Board and Senior Leadership Teams and have also been widely shared with staff and commissioners.

8.3 Jeremy Pease sought assurance that work will continue around environmental sustainability particular with the view if there is a change in direction and

government in July 2024. Peter Reading advised that further discussions with our commissioners will continue if any of these supporting business items need to be prioritised.

8.4 **Resolved:**
The Board approved the nine Trust Priorities and make a commitment to the Trust's patients, staff and stakeholders to deliver these in 2024-25.

BoD24/05/9 **Business Plan 2024-25**

9.1 Carol Weir presented the 2024-25 Annual Business Plan outlining the key priorities for the Trust and commitments to patients, staff, and partners for the 2024-25 financial year. Carol was seeking provisional approval of the draft Business Plan subject to final approval of the Financial Plan.

9.2 The workstreams for each priority are listed with a key focus on the Trust looking to improve ambulance and 999 and 111 call response particularly Category 2 ambulance response times. All the priorities are supported by the Trust values and actions to support our workforce.

9.3 Anne Cooper questioned the governance around the delivery of the Business Plan. Carol Weir confirmed all of the metrics are included within the BI dashboard and the performance data will be reviewed by the Financial and Performance Committee and then to Board for assurance. All nine Trust Priorities will have an Executive lead.

9.4 Jeremy Pease challenged whether the commissioners are happy with the Trust priorities as they had concerns in respect of our workforce. Peter Reading explained that no Trusts, ICBs or NHS England have signed off their plans, however he is optimistic that following ongoing discussions our plan will be signed off with our workforce numbers.

9.5 Rachel Gillott commented the table on Page 10 is very useful and asked if this could be summarised and shared. Carol Weir agreed to produce a simple user guide.

Action: Carol Weir

9.6 **Resolved:**
The Board provisionally approved the Business Plan 2024-25.

BoD24/05/10 **Financial Plan 2024-25**

10.1 Kathryn Vause gave a verbal update on the 2024-25 Financial Plan. The Trust is unable to bring the Financial Plan to Board due to the system plans not being signed off. However the Plan was signed off in principal at the Board meeting last month. It was noted a final submission maybe required in June 2024.

10.2 **Resolved:**
The Board noted the update.

BoD24/05/11 **Risk Report and Board Assurance Framework (BAF)**

11.1 Dave Green presented the Risk Report on behalf of David O'Brien and highlighted the following key points. Dave drew particular attention to the new

report format which has substantially changed from previous risk reporting, with additional information and presentational enhancements in appendices including use of the 'WHAT / SO WHAT / WHAT NEXT' assurance structure.

11.2 The greatest individual corporate risk is Risk 35: Hospital Handovers (25, high risk) and data can be shown between all ICB areas. Under 3.1 the new corporate risks are Risk 599: Safeguarding Referrals to Local Authorities and Risk 598: Transportation of Neonates weighing less than 2.5kg. Although the latter is rare we have been made aware of it and will be addressed.

11.3 Anne Cooper confirmed all these risks have been discussed at the Quality Committee for assurance and an internal audit will be carried out on the emerging risk of International Nurses Registration.

11.4 The BAF report outlines areas of strategic risk which include the Clinical Workforce capacity; staff physical and mental well-being and positive and inclusive workplace culture. It was noted the Head of Internal Audit has given 'Significant Assurance' to the BAF.

11.5 **Resolved**
The Board noted:
1. Two new corporate risks.
2. Three areas of emerging risk, one of which has been mitigated.
3. The year-end position for the 2023/24 BAF
4. Proposed strategic risks for inclusion in the new BAF
5. The development timeline for the new BAF

BoD24/05/12 **Integrated Performance Report**

12.1 The Integrated Performance Report was presented as reference material to inform the directorate and committee assurance reports to be considered during the subsequent agenda items.

12.2 **Resolved**
The Board noted the Integrated Performance Report.

BoD24/05/13 **Operational Assurance Report**

13.1 Nick Smith presented the assurance report covering the Chief Operating Officer remit, drawing attention to the following key highlights:

- A new Head of Integrated Urgent Care (IUC) has been appointed for the Remote Urgent Care therefore the Trust now has a full and substantive leadership team across remote care and so can progress with the transformation plan.
- The IUC Transformation Programme (Case for Change) is progressing well with new rotas to be in place during June 2024 and various consultation.
- Good progress is being made with the EPRR Core and Interoperability Standards.

- The Category 2 standard of 30 minutes was achieved in April (26m). The year-to-date position is 29 minutes. Both West Yorkshire and South Yorkshire YTD are below 30 minutes.

13.2 Nick Smith advised the following key lowlights:

- Emergency Operations Centre (EOC) turnover in April remains around 21% against a trajectory of 18% (rolling 12 month).
- IUC we still have high reliance on agency for recruiting new staff.
- A&E demand and handover delays have increased during May. The average turnaround time is 53 minutes with variance between 46 in West Yorkshire, 52 in South Yorkshire and 71 minutes in Humber and North Yorkshire ICB. We are working with system partners to address these

13.3 Proposed implementation of Eligibility to provide the Patient Transport Service to the right patients. Visits undertaken at Ambulance Services with good numbers of clinicians in EOC. Remote Clinical Hubs in place in Hull, Leeds, Keighley, Sheffield for rotation. NARU contract has been novated from WMAS to LAS and increased capacity for training is expected.

13.4 Following quality and safety visits, Anne Cooper raised the culture issues around urgent care compared to emergency care. Nick Smith responded and confirmed there are areas in EOC that need to be strengthened. However Dave Green added that specialist paramedics are being asked about what expertise they can provide and compared to other ambulance seervices the Trust is doing well. There is still a lot of cultural work to be done and this will continue to be addressed.

13.5 Jeremy Pease raised whether the Trust has considered the continuous flow model similar to the South as hospital turn-around times have deteriorated. Peter Reading confirmed although the continuous flow model has been promoted nationally, this is only successful in a limited number of acute trusts and is dependent on space within hospitals with some serious pushback if extra patients are put in wards. There is more resistance for this model as not fit for all. Adam Layland added that this model is being used in Sheffield, however it has reduced handover times but not eradicated them. It is hindering the acuity levels going through Emergency Departments and affecting our service for Category 1 and 2.

13.6 Rachel Gillott gave the Board assurance that partners are taking handover delays very seriously and are continuously looking for any mitigations at service level and the best use of our workforce.

13.7 **Resolved**
The Board noted the report.

BoD24/05/14 **People and Organisational Development Highlight Report**

14.1 Mandy Wilcock presented the People and Organisational Development highlight report with the following key highlights. The main focus has been around recruitment and retention in the contact centres for both 111 and 999. All IUC and EOC staff, existing or exiting, are offered a ‘stay’ conversation on a routine

basis in their regular one-to-one meetings and, for those leaving their role, they are offered the opportunity to complete an exit questionnaire as well as a conversation. A summary of themes will be produced after Q1.

14.2 Rapid Process Improvement Workshop (RPIW) - Phase 2, Readiness to Learn, of the quality improvement initiative started in early May. This aims to ensure a positive onboarding and learning experience for new starters to YAS Academy programmes. It was noted that Nick Smith has provided good Executive Sponsorship and is engaged with stakeholders.

14.3 In April, there was a 6-month post launch review. This identified that in the 12-month period prior to its launch we had 23 disciplinary cases that were categorised as sexual safety. So far, in the 6 months post launch we have had 23. The same number in half the time indicates that people are feeling more comfortable in raising concerns of this nature. Future plans include considering opportunities for collaboration with the NAA and other Ambulance Trusts to create efficiencies.

14.4 Investigators require a different skill set and need specialised training. Ongoing work with NHS England nationally and regionally and some of the serious cases maybe taken outside of the Trust.

14.5 Jeremy Pease is a member of the South Yorkshire Strategy Group whom the Trust has shared some learning. They have complimented on the work the Trust has have done around the Sexual Safety Charter.

14.6 **Resolved**
The Board noted the report.

BoD24/05/15 **People Committee Report : Chairs Report**

15.1 Jeremy Pease presented the People Committee report as Tim Gilpin was acting as Trust Chair. Risks discussed included recruitment and retention in call centres. A deep dive has been completed to ensure we recruit staff and work is progressing well. New risks identified is due to infrastructure issues in relations to increasing headcount, vehicle availability and car parking. It was noted if the Trust is looking to employ 598 WTE this will be circa 800 more staff in the Trust.

15.2 **Resolved**
The Board noted the report.

BoD24/05/16 **Quality Committee Report : Chairs Report**

16.1 Anne Cooper, in her capacity of Chair of Quality Committee, presented the Quality Committee report and confirmed the Quality Committee approved the Quality Accounts for 2023-24.

16.2 The committee received a further update on progress to address identified issues with the management of controlled drugs. The Board should note that the Trust remains non-compliant, however, the committee received an action plan that has been put in place to improve the current position. The Board

should note that an internal audit is planned later in the year to assess progress.

16.3 Anne Cooper added that Phil Gleeson, the patient representative plays an active role in the committee.

16.4 There were no alerts, and no new risks identified for this meeting.

16.5 **Resolved**
The Board noted the report.

BoD24/05/17 **Freedom To Speak Up (FTSU): Quarterly Report**

17.1 Jeremy Pease presented on behalf of the Freedom to Speak Up Guardians, Sam Bentley and Kirsty Holt for the FTSU quarterly report. The key highlights included the additional FTSU Guardian to cover the increased workload and data collection. The Trust is collating data on themes around patient safety and quality. There are new cases identified via the Sexual Safety Charter and the HR process and legal requirements can slow things down.

17.2 The Board of Directors approved the updated FTSU policy. There are 3 FTSU e-learning modules available to staff which were created in collaboration with the National Guardian's Office & Health Education England. There are clear spikes in FTSU contact and the reasons are explained in 3.1.

17.3 Some cases highlighted concerns held in multiple areas i.e. Datix/FTSU/Local Management which were all being dealt with in silo. This emphasised the need to strengthen data triangulation across the Trust. It was noted there is no further funding this year but need to ensure both FTSU Guardians work separately with no duplication. Plans are in place to work collaboratively with Human Resources and the new 360 Assurance Counter Fraud Specialist for YAS to refine process.

17.4 Adam Layland raised concerns in respect of only 55% of senior leaders had completed e-learning and we set a deadline for completion for September 2023. The Board agreed this does not set a cultural message and needs focus.

17.5 Both FTSU Guardian roles are secondments, and the National Guardian office proposal is to have 3 FTSU Guardians. This will be determined on the audit carried out and the development of these roles over the next year. Tim Gilpin as Trust Chair wanted to note that the Board is extremely supportive of this
17.6 agenda, and wants to encourage staff to come forward as the Trust is committed to address all concerns.

17.7 **Resolved**
The Board agreed to continue in their support of speaking up at YAS and encouraging learning from concerns.

The Board is asked to commit to supporting the future plans/developments with a view to strengthening the speak up provisions within YAS.

BoD24/05/18 **Fit and Proper Persons Policy**

18.1 Mandy Wilcock presented the Fit and Proper Persons Policy on behalf of David O'Brien. NHS provider organisations have been required to meet regulatory requirements regarding director-level appointments to ensure that individuals appointed to such positions are 'fit and proper persons.'

18.2 The Trust Board received an update following the Kark Review in the context of the Trust's response to lessons about leadership, governance and accountability emerging from high-profile incidents involving the Counter of Chester Hospital ('the Lucy Letby trial').

18.3 The content of the updated policy aligns with guidance and other material issued by NHS England to support implementation of the stronger FPPT framework. Strengthened arrangements for undertaking reference checks for prospective Board members and the Trust Chair is accountable for ensuring FPPT arrangements have taken place effectively each year.

18.4 The FPPT Policy has been approved at the Trust Executive Group and People Committee. It was confirmed an enhanced DBS check will be completed. Peter Reading added if we were to have a CQC inspection they will look closely at our FPPT checks.

18.5 **Resolved**

The Board approved the updated Fit and Proper Persons Policy.

BoD24/05/19 **Any Other Business**

19.1 Adam Layland drew attention June is PRIDE month and the following LGBT+ events across the three ICB areas and all Board members and staff are welcome:

- Saturday 01 June 2024 – York
- 21 July 2024 - Leeds
- 10 August 2024 - Doncaster

BoD24/05/20 **Risks**

20.1 There were no additional risks raised for consideration of inclusion on risk registers of the Board Assurance Framework.

BoD24/05/21 **Evaluation Of Meeting**

21.1 Mandy Wilcock provided the evaluation of the meeting.

BoD24/05/22 **Date and Time of Next Meeting**

22.1 The next meeting is scheduled to take place on Thursday 25 July 2024.

The meeting closed at 11.33 hrs.

CERTIFIED AS A TRUE RECORD OF PROCEEDINGS

_____ CHAIRMAN

_____ DATE

Yorkshire Ambulance Service NHS Trust

Minutes of the Board of Directors Meeting (held in PUBLIC)

Thursday 20 June 2024 at 1300

Venue: Roche Meeting Room, SH2, Wakefield

Present:

Tim Gilpin	Non-Executive Director/ Deputy Chair
Anne Cooper	Non-Executive Director (Senior Independent Director)
Jeremy Pease	Non-Executive Director
Andrew Chang	Non-Executive Director
Amanda Moat	Non-Executive Director
Peter Reading	Chief Executive
Nick Smith	Chief Operating Officer
Dave Green	Executive Director of Quality and Chief Paramedic
Julian Mark	Executive Medical Director
Kathryn Vause	Executive Director of Finance

In Attendance:

Marc Thomas	Deputy Chief Executive
Adam Layland	Director of Partnerships and Operations
Rachel Gillott	Director of Partnerships and Operations
Jeevan Gill	Director of Partnerships and Operations
Carol Weir	Director of Strategy, Planning and Performance
Helen Edwards	Head of Communications and Community Engagement
David O'Brien	Director of Corporate Services and Company Secretary
Odette Colgrave	Corporate Business Officer
Jo Jennings	Senior Executive Officer

Apologies:

Martin Havenhand	Chair
Mandy Wilcock	Director of People and Organisational Development
Rebecca Randell	NExT Director

BoD24/06/1 **Welcome and Apologies**

1.1 Tim Gilpin welcomed all to the Board.

1.2 Apologies were received from Martin Havenhand, Mandy Wilcock and Rebecca Randell.

1.3 The meeting was quorate.

1.4 On behalf of the Board, Tim Gilpin wanted to congratulate two members of staff at Yorkshire Ambulance Service NHS Trust who have been awarded in the King's Birthday Honours list 2024:

- Ola Zahran, Chief Technology Officer has been awarded the King's Ambulance Medal for Distinguished Service (KAM).

- Jason Carlyon who has been awarded an MBE in recognition of his services to resuscitation.

BoD24/06/2 2.1 **Declaration of Interests**
No declarations of interest were reported. If any declarations of interest did arise during the meeting these would be considered at that time.

BoD24/03/4 3.1 **2024/25 Financial Plans:**
Revenue Plan
Kathryn Vause presented the 2024-25 Revenue Plan which had been previously discussed at TEG and Finance and Performance Committee, and had received provisional approval from the Board on 30 May . The submitted financial plan for 2024/25 shows a break-even position, with an underlying deficit of £8.4m which is a deterioration from the 2023/24 plan.

3.2 The Board agreed and acknowledged this was an acceptable level of risk and there was nothing new in terms of the plan.

3.3 **Resolved**
The Trust Board:

- **Noted** the financial framework for 24/25.
- **Noted** the underlying recurrent deficit position in the 24/25 plan.
- **Noted** the risks to delivery of the plan.
- **Approved** the break-even financial plan for 24/25 (acknowledging the risk identified in section 7 that further changes/planning submissions may be required if systems are not able to achieve balanced positions).
- **Approved** budgets to be set within the parameters of this plan.

BoD24/06/4 4.1 **Capital Plan**
Kathryn Vause presented the 2024-25 Capital Plan which had been previously discussed at TEG and Finance and Performance Committee, and had received provisional approval from the Board on 30 May . It is assumed the Trust must continue to manage the “limits” for purchased and leased assets separately. The paper highlighted whether individual “schemes” have already been approved in line with SFIs, or if they need further approval once further developed. Risks to the plan were also detailed in the paper.

4.2 Nick Smith sought assurance from Fleet around the potential number of incomplete vehicle conversions during this financial year and the level of risks associated with this. Kathryn Vause confirmed the Trust cannot give any level of confidence around conversions and it is noted that some national converters have gone into liquidation. To mitigate some of these risks new contracts may have to be implemented through which the Trust would use more than one converter.

4.3 Anne Cooper raised the issue that some of the ambulance stations are slipping further behind in terms of premises condition and facilites, and what mitigations are being put in place. Kathryn Vause gave the Board assurance that all three ICBs will be developing their own infrastructure strategies. A directive from NSHE confirmed that YAS needs to be included in all of these strategies. It was confirmed conversations have taken place with ICBs and therefore YAS will feature in all of their strategies.

4.4 **Resolved**
The Trust Board:
- **Noted** the capital funding.
- **Noted** the risks in section 7.
- **Approved** the 24/25 capital plan for purchased/owned assets.
- **Approved** the 24/25 capital plan for leased/right of use assets.

BoD24/06/5 **2024/25 Business Plan**

5.1 Carol Weir presented the 2024-25 Annual Business Plan outlining the key priorities for the Trust and commitments to patients, staff, and partners for the 2024-25 financial year. This was agreed in principle at Board on 30 May 2024 subject to the approval of the 2024/25 Financial Plans.

5.2 **Resolved**
The Board formally approved the 2024-25 Business Plan.

BoD24/06/6 **Any Other Business**

6.1 There were no items of any other business.

BoD24/06/7 **Risks**

7.1 There were no additional risks raised for consideration of inclusion on risk registers of the Board Assurance Framework.

BoD24/06/8 **Date and Time of Next Meeting**

8.1 The next meeting is scheduled to take place on Thursday 25 July 2024.

The meeting closed at 13.19 hrs.

CERTIFIED AS A TRUE RECORD OF PROCEEDINGS

_____ CHAIRMAN

_____ DATE

NHS Yorkshire Ambulance Service NHS Trust

Action Log: Board of Directors (in Public)

(Completed items will be removed for the subsequent meeting)

Item 1.5

Action Ref	Meeting date	Item Title and Action Required	Lead	Comments/progress update	Due Date	Status
Actions Arising in 2023-24						
BoD24/05/5.3	30/05/2024	**Patient Story (Rough Sleepers)** A steering group has now been set up and will involve Communications for wider shared learning. Helen Edwards agreed to take an action to raise the profile with all ICBs to build a multi-agency response. Peter Reading also suggested to take the report to AACE. Rachel Gillott will also provide contact details for the West Yorkshire BEVAN healthcare organisation.	Helen Edwards Rachel Gillott	The report was published by Hull Healthwatch on 18 July 2024 and a task and finish group is not established to take forward recommendations. This includes all partners and the Humber and North Yorkshire ICB is represented by their head of Voluntary Community and Social Enterprise. The report is being shared with AACE.	25/07/2024	**Completed**
BoD24/05/9.5	30/05/2024	**Business Plan 2024-25** Carol Weir agreed to produce a simple user guide and summarise the table on Page 10 for sharing.	Carol Weir/ Helen Edwards	Information summarised, with links to both the strategy and business plan and shared via the intranet on PULSE.	25/07/2024	**Completed**

Board of Directors (held in Public)
25 July 2024
Agenda Item: 1.7

Report Title	Chair's Report
Author (name and title)	Martin Havenhand, Chair
Accountable Director	Martin Havenhand, Chair
Previous committees/groups	None
Recommended action(s) Approval, Assurance, Information	Information/Assurance
Purpose of the paper	To brief Board members of the activity and stakeholder engagement undertaken by the Chair since the last report presented to the Board in Public on 25 April 2024.
Recommendation(s)	Note the update from the Chair's Report.

Executive summary (overview of main points)

The paper gives a summary of the following key items:

- New Government
- Regional Director of NHS England
- Performance Development Reviews
- Investing in Volunteers Accreditation
- Ambulance Leadership Forum (ALF) 2024

Strategic ambition(s) this supports Provide brief bullet point details of link to Trust strategy	Our Patients	Understand and reduce unwarranted variation and support system-wide work to reduce health inequalities, positively impacting our local communities through our role as an anchor organisation.
	Our People	Invest in leadership development to ensure that our people are well supported by their exceptional leaders. Value difference and improve equality, diversity and inclusion of our people at all levels of the organisation, to reflect the population we serve.
	Our Partners	Work in partnership to maximise the benefit of our collective knowledge, with academic and education partners and be a leading service provider in partnership with the voluntary, community and social enterprise (VCSE) partners.
	Our Planet and Pounds	Develop and deliver improvement, through learning and adoption of best practice.
Link with the BAF Include reference number (board and level 2 committees only)		2c, 3a, 3b

Board of Directors (held in Public)
25 July 2024
Chair's Report

1. Summary

1.1 This report briefs Board members of the activity and stakeholder engagement undertaken by the Chair since the last report presented to the Board in Public on 25 April 2024.

2. New Government

2.1 Following the election and the establishment of a new government the immediate key issue for the NHS is the announcement that Lord Ara Darzi will lead a rapid assessment of the issues facing the NHS.

2.2 Over the next 6 weeks or so, NHS England will be working closely with Lord Darzi and his team, as well as colleagues in the Department of Health and Social Care (DHSC), to support a comprehensive analysis of what the NHS does now and the scale of the challenges we face. Importantly, Lord Darzi's audit will provide a starting point for the development of a 10 year plan for health – which will be led by Sally Warren, lately Director of Policy at the Kings Fund, again with support from teams at DHSC and NHS England.

2.3 Plans for how NHS staff and leaders will be able to contribute to both phases of this work are being developed now, but with a clear expectation that they both reflect current experience, and draw on solutions best practice from staff, patients, the public and other experts.

3. Regional Director of NHS England

3.1 Richard Barker, Regional Director of NHS England retired at the end of June 2024 and Robert Cornel has been appointed interim director until a substantive appointment is made.

4. Performance Development Reviews (PDRs)

4.1 The Chairs, Non-Executive Directors and Chief Executives PDRs have all been completed in line with the Boards Business Planning Programme timetable.

5. Investing in Volunteers Accreditation

5.1 The Trust currently has the Investing in Volunteers (IiV) accreditation, which is the UK quality standard in good practice volunteer management. It is used to assess the quality of volunteer management and involvement and reviews the effectiveness of the organisations work with volunteers.

5.2 The Trust achieved the award in 2019 and is currently working with IiV towards reaccreditation. An Assessor from IiV is undertaking an external assessment of the

arrangements the Trust has in place to support volunteers and volunteering to ensure it has a positive impact.

5.3 The Trust has a volunteer development framework which aims to establish a planned approach to volunteer development and sets out 4 ambitions for volunteering across the Trust.

1. A robust infrastructure to enable, sustained and enhanced current and future volunteering opportunities.
2. An organisational culture that values, encourages, promotes and supports volunteering.
3. Volunteer programmes that maximise volunteer contribution and represents the diversity of our communities.
4. Build collaborative partnerships with other health and care providers, voluntary, community and third sector organisations to further enhance our care offer through volunteering.

Our current volunteer opportunities are within passenger transport services, community resilience, community engagement and patient engagement.

6. Ambulance Leadership Forum (ALF) 2024

6.1 ALF 2024 online will be delivered on Tuesday October 8th. It will be free to attend, and registration will be open to all Association of Ambulance Chief Executives (AACE) member trust colleagues. The theme will be 'Leading at all levels' and the content will be relevant to the wider audience. The intention is that the online platform will be formatted for handheld devices and desk top screens as well as for live broadcast with subtitles in control rooms, increasing access for frontline teams. Content will be available for six months after the event where the relevant permissions are in place.

6.2 The AACE team has secured a number of sponsorship agreements building towards full cost recovery for the 2024 online ALF and subsidising the costs of the 2025 face to face event. The ALF 2024 - aace.org.uk website page will be updated regularly to increase interest and awareness. We expect registration to open late August.

7. Recommendation

7.1 It is recommended that the Board note the report.

Meeting Title: Board of Directors (held in public)
Meeting Date: 25 July 2024
Agenda Item: 1.8

Report Title	Chief Executive's Report
Author (name and title)	Peter Reading, Chief Executive
Accountable Director	Peter Reading, Chief Executive
Previous committees/groups	None
Recommended action(s) Approval, Assurance, Information	Information/ Assurance
Purpose of the paper	To brief Board members on some important matters for the Trust, some of which may be covered in more detail elsewhere in the Public or Private meetings of the Board.
Recommendation(s)	Note the update from the Chief Executive's Report

Executive summary (overview of main points)

The paper gives a summary of the following key items:

- Video triage for stroke patients in Hull and East Yorkshire
- YAS staff recognised in King's Birthday Honours list
- International Paramedics Day 2024
- Volunteers' Week at YAS
- Armed Forces Day
- New Chief Digital Information Officer
- Apprenticeship programme success
- New Patient Transport Service vehicles

Strategic ambition(s) this supports Provide brief bullet point details of link to Trust strategy	Our Patients	Deliver high-quality patient care and achieve the Ambulance Clinical Outcome measures.
	Our People	Invest in developing our people (staff and volunteers), ensuring they have the skills, support and resources they need to deliver high-quality care and services, now and in the future.
	Our Partners	Listen and respond to patients, partners and our communities to develop and deliver high-quality care, which is continuously improving.
	Our Planet and Pounds	Use our resources wisely and ensure value for money.
Link with the BAF Include reference number (board and level 2 committees only)		1a, 1b, 1c, 3a

Board of Directors (held in Public)
25 July 2024
Chief Executive's Report

1. Summary

1.1 This paper briefs Board members on some important matters for the Trust, some of which may be covered in more detail elsewhere in the Public or Private meetings of the Board. Board members are invited to discuss any of these items, as they choose, and to note them for information.

2. Video triage for stroke patients in Hull and East Yorkshire

2.1 Stroke patients in Hull and parts of East Yorkshire are to benefit from a new rapid assessment system aimed at saving lives and improving care.

2.2 Hull University Teaching Hospitals, part of NHS Humber Health Partnership, is introducing a Pre-Hospital Video Triage Scheme next month (August) after securing some funding from NHS England on a trial basis.

2.3 Stroke Co-ordinators, supported by Stroke Services Consultants, will connect to Yorkshire Ambulance Service crews using video technology enabling visual checks and digital evaluation of patients.

2.4 Patients with a suspected stroke will be "blue-lighted" to Hull Royal Infirmary, straight into the care of the specialist stroke team for CT scans or to begin life-saving treatment such as mechanical thrombectomy to remove blockages from their arteries. Some patients who do not require hospital admission will be redirected to community services.

3. YAS staff recognised in King's Birthday Honours list

3.1 Jason Carlyon, Community Engagement Manager and Paramedic, was awarded an MBE in the King's Birthday Honours list 2024 in recognition of his services to resuscitation.

3.2 Jason has been given the honour for being a driving force behind the local, national and international roll-out of the multi-award-winning Restart a Heart campaign which provides life-saving cardio-pulmonary resuscitation (CPR) training to members of the public.

3.3 Ola Zahran, Chief Technology Officer, was awarded the King's Ambulance Medal for Distinguished Service (KAM).

3.4 During her career, Ola has played a key role in the development of the digital agenda and healthcare technologies at the Trust, regionally and nationally. She has led on a number of complex national projects for the ambulance sector and wider healthcare community, including the Unified Communications project where she was responsible for supplier engagement and implementation, and was instrumental in sharing learning from the roll-out in Yorkshire to benefit other ambulance services across the country.

4. International Paramedics Day 2024

4.1 On Monday 8 July, we celebrated International Paramedics Day which is hosted by the UK's College of Paramedics to honour the dedication and impact of paramedics, first responders and community volunteers around the world.

4.2 We joined forces with more than 100 organisations to promote the campaign theme, "The Difference We Make", which will look at the many ways our frontline clinicians make a difference, from responding to life-threatening emergencies to providing comfort to patients and their loved ones in their hour of need. Our staff have shared their stories about the difference they make.

4.3 Dave Green, Executive Director of Quality and Chief Paramedic at YAS, said: "International Paramedics Day provides us with perfect opportunity to celebrate the incredible contribution that paramedics make to patients every minute of every day.

4.4 "At YAS we have 1,960 paramedics who work in a variety of roles, including on the frontline, in our Emergency Operations Centre and NHS 111 service as well as in other departments such as research and quality improvement. They do a fabulous job, often in challenging and unpredictable circumstances, alongside our other frontline clinicians.

4.5 "Healthcare is continually evolving, and the role of the paramedic is no different. As the profession continues to develop, our patients benefit from enhanced learning in areas such as critical care where we help those who are seriously ill or injured, and urgent care where we are often able to treat our patients in their own home and prevent unnecessary hospital admissions."

5. Volunteers' Week at YAS

5.1 In June, during Volunteers' Week, we celebrated the amazing people who give up their spare time to support our service for the benefit of their local communities. We have almost 1,000 volunteers who have offered over 267,000 hours, supported over 64,000 patients and engaged with an estimated 3,200 people in our communities over the last year.

5.2 Volunteering enables us to dedicate more time, care and attention, not only to our patients and communities, but also for the benefit of our staff. This is possible because volunteers can take on tasks that free up staff to focus on patients with more complex needs, or by contributing to service improvements by providing a patient voice, which ultimately enhances the quality of care we provide.

6. Armed Forces Day

6.1 To mark Armed Forces Day, members of our Armed Forces Network have shared their military and ambulance journeys.

6.2 We are a proud recipient of the Ministry of Defence's Employer Recognition Scheme (ERS) Silver Award which recognises our contribution to supporting the military community. Our Armed Forces Network offers support and comradeship for staff and volunteers of the armed forces community at YAS.

7. New Chief Digital Information Officer

7.1 Sam Robinson has now joined the Trust as our Chief Digital Information Officer (CDIO), The leading our information technology and business intelligence teams.

7.2 Sam joined YAS in June from NHS England, where she was Associate Director for Live Services.

8. Apprenticeship programme success

8.1 YAS has scooped the Large Employer of the Year Award in the University of Huddersfield's annual Apprenticeship Awards.

8.2 We were recognised for our excellent career path which supports apprentices to develop through apprenticeships and enables those who may have not otherwise had the opportunity to attend university to gain a degree.

8.3 The award was also a recognition of our partnership with the University and how we have supported one another to develop and continually improve the apprenticeship program

9. New Patient Transport Service vehicles

9.1 PTS has started to receive delivery of new Peugeot Boxer diesel vehicles and, over the coming months, each area of the Trust will receive a number of new vehicles. In total, PTS will receive 25 diesel vehicles and 35 electric vehicles, and they will all be operational by the end of the summer.

9.2 Both vehicles (electric and diesel) will be a mixture of stretcher and multi-purpose vehicles.

9.3 The electric vehicles will be Ford E-Transits, which offer up to 120 miles on full charge and will support the Trust in delivering the new non-emergency PTS contractual and legislative changes that require an increase in zero emission vehicles in the YAS fleet

10. Recommendation

10.1 It is recommended that the Board:

- Note the Chief Executive's Report

Board of Directors (in Public)
25 July 2024
Agenda Item: 2.1

NHS Yorkshire Ambulance Service NHS Trust

Report Title	Business Plan 2024/25 – Q1 Performance and Assurance Progress Report
Author (name and title)	Gavin Austin, Head of Performance & Improvement Catherine Taylor, Strategic Planning Officer Carol Weir, Director of Strategy, Planning & Performance
Accountable Director	Carol Weir, Director of Strategy, Planning & Performance
Previous committees/groups	
Recommended action(s)	Assurance
Purpose of the paper	This paper provides a progress update on delivery of the Trust's 2024/25 business plan.
Recommendation(s)	It is recommended that the Trust Board: • Notes the progress in Q1 on delivery of the Trust business plan priorities for 2024/25. • Understands the impact of workstreams that are off-track and supports the recovery plans for each of the workstreams that are off-track to improve progress and delivery of the Trust business plan priorities.

Executive summary

This paper provides a progress update on delivery of the Trust's 2024/25 business plan and planned tracking and reporting arrangements.

Strategic ambition(s) this supports	Our Patients	The 9 priorities and their deliverable workstreams in the 2024-25 business plan deliver on the strategic objectives of the Trust Strategy (2024-29).
	Our People	
	Our Partners	
	Our Planet and Pounds	
Link with the BAF		3a (plan, govern and deliver Trust strategy and business priorities).

1. Background

1.1 Delivery of the 2024-2029 Trust Strategy is through the Annual Business Plan, which details the in-year priorities against the strategic ambitions and defines the actions that the organisation will take each year to deliver the Strategy and four bold ambitions – Our Patients, Our People, Our Partners, and Our Planet and Pounds. The 2024-25 Annual Business Plan outlines key priorities for YAS and commitments to patients, staff and partners for the 2024-25 financial year. The plan delivers on the NHS England (NHSE) Operating Plan 2024-25 and the first year of the YAS Trust Strategy 2024-29, aligned to the three Integrated Care Board Joint Forward Plans, and local Place priorities in the context of system-wide financial challenges, to provide and coordinate safe, effective, responsive and patient-centred out-of-hospital emergency, urgent and non-emergency care, so all YAS patients can have the best possible experience and outcomes through great care, great people and great partners.

1.2 Performance is monitored through the Performance Improvement process tracking the identified workstream metrics and milestones, as detailed in the four mandates (aligned to Our Patients, Our People, Our Partners and Our Planet and Pounds) which have been co-produced with the SROs and Executive Directors. Together these deliver the nine priorities. The mandates[1] ensure delivery of the stated objectives and track progress, enabling mitigations to be identified at an early stage to ensure targets and benefits are realised and maximised. (See Appendix A).

1.3 The nine priorities and workstreams across the four mandates, agreed by Trust Board are as follows:

YAS Strategic Objectives & Priorities	Workstreams that YAS will focus on in 24/25
OUR PATIENTS: To improve safety and quality for patients.	
1) Improve Response including Category 2: YAS will improve ambulance and 999 and 111 call response times, particularly Category 2 ambulance response, by strengthening staffing and vehicle availability and deployment, by working intensively with acute partners to reduce Emergency Department (ED) handover times and by strengthening collaboration with Place partners to deliver more care remotely, in people's own homes and closer to home, utilising analysis of clinical and population health data, so that only where it is the best option for the patient are they conveyed to ED.	<u>Manage Demand:</u> ➢ Increase Hear and Treat rates ➢ Reduce avoidable conveyance rates ➢ Appropriate management of Health Care Professional calls <u>Manage Capacity:</u> ➢ Maximise on shift availability ➢ Optimise use of Community First Responders ➢ Optimise appropriate deployment of Specialist Paramedics for Urgent Care <u>Maximise Efficiency</u> ➢ Reduce crew clear times ➢ Improve productivity around meal break management ➢ Improve category 2 response, by developing a future operating model ➢ Improve efficiency by reducing appropriately, on scene times ➢ Agree to implement/commence the migration from AMPDS to NHS Pathways
2) Strengthen Quality and Safety: YAS will improve quality and safety through strengthening Quality Governance (including complaint handling) and medicines management, embedding the Patient Safety Incident Response	➢ Reduce the number of patient incidents through implementing the Patient Safety Incident Response Framework (PSIRF) ➢ Embed Quality Improvement Training ➢ Embed Clinical Supervision

[1] Some metrics and milestones are currently subject to change as further work required to ensure consistent and efficient reporting requirements are met.

YAS Strategic Objectives & Priorities	Workstreams that YAS will focus on in 24/25
Framework (PSIRF), implementing Clinical Supervision for all front-line staff, and evolving Quality Improvement (QI) to embed it culturally across the Trust.	➢ Improve Medicines Governance
3) Deliver Integrated Clinical Assessment: YAS will invest further in developing integrated clinical assessment across 999 and 111, streamlining triage and care navigation processes to ensure patients get the most appropriate care at the earliest point in their journey. YAS will deliver this by aligning systems, expanding multi-disciplinary clinical capacity and support for clinical staff, and working closely with each of our 15 Places to develop consistent pathways into Place-based care coordination services.	➢ Develop an Integrated Clinical Assessment Service
OUR PEOPLE: To invest in our people to improve care and support delivery.	
4) Deliver Workforce Plans: YAS will strengthen the workforce within existing establishments, through improvements in recruitment, retention, training, staff support and sickness management across EOC, 999, 111 and PTS, with a particular focus on implementing the IUC change programme and the EOC change programme.	➢ Achieve the Workforce Plan (Recruitment & Retention) ➢ Implement International recruitment for clinicians in IUC ➢ Implement Training Plans ➢ Implement IUC and EOC Improvement Programmes
5) Improve Health, Wellbeing and Safety: YAS will improve the health, wellbeing and safety of staff with a particular focus on strengthening Mental Health and Wellbeing support, implementing the Sexual Safety Charter and the deterrence of violence and aggression including funding and extending the continued deployment of body-worn cameras.	➢ Embed Body Worn Cameras ➢ Reduce Sickness Absence, including improving PDR/Appraisal Compliance and delivery of the annual Health and Wellbeing Plan
6) Culture, Equality, Diversity and Inclusion: YAS will drive improvements in the culture of the organisation by implementing the NHS People Promise and the YAS Together programme, with a particular focus on leadership development, improving equality, diversity and inclusion, and creating a more open culture, where staff are well informed and are encouraged and supported to Speak Up	➢ Implement YAS Together aligned to NHS People Promise exemplar ➢ Embed Equality, Diversity and Inclusion
OUR PARTNERS: To collaborate with our partners to improve response and population health outcomes.	

7) Partnership working to improve response:
YAS will further embed partnership working and system collaboration, with a particular focus on working with acute partners on handover delays and Place partners on appropriate clinical pathways for patients
	➢ Work with system partners to develop and increase access to appropriate alternative pathways
	➢ Work with system partners to support Arrival to Handover
	➢ Embed the Mental Health and Learning Disabilities Programme increasing:
	  ➢ Utilisation of specialist resource
	  ➢ Implement Oliver McGowan training

Our Planet and Pounds: To invest in the infrastructure and resources to improve the effectiveness of direct delivery.	
8) Effective use of Resources, Efficiencies and Value for Money: YAS will deliver a balanced break-even financial plan and drive more effective use of resources, through implementing a structured productivity and cost improvement programme.	➢ Maximise Organisational Efficiencies and deliver the Trust wide efficiency target ➢ Implement NEPTS Eligibility
9) Optimise fleet availability & performance: YAS will strengthen staffing and vehicle availability by investing further in the ambulance fleet and fleet	➢ Implement the Fleet Plan to support availability (reducing VOR) and improve Category 2 performance ➢ Implement Telematics

YAS Strategic Objectives & Priorities	Workstreams that YAS will focus on in 24/25
management support, increasing the numbers and reducing the average age of vehicles, and reducing environmental impact through telematics systems.	

YAS's Business Plan supports the ongoing strategic focus on:
➢ Emergency Preparedness, Resilience and Response, implementing the Manchester Arena inquiry recommendations if the required funding (revenue and capital) is made available.
➢ Addressing health inequalities, improving population health outcomes and delivering on the Core20PLUS5 approach.
➢ Continuing to utilise and develop digital technology to support and improve patient care, including investment in development of an iPad-based ePR application for A&E crews in 2024-25.
➢ Environmental sustainability, with continuing efforts to tackle climate change and progress towards net zero.
➢ Improving the Estate by creating options for new ambulance stations in Scarborough and Hull which reflect escalating building costs and available capital and implementing (within resource availability) a planned maintenance and refurbishment programme to support service delivery and staff wellbeing.

1.4 The Business Plan monitoring aligns to the Trust's Performance and Improvement process with KPIs tracked against the 24/25 nine priorities. Metrics and KPIs for the Business Plan and Performance Reviews are included where possible in the BI Trajectory data pack which is published on the 5th of each month. The milestones are tracked through SRO reporting and the overall position is submitted by the SRO with Executive Director approval.

1.5 The Business Plan is reported quarterly through governance structures to Trust Board, aligned to the Board Assurance Framework to identify and control strategic risks.

2. 2024/25 Quarter 1 Exception Report

2.1 Ten workstreams were rated off-track affecting the delivery of six of the nine business plan priorities. The high-level detail is provided below.

Priority 1

1) Improve Response including Category 2: YAS will improve ambulance and 999 and 111 call response times, particularly Category 2 ambulance response, by strengthening staffing and vehicle availability and deployment, by working intensively with acute partners to reduce Emergency Department (ED) handover times and by strengthening collaboration with Place partners to deliver more care remotely, in people's own homes and closer to home, utilising analysis of clinical and population health data, so that only where it is the best option for the patient are they conveyed to ED.	<u>Manage Demand:</u> ➢ Increase Hear and Treat rates ➢ Reduce avoidable conveyance rates ➢ Appropriate management of Health Care Professional calls <u>Manage Capacity:</u> ➢ Maximise on shift availability ➢ Optimise use of Community First Responders ➢ Optimise appropriate deployment of Specialist Paramedics for Urgent Care <u>Maximise Efficiency</u> ➢ Reduce crew clear times ➢ Improve productivity around meal break management ➢ Improve category 2 response, by developing a future operating model ➢ Improve efficiency by reducing appropriately, on scene times ➢ Agree to implement/commence the migration from AMPDS to NHS Pathways

2.2 The majority of actions and milestones planned have been delivered in Q1, except for an action within optimising CFR's (see exceptions below). It should be noted that most actions and milestones in Q1 were on planning and

developing actions to implement. There was no planned paramedic recruitment in Q1 due to university timelines with recruitment starting from Q2.

2.3 Category 2 performance was behind plan in May by 5 mins 24 secs and in June by 3 mins with a forecast year end figure of 2 mins 23 secs above target. This has been driven by increased demand and increased handover.
Hear and treat is also behind plan in June at 15.3% against a target of 15.9% further impacting on Cat 2 performance.

2.4 Most of the performance improvement planned in Q1 trajectory would have been driven by seasonal fall in demand rather than planned actions, however demand has increased in Q1.

2.5 The majority of actions that drive performance improvement for Priority 1 are planned in Q2/Q3 and will be monitored and supported through the performance process.

Priority 2

2) Strengthen Quality and Safety: YAS will improve quality and safety through strengthening Quality Governance (including complaint handling) and medicines management, embedding the Patient Safety Incident Response Framework (PSIRF), implementing Clinical Supervision for all front-line staff, and evolving Quality Improvement (QI) to embed it culturally across the Trust.	➢ Reduce the number of patient incidents through implementing the Patient Safety Incident Response Framework (PSIRF) ➢ Embed Quality Improvement Training ➢ Embed Clinical Supervision ➢ Improve Medicines Governance

2.6 PSIRF
The PSIRF workstream actions and milestones are on track but these have not yet seen the planned reduction in incidents, with the number of incidents currently within normal variations. It is too early to fully understand the impact in Q1 with not enough data points available to establish if a change has been made, recognising PSIRF is also new, with impact yet to be fully understood.

2.7 QI
Good progress against plan, on track with QI plan seeking Board approval in July.

2.8 Clinical Supervision
Good progress, with recruitment of facilitators, training and sessions delivered, all actions on track against plan.

2.9 Medicines Governance
Controlled Drugs app usage (where implemented in 3 station in West Yorkshire) has increased from average of 80% in the 4th Quarter of 23/24 to 96% at the end of the 1st Quarter 24/25. Medicines management is reported as an exception (see below) due to the medicines optimisation policy and plan being slightly delayed, however this will be back on track in July through planned recovery action.

2.10 The majority of actions that strengthen quality and safety are planned in Q2/Q3 and will be monitored and supported through the performance process.

Priority 3

3) Deliver Integrated Clinical Assessment: YAS will invest further in developing integrated clinical assessment across 999 and 111, streamlining triage and care navigation processes to ensure patients get the most appropriate care at the earliest point in their journey. YAS will deliver this by aligning systems, expanding multi-disciplinary clinical capacity and support for clinical staff, and working closely with each of our 15 Places to develop consistent pathways into Place-based care coordination services.	➢ Develop an Integrated Clinical Assessment Service

2.11 All milestones and measures are either on plan or close to plan. Calls assessed by a clinician in 111 is 40% YTD in June against a target of above 40% for the year.

2.12 Hear and Treat was 0.6% behind plan in June with a year-end forecast of 16.2% which is 0.1% behind full year plan.

2.13 Q1 milestones were delivered with an emerging risk highlighted related to capital costs for additional MIS licences to join the clinical queues. A paper is planned for discussion at TEG to agree next steps for the single clinical queue early in Q2.

Priority 4

4) Deliver Workforce Plans: YAS will strengthen the workforce within existing establishments, through improvements in recruitment, retention, training, staff support and sickness management across EOC, 999, 111 and PTS, with a particular focus on implementing the IUC change programme and the EOC change programme.	➢ Achieve the Workforce Plan (Recruitment & Retention) ➢ Implement International recruitment for clinicians in IUC ➢ Implement Training Plans ➢ Implement IUC and EOC Improvement Programmes

2.14 <u>A&E</u>

A&E recruitment plans on track with 86 ASW/ACA recruited against plan of 84 in Q1. Paramedic recruitment is 6 FTE behind plan, but these have been planned into later courses. A large percentage of paramedic recruitment is planned in Q2 in line with university/course completion dates with 120 FTE in the pipeline for Q2. The net gain from recruitment in Q1 is 31 FTE. Substantive FTE in post is 3123 against a plan of 3143.Turnover is lower than planned at 5.5% (see table below).

2.15 <u>EOC</u>

EOC recruitment on track with 70 EMD's recruited against plan of 72. This gives a total of 232 FTE in post vs plan of 234 FTE, a net increase of 30 since start of Q1. Clinical advisor recruitment is 1 behind plan with 12 recruited in Q1 for a total of 59 FTE in post against a plan of 60 FTE. This gives a net increase of 7 FTE since the start of Q1. Turnover is on track and below plan at 15.5% (see table below).

2.16 <u>IUC</u>

Total IUC recruitment is on track with 93 Health Advisors recruited taking total FTE to 307 against plan of 316. This gives a net decrease of 9 FTE since the start of Q1 with attrition still high at 34.7% but reducing. However, substantive recruitment is 28 against plan of 48. The shortfall has been addressed through

use of agency with 65 recruited against plan of 45. Agency recruitment is being reprofiled after over recruiting in April and May which has led to an overspend (see exception below).

2.17 14 Clinical Advisors were recruited against a plan of 7 this takes total FTE to 56 against a plan of 58. This is a net increase of 8 FTE since start of Q1. Turnover is reducing but higher than planned. (see table below).
International recruitment for Nurses is on track with arrivals planned from Q2.

2.18 IUC case for change milestones have been delivered in Q1 with call answer performance above 80% target with 93.1% achieved in June.

2.19 PTS
PTS recruitment is behind plan with 22 FTE recruited against plan of 40 giving a net decrease of 1. However, this has been off set with decreased turnover of 11% with 429 FTE in post against a plan of 433 FTE at the end of June (see table below).

2.20 There is further work required to understand the offered versus started from the recruitment process to support delivery of workforce plans.

	Substantive FTE (year end 23/24)*	Substantive FTE (June 24)*	Growth	Substantive Planned FTE	Variance	Planned Recruitment	Actual Recruitment	Variance	Attrition**
A&E Operations	3,092	3,123	31	3,143	-20	96	92	-4	61
PTS	430	429	-1	433	-4	40	22	-18	23
EOC EMD	202	232	30	234	-2	72	70	-2	40
EOC Dispatch	135	135	0	147	-12	10	5	-5	5
EOC Clinical	48	55	7	58	-3	13	12	-1	5
IUC HA	316	307	-9	316	-9	48	28	-20	37
IUC CA	48	56	8	58	-2	7	14	7	6
Total	4,281	4,337	66	4,391	-50	286	241	-43	177

All areas exclude overtime and agency
***Attrition is difference between recruitment and growth, includes leavers and movers (promotion, moves to other directorates)*

Priority 5

5) Improve Health, Wellbeing and Safety: YAS will improve the health, wellbeing and safety of staff with a particular focus on strengthening Mental Health and Wellbeing support, implementing the Sexual Safety Charter and the deterrence of violence and aggression including funding and extending the continued deployment of body-worn cameras.	➢ Embed Body Worn Cameras ➢ Reduce Sickness Absence, including improving PDR/Appraisal Compliance and delivery of the annual Health and Wellbeing Plan

2.21 Body Worn Cameras
Good progress on agreed Q1 activity especially training to continue to embed body worn cameras and associated improvements and benefits from their deployment.

2.22 Health & Wellbeing

Sickness absence has been static over Q1 at 6.3% at the end of June against a target of 6.08%. Although sickness has remained static, improvements will need to be realised going forward to achieve plan. Historically sickness rates fall in Q1 but this has not been seen this year.

2.23 There have been notable improvements in 6/10 WDES measures including reduction in percentage of staff experiencing bullying and harassment.

2.24 Appraisal rates have improved in line with plan at 78.9% an improvement of 5.2% from March.

Priority 6

6) Culture, Equality, Diversity and Inclusion: YAS will drive improvements in the **culture** of the organisation by implementing the NHS People Promise and the YAS Together programme, with a particular focus on leadership development, improving **equality, diversity and inclusion**, and creating a more open culture, where staff are well informed and are encouraged and supported to Speak Up	➢ Implement YAS Together aligned to NHS People Promise exemplar ➢ Embed Equality, Diversity and Inclusion

2.25 YAS Together

YAS Together milestones are on track with roll out to all staff progressing well. Succession planning rollout began as planned in Q1 with all operational areas set to be completed by end of Q2.

Turnover in EOC (15.5%) is in front of plan and IUC turnover 34.7% has improved but is behind plan of 29.1% annualised average. PTS turnover is lower than plan.

2.26 Equality, Diversity and Inclusion (EDI)

EDI activity and milestones are on track although work on streamlined processes for inclusive practice in recruitment had a delayed start due to capacity issues but now has PMO support to progress.

Updated metrics will not be available until staff survey results are released in 2025.

Priority 7

7) Partnership working to improve response: YAS will further embed **partnership working** and **system collaboration**, with a particular focus on working with acute partners on handover delays and Place partners on appropriate clinical pathways for patients	➢ Work with system partners to develop and increase access to appropriate alternative pathways
	➢ Work with system partners to support Arrival to Handover
	➢ Embed the Mental Health and Learning Disabilities Programme increasing:
	  ➢ Utilisation of specialist resource
	  ➢ Implement Oliver McGowan training

2.27 Arrival to Handover

The milestones for Q1 have been delivered however performance is off trajectory. Year end forecast for handover is now 33:11 which is 09:13 behind plan with April, May and June all behind trajectory. All 3 ICB's are exceeding the handover times submitted for our Category 2 modelling. This is being supported through system partnership working led by the DPOs across UEC Boards and monitored through performance process and discussed at collaborative forums (see exception below).

2.28 Appropriate Pathways

Delayed agreement of Trust budgets has resulted in delayed recruitment of pathways coordinator and clinical analyst roles. However, Pathway development is continuing across all areas through the SSDM/DPO. Use of and acceptance rate is monitored which will lead to pathway development in future quarters. Staff survey on pathways currently out for responses to establish reporting issues for action.

2.29 Mental Health Programme

The mental health programme is underspent by £706k (see exception below). This has been driven by staff shortage and vacancy and low take up of overtime to fill shifts. By the end of August 2024 20 of 30 substantive Mental Health Specialist Paramedics will be in post which will improve the position in Q3/Q4. There are now 7 out of 10 services onboarded to the push model and 5% of all MH jobs are supported by the mental health vehicle against year-end target of 20%.

Priority 8

8) Effective use of Resources, Efficiencies and Value for Money: YAS will deliver a balanced break-even financial plan and drive more effective use of resources, through implementing a structured productivity and cost improvement programme.	➢ Maximise Organisational Efficiencies and deliver the Trust wide efficiency target ➢ Implement NEPTS Eligibility

2.30 Organisational Efficiency

The overall efficiency target is £21.3m, this equates to 5.2% of Trust income. This is made up of Identified Schemes £6.5m, Vacancy Factor £6.4m (1.8% of operational services pay budgets and 1% of support services pay budgets). There is an additional CIP £4.1m (1.1%, across all budgets where schemes are not identified) and Performance Efficiencies £4.3m.

2.31 YTD expenditure on pay is £76.79m against a plan of £76.84m, an underspend of £51k, therefore the vacancy factor and pay savings target are being achieved overall.

2.32 Plans for each area are set to be agreed in Q2 for the 1.1% detailed above along with development of longer-term plans for 24/25. Plans for achieving the target in each area are set to be agreed in Q2 along with development of longer-term productivity and efficiency plans for 24/25.

2.33 NEPTS Eligibility

PTS eligibility criteria is off track (see exceptions below). ICB's have agreed a go live of April 25, therefore no benefits will be delivered in year. To complete the preparatory work needed for an April 25 go live YAS will be required to invest in recruitment and training within year. This is an anticipated cost of £163,402. These costs need to be identified from within existing budget allocations. It had been anticipated that the costs required would have been offset by in year efficiency savings, prior to ICBs advising that in year go live was not possible.

Priority 9

9) Optimise fleet availability & performance: YAS will strengthen staffing and vehicle availability by investing further in the ambulance fleet and fleet management support, increasing the numbers and reducing the average age of vehicles, and reducing environmental impact through telematics systems.	➢ Implement the Fleet Plan to support availability (reducing VOR) and improve Category 2 performance ➢ Implement Telematics

2.34 Fleet

All milestones delivered in Q1 with vehicle availability achieving 82% target over Q1. The current fleet availability measure does not include vehicles that are off road due to non-mechanical issues such as medical equipment faults or IT equipment faults. A trial is underway in South Yorkshire to capture data on all vehicles off road. It has also been identified that high availability of RRV's may be skewing the data on local issues around DCA availability so these figures will be split going forward to enable clarity of understanding and associated plans.

2.35 Telematics

Timescales for telematics have slipped due to delays in the approval and sign off process (see exceptions below). The plan was reprofiled to account for the delayed start in the business plan. Implementation is now planned for Q3 with benefits being delivered from Q4 against an original benefits start of Q2. The financial impact of this delay is being calculated.

The information below presents a quarter 1 summary of the recovery plans for each of the priority workstreams from the 2024/25 Business Plan that are off-track. An off-track status has been determined by monitoring the priority workstream metrics and milestones (Appendix A and summary in Appendix B), through the performance reviews, and in collaboration with Senior Responsible Officers and Executive Leads. The status rating criteria is provided in through the SRO reports.

OUR PATIENTS: TO IMPROVE SAFETY AND QUALITY FOR PATIENTS						
Workstream	**Off-Track Reason**	**Recovery Action**	**Recovery Timescales**	**Support Required**	**Executive Lead**	**TEG ESCALATION REQUESTED**
Priority 1) Improved Response including Cat 2						
Increase capacity by optimising use of Community First Responders (CFRs).	Time - A reduction in the number of hours of CFR availability. Down from 17,924 in Mar 24 to 15,804 in Jun 24. Target is 20,000.	Area level plans being developed to recover.	Q1-Q2	Planning and development support to get milestones and actions back on track.	Nick Smith	No
Priority 2) Quality and Safety						
Embed the Patient Safety Incident Framework (PSIRF)	Quality - M1 Q1 data shows normal variation for incidents relating to PSIRF themes, but no improvement.	Interventions are being defined as part of the PSIRF process but will need time to implement and embed before impact can be assessed.	PSIRF is an ongoing plan with monthly review	None at this stage	Dave Green	No
Improve Medicines management	Time – Medicines optimisation policy and action plan delayed slightly. At CGG end of July.	Action plan support from Planning & Development Team	Q1-Q2	Planning and development support to get milestones and actions back on track.	Dr Julian Mark	No

OUR PEOPLE: TO INVEST IN OUR PEOPLE TO IMPROVE CARE AND SUPPORT DELIVERY						
Workstream	**Off-Track Reason**	**Recovery Action**	**Recovery Timescales**	**Support Required**	**Executive Lead**	**TEG ESCALATION REQUESTED**
Priority 4) YAS will strengthen the workforce within existing establishments, through improvements in recruitment, retention, training, staff support and sickness management across EOC, 999, 111 and PTS, with a particular focus on implementing the IUC change programme and the EOC change programme.						
Deliver the agreed workforce plan of 276 FTE Health Advisors and 90 FTE Clinical Advisors across 111 through delivery of recruitment and management of overtime.	Cost	Weekly oversight, reprofiling agency and reduction in agency recruitment.	Jul-Sep 24	People Directorate/Team support to process high numbers of substantive recruitment	Nick Smith	Yes
Deliver the Training Plan	Cost - Paramedic requirement changed in-year from 252 to 288, Educator resource calculator applied and additional Educator needed but not in budget	Additional budget needed for 1 WTE Clinical Educator	Budget confirmation needed to enable recruitment	Additional budget Band 7 Clinical Educator	Mandy Wilcock	Yes

OUR PARTNERS: TO COLLABORATE WITH OUR PARTNERS TO IMPROVE RESPONSES AND POPULATION HEALTH OUTCOMES						
Workstream	**Off-Track Reason**	**Recovery Action**	**Recovery Timescales**	**Support Required**	**Executive Lead**	**TEG ESCALATION REQUESTED**
Priority 7) Partnership working to improve response						
Work with system partners to support Arrival to Handover	System delivery is not meeting trajectory.	Raising at UEC Boards.	Unclear with system at present.	None at present	Nick Smith	No
Embed the Mental Health and Learning Disabilities Programme.	Cost - Current underspend of budget. At the end of June, this is £706k and is attributed to the MHRVs not running due to staffing shortages and a low take up on overtime.	increase shift fill for MHRVs by adding vacant shifts on vacancy filler. 20 out of 30 SPMHs recruited and due to start mid-August. Ops MHRV group created to deal with ongoing issues	Actions completed by mid-August.	Senior Ops Management commitment required to staff the vehicles where we have gaps.	Dave Green	Yes
Increase, where appropriate, pathways and improve utilisation	Delay to budget approval has delayed recruitment to posts to support pathway development	Using staff on alternative duties in interim	Actions completed by end of Q2	None	Dr Julian Mark	No

OUR PLANET AND POUNDS: TO INVEST IN THE INFRASTRUCTURE AND RSOURCES TO IMPROVE THE EFFECTIVENESS OF DIRECT DELIVERY						
Workstream	**Off-Track Reason**	**Recovery Action**	**Recovery Timescales**	**Support Required**	**Executive Lead**	**TEG ESCALATION REQUESTED**
Priority 8) YAS will further embed partnership working and system collaboration, with a particular focus on working with acute partners on handover delays and Place partners on appropriate clinical pathways for patients.						
Implement Non-Emergency Patient Transport Service (PTS) Eligibility.	Cost - To complete the preparatory work needed for an April go live YAS will be required to invest in recruitment and	1) Reset project plan to reflect new go live date, once confirmed by ICBs	1) End August 24. 2) End Sept 24 in order for recruitment	Execs to continue to robustly remind System of need to implement Eligibility with some	Nick Smith	No

OUR PLANET AND POUNDS: TO INVEST IN THE INFRASTRUCTURE AND RSOURCES TO IMPROVE THE EFFECTIVENESS OF DIRECT DELIVERY						
Workstream	**Off-Track Reason**	**Recovery Action**	**Recovery Timescales**	**Support Required**	**Executive Lead**	**TEG ESCALATION REQUESTED**
	training within year. This is an anticipated cost of £163,402 in year. These costs need to be identified from within PTS budget allocation. It had been anticipated that the costs required would have been offset by in year efficiency savings, prior to ICBs advising that in year go live was not possible.	2) PTS to identify possible efficiencies over CIP requirement to fund the in year costs.	process to begin.	urgency Track and propose alternative funding to be made available to support the in year implementation spending requirements		
Introduce in-vehicle telematics to the A&E, PTS and Support Service Vehicle Fleet to increase productivity and efficiency and reduce the trust's carbon footprint.	Cost & Time - The project will not deliver full year cost savings due to delays in the approval and signoff process which has led to delays in the procurement and roll out process.	To offset the saving element, we have not had any expenditure to the scheme to date.	Initial efficiency savings are likely to commence Q4.	Successful delivery is dependent on support from procurement and project management.	Kathrnyn Vause	Yes

4. Financial implications

4.1 Any financial implications are identified for the relevant priorities and associated workstreams within the exception report and reported through the finance updates.

5. Risks

5.1 Key risks have been highlighted within the exception report, these are addressed as part of the monitoring and review process and through the performance process.

6. Communication and Involvement

6.1 The priorities and deliverable workstreams are reviewed by Senior Responsible Officers and designated Executive Leads. These are monitored and reported through the Performance Review Process, and through agreed Trust governance routes into TEG, Finance and Performance and Trust Board.

7. Equality Analysis

7.1 Equality analysis has been undertaken as part of the development of each business plan priority, deliverable workstream and overall Trust Business Plan for 2024/25.

8. Publication Under Freedom of Information Act

8.1 This paper has been made available under the Freedom of Information Act 2000.

9. Next Steps

9.1 The Performance Review Process will continue to monitor the 2024/25 business plan priorities and deliverable workstreams every two months. Identified actions will be supported through this process and team, with TEG escalation where appropriate.

9.2 A quarterly exception report, highlighting off-track workstreams and reasons, the recovery actions, support required, and recovery timescales will continue to be provided to the Quality, People and Finance and Performance committees and the Trust Board for assurance.

10. Recommendation

10.1 It is recommended that the Trust Board:

- Notes the progress in Q1 on delivery of the Trust business plan priorities for 2024/25.

- Understands the impact of workstreams that are off-track and supports the recovery plans for each of the workstreams to improve progress and delivery of the Trust business plan priorities.

11. Supporting Information

11.1 The following papers makes up this report:

- **Appendix A** 2024/25 Business Plan Mandates: Our Patients, Our People, Our Partners, and Our Planet and Pounds
- **Appendix B** Business Plan Priorities: Key Workstreams and Measures

Trust Strategy Bold Ambition:	**Our Patients**		
Ambition Statement:	YAS will deliver exceptional patient-centred out-of-hospital emergency, urgent and non-emergency care, which is safe, kind and responsive, seamlessly integrating services and utilising technology to deliver a high-quality patient experience.		
YAS 2024/25 Business Plan Strategic Objectives:	To improve safety and quality for patients.		
Agreed Start Date:	01/04/2024	**Forecast End Date:**	31/03/2025
Assurance Reporting Committee:	Quality Committee	**Reporting Timeframe:**	Quarterly
Trust Strategy Outcome Measure:	• YAS will deliver improved patient care and achieve the Ambulance Clinical Outcome measures. • YAS will deliver the national, regional and system performance targets for 999, 111 and PTS. • YAS will reduce inappropriate conveyances to hospital where it is more appropriate that care is provided out of hospital. • YAS will continually improve our clinical services and embed Quality Improvement throughout the Trust. • YAS will achieve the highest possible rating of 'outstanding', by the health and social care regulator (Care Quality Commission, CQC). • YAS will deliver the highest standards of emergency preparedness, resilience, and response, and continually improve to ensure we provide the best possible response to the most significant incidents impacting the region. • YAS will understand and reduce unwarranted variation and support system-wide work to reduce health inequalities, positively impacting our local communities through our role as an anchor organisation.		
Trust Enabling Plan:	• Clinical and Quality Plan • Area Plans		
System Wide Alignment:	**Humber & North Yorkshire:**		
	West Yorkshire:		
	South Yorkshire:		
NHSE Operating Task:	Recover our core services and productivity and improve quality and patient safety.		
NHSE National Objective:	**Quality and patient safety:**	Implement the Patient Safety Incident Response Framework (PSIRF).	
	Urgent and emergency care:	Improve Category 2 ambulance response times to an average of 30 minutes across 2024/25.	
	Primary and community services:	Continue to improve the experience of access to primary care. Increase dental activity by implementing the plan to recover and reform NHS dentistry, improving units of dental activity (UDAs) towards pre-pandemic levels.	
	Elective care:	Improve patients' experience of choice at point of referral.	
	Maternity, neonatal and women's health:	Continue to implement the Three-year delivery plan for maternity and neonatal services, including making progress towards the national safety ambition and increasing fill rates against funded establishment.	
	Mental health:	Improve patient flow and work towards eliminating inappropriate out of area placements.	
	People with a learning disability and autistic people:	Reduce reliance on mental health inpatient care for people with a learning disability and autistic people, to the target of no more than 30 adults or 12–15 under 18s for every 1 million population.	

Priorities and Workstreams	Executive Lead	Senior Responsible Officer	Outcome Measures: Metric Key Performance Indicator Definition	Outcome Measures: Baseline Key Performance Indicator 31st March 2024	Outcome Measures: Key Performance Indicator Target 31st March 2025	Key Milestones: Milestones and Delivery Quarter
Improve Response including Category 2:	(1) YAS will improve ambulance and 999 and 111 call response times, particularly Category 2 ambulance response, by strengthening staffing and vehicle availability and deployment, by working intensively with acute partners to reduce Emergency Department (ED) handover times and by strengthening collaboration with Place partners to deliver more care remotely, in people's own homes and closer to home, utilising analysis of clinical and population health data, so that only where it is the best option for the patient are they conveyed to ED.					
Manage demand by increasing Hear and Treat rates.	Chief Operating Officer: Nick Smith	Directors of Partnerships and Operations: Jeevan Gill, Rachel Gillott & Adam Layland & Associate Chief Operating Officer - Remote Patient Care: Julia Nixon	**M1:** Increase proportion of Hear and Treat (FYE).	**BM1:** 13.6% FYE	**TM1:** 16.3% FYE	**Q2:** Opportunities to increase Remote Hubs reviewed. **Q4:**Clinical workforce increased. **Q4:** PUSH models developed and maximised. **Q4:** iCAS delivered. **Q4:** Fully implement Category 2 segmentation.
Appropriate management of Health Care Professional (HCP) calls.	Chief Operating Officer: Nick Smith	Directors of Partnerships and Operations: Jeevan Gill, Rachel Gillott & Adam Layland & Associate Chief Operating Officer - Remote Patient Care: Julia Nixon	**M1:** Reduce the proportion of HCP responses.	**BM1:** Trust-wide 12.3%.	**TM1:** Reduction of 1% Trust-wide.	**Q1:** Area Plan developed and system joint commitment. **Q2:** Review of all HCP demand. **Q3:** Actions in Area Plans and implementation.
Managing Demand: Working with system partners to develop and increase access to appropriate alternative pathways. - See Our Partners Plan Priority 7.						
Increase capacity by maximising on shift availability.	Chief Operating Officer: Nick Smith	Directors of Partnerships and Operations: Jeevan Gill, Rachel Gillott & Adam Layland	**M1:** Increase resource availability.	**BM1:** Trust-wide overall, 21%.	**TM1:** Increase overall to 23%.	**Q1/2:** Unavailability reviewed and focus plans to minimise at area level agreed. **Q3/4:** Unavailability findings reflected in Area Plans and implemented.
Increase capacity by optimising use of Community First Responders (CFRs).	Chief Operating Officer: Nick Smith	Head of Service and Quality (central delivery): Elizabeth Eastwood	**M1:** Increase availability of CFRs. **M2:** Increased activation of CFRs.	**BM1:** 17,924 Hours March 2024. **BM2:** 05:13 Seconds March 2024.	**TM1:** 20,000 Hours Region wide (review localised targets). **TM2:** Overall, 10 second contribution.	**Q1:** Targeted recruitment plan in place, focussed work with existing schemes to maximise logged on hours, ongoing work with EOC to target dispatch. **Q1:** Work with Operational teams to look for opportunities to increase CFR schemes where needed. **Q2-Q4:** Ongoing delivery of targeted recruitment plan focussed work with existing schemes to maximise logged on hours, ongoing work with EOC to target dispatch.
Increase productivity of Specialist Paramedics for Urgent Care (SPUCs).	Chief Operating Officer: Nick Smith	Consultant Practitioners: Claire Craft, Jonathan Milnes & Tim Millington	**M1:** Increase proportion of C3 calls vs total C1&2 calls SPUCs attend. **M2:** Decrease conveyance rates of SPUCs for each Category 2,3,4 call.	**BM1:** 56%. **BM2:** SPUCs conveyed 50.7% C2 calls. SPUCs conveyed 23.5% C3 calls. SPUCS conveyed 15% C4 calls.	**TM1:** Increase by 10%. **TM2:** Reduce by 5%.	**Q1:** Outline plan for reviewing utilisation of SPUCs developed. **Q2:** Review of utilisation for the specialist paramedic (urgent care) complete and plan developed. **Q3:** Implementation plan for utilisation of specialist paramedic (urgent care) commenced. **Q4:** Continuation of implementation and dynamically continue to review plans considering winter pressures and implement any adaptations.
Managing Capacity: Achieve the workforce (recruitment and retention) FTE Plan. – See Our People Plan Priority 4.						
Managing Capacity: Improve absence management and reduce sickness absence.- See Our People Plan Priority 5.						
Improve Crew Clear efficiency.	Chief Operating Officer: Nick Smith	Directors of Partnerships and Operations: Jeevan Gill, Rachel Gillott & Adam Layland	**M1:** Reduce crew clear time by 10%.	**BM1:** Hull – 20:22. NY – 20:52. SY – 18:26. L/W – 25:24. B,C,K – 26:58.	**TM1:** 10% reduction. YAS – 20:30 Hull – 18:04. NY – 18:48. SY – 16:48. L/ W– 22:50. B,C,K – 24:01.	**Q1:** Area Plans developed. **Q2:** Area Plans implemented.
Improve productivity around meal break management.	Chief Operating Officer: Nick Smith	Associate Chief Operating Officer - Remote Patient Care: Julia Nixon & Director of Partnership and Operations: Adam Layland	**M1:** Increased compliance with meal break arrangements. **M2:** Development of new Meal Break Policy.	**BM1:** Trust-wide 42% compliance. **BM2:** Current Meal Break policy	**TM1:** Increase to at least 50%. **TM2:** New Meal Break Policy Developed and approved.	**Q1:** Understanding of non-compliance with current meal break arrangement reviewed and understood. **Q2:** Actions arising from the review of non-compliance with current meal break arrangements implemented. **Q1-Q3:** New Meal Break Policy engagement and development complete. **Q4:** New Meal Break Policy recommendations shared.

Priorities and Workstreams	Executive Lead	Senior Responsible Officer	Outcome Measures			Key Milestones
			Metric Key Performance Indicator Definition	Baseline Key Performance Indicator 31st March 2024	Key Performance Indicator Target 31st March 2025	Milestones and Delivery Quarter
Improve efficiency by reducing appropriately, on Scene Times.	Chief Operating Officer: Nick Smith	Consultant Practitioners: Claire Craft, Jonathan Milnes & Tim Millington Directors of Partnerships and Operations: Adam Layland	**M1:** Maximise the efficiency of clinical decision making to reduce on-scene times and provide optimum patient care. **M2:** Ensure minimum cover for crew lines.	**BM1:** 30 minutes (conveyed) or 60 minutes (non-conveyed) on scene. **BM2:** N/A	**TM1:** Reduce the mean towards the target. (TBC Q2 after review of data). **TM2:** A day and a night minimum in each ICB. (x3 day and x3 night minimum across each ICB).	**Q1:** Best practice for clinical assessments and decision making identified. **Q1:** Baseline of current performance for on-scene time for conveyed and non-conveyed to inform areas for improvement established. **Q2:** A proportion of all cases have been reviewed, where the patient is conveyed, and the on-scene time was greater than 30 minutes and on-scene time of 60 minutes where patients were not conveyed (EPR) and thematic analysis of the data complete. **Q2:** Education package developed, and package of crew support measures commenced. **Q3-Q4:** Continued roll out of education package. **Q4:** Review and re-audit of the proportion of all cases, where the patient is conveyed, and the on-scene time was greater than 30 minutes and on-scene time of 60 minutes, where patients were not conveyed (EPR) and thematic analysis of the data complete.
Develop the future operating model.	Chief Operating Officer: Nick Smith	Director of Partnership and Operations: Adam Layland	**M1:** Improve and agreed future operating model.	**BM1:** Current operating model in place.	**TM1:** Improved operating model agreed.	**Q3:** Future operating model options explored. **Q4:** Future operating model agreed.
Implement the migration from AMPDS to NHS Pathways.	Chief Operating Officer: Nick Smith	Associate Chief Operating Officer: Julia Nixon	**M1**: EOC staff trained in use of Pathways.	**BM1:** N/A – no staff currently trained to use Pathways.	**TM1:** 50% (144 staff).	*Note: All milestones for tranches 2/3 are subject to securing external funding / Board approval, with timescales to be confirmed once timescales of approval are confirmed.* **Q1:** Tranche 1 commenced: staff in place to update SOPs / training materials. **Q2:** Tranche 1 completed: SOPs / training materials updated. Tranche 2 commenced: Staff identified and in place to support the transition from AMPDS to Pathways, Expert Users identified, and Project Trainers trained. **Q3:** Tranche 2 completed: expert users trained; system / DOS development complete. **Q4:** Tranche 3 commenced: Training of staff begins Jan-25. First go-live mid-Feb.
Efficiency: Handover to clear – See Our Partners Plan Priority 7.						
Strengthen Quality and Safety:	(2) YAS will improve quality and safety through strengthening Quality Governance (including complaint handling) and medicines management, embedding the Patient Safety Incident Response Framework (PSIRF), implementing Clinical Supervision for all front-line staff, and evolving Quality Improvement (QI) to embed it culturally across the Trust.					
Embed the Patient Safety Incident Response Framework (PSIRF).	Executive Director of Quality, Governance and Performance Assurance: Dave Green	Deputy Director of Quality and Nursing: Clare Ashby	**M1:** Reduce patient incidents in: - Care fallen or injured whilst in our care patients. - On-scene decision making incidents. - EOC (999) telephony issues. - IUC (111) telephony issues. **M2:** Understand baseline of x7 national patient safety incidents.	**BM1:** 33,736 incidents overall. - Care fallen or injured whilst in our care patients = 319. - On-scene decision making incidents = 248. - EOC (999) telephony issues = 452. - IUC (111) telephony issues = 573. **BM2:** N/A	**TM1:** Reduce patient incidents by of 5%. **TB2:** Baseline understood.	**Q2:** Recruitment complete. **Q3:** PSIRF Policies implemented. **Q3:** New starters commenced. **Q4:** Local organisational actions created from national patient safety incidents/learnings and fed into improvement plan. **Q4:** Delivery of the PSIRF plan for 24/25 complete.
Increase number of staff trained in QI Methodology.	Executive Director of Quality, Governance and Performance Assurance: Dave Green	Head of Quality Improvement: Spencer LeGrove	**M1:** Increased numbers of staff at all levels, across the Trust trained and competent in QI methodology, under three tiers: - Introduction to QI. - QI foundation. - QI leaders. **M2:** x1 Quality Improvement conference delivered.	**BM1:** 10% of staff with some QI training. **BM2:** N/A	**TM1:** - Introduction to QI = 1,750 staff (approx. 25%). - QI foundation = 90 staff. - QI leaders = 32 leaders. **TM2:** X1 QI conferences delivered.	**Q1:** Quality Improvement enabling plan approved by TEG and Trust Board. **Q2:** QI enabling plan launched. **Q2:** Training offer launched. **Q3:** Continuation of QI education across the Trust. **Q4:** Continuation of QI education across the Trust.
Implement Clinical Supervision for all front-line staff.	Executive Director of Quality, Governance and Performance Assurance: Dave Green	Associate Director of Paramedic Practice: Mark Millins	**M1:** Maintain qualitative feedback demonstrating Clinical Supervision improvements for patients. **M2:** Increase positive Clinical Supervision staff feedback. **M3:** Increase the number of staff offered Clinical Supervision. **M4:** Increase the number facilitators trained in Clinical Supervision.	**BM1:** Ongoing examples. **BM2:** 0 Clinical Supervision staff feedback. **BM3:** N/A **BM4:** N/A **BM6:** N/A	**TM1:** Maintain gathering examples. **TM2:** Collect staff feedback. Analyse themes and set improvement metrics. **TM3:** 100 facilitators Q2. **TM4:** 100 facilitators trained by Q3.	**Q1:** Clinical Supervision workshop held. **Q2:**Clinical Supervision Framework policy approved and implemented. **Q2:** Clinical Supervision assurance process approved. **Q2:** Clinical Supervision offered to 100 facilitators. **Q2:** Clinical Supervision Facilitators identified and trained. **Q3:** 20% of staff offered Clinical Supervision sessions. **Q3:** Clinical Supervision staff feedback survey implemented. **Q4:** Clinical Supervision Framework rolled-out.

Priorities and Workstreams	Executive Lead	Senior Responsible Officer	Outcome Measures			Key Milestones
			Metric Key Performance Indicator Definition	Baseline Key Performance Indicator 31st March 2024	Key Performance Indicator Target 31st March 2025	Milestones and Delivery Quarter
			M5: Increase number of staff offered Clinical Supervision sessions.		**TM6:** 20% of staff offered Clinical Supervision session by Q3, 40% byQ4.	**Q4:** Interim review of the Clinical Supervision programme (implementation against plan) complete. **Q4:** Interim Clinical Supervision benefits realisation report complete. **Q4:** 40% of staff offered Clinical Supervision sessions.
Improve medicine governance.	Executive Medical Director: Dr Julian Mark	Trust Pharmacist: Rebecca McClaren	**M1:** Reduction in out-of-date medicine management incidents – linked to medicines dashboard. **M2:** Improvement in controlled drug adherence. **M3:** Clinicians signed declaration on ESR for Medicines Optimisation policy.	**BM1:** Out-of-date Medicine Management Incidents = 135. **BM2:** Not compliant. **BM3:** N/A	**TM1:** 25% reduction to 101 incidents. **TM2:** 100% compliant in controlled drug adherence. **TM3:** 50% of Clinicians signed declaration on ESR.	**Q1:** Recruitment and Chief Pharmacist role change complete. **Q1:** Medicines Policy on ESR embedded. **Q1:** Competency framework approved. **Q1:** Medicines Assurance Action Plan commenced. **Q2-4:** Medicines Assurance Action Plan continuous roll out embedded. **Q4:** Medicines optimisation improvement plan developed. **Q4:** Medicines dashboard developed and embedded. **Q4:** Review of Medicine Assurance Action Plan completed.
Deliver an Integrated Clinical Assessment Service:	(3) YAS will invest further in developing integrated clinical assessment across 999 and 111, streamlining triage and care navigation processes to ensure patients get the most appropriate care at the earliest point in their journey. YAS will deliver this by aligning systems, expanding multi-disciplinary clinical capacity and support for clinical staff, and working closely with each of our 15 Places to develop consistent pathways into Place-based care coordination services.					
Develop an integrated clinical assessment service across 999 and 111.	Chief Operating Officer: Nick Smith	Associate Chief Operating Officer: Julia Nixon	**M1:** Improve IUC KPI 4 (calls assessed by a Clinician/Clinical Advisor). **M2:** Reduce Category 2 mean response time. **M3:** Recruit Clinical Advisors. **M4:** Recruit operational Senior Clinical Advisors and train staff in remote clinical triage. **M5:** Increase Hear & Treat. **M6**: Increase Category 2 segmentation. **M7:** Reduction in conveyance to ED.	**BM1:** 40.6% **BM2:** 33 minutes, 32seconds. **BM3:** N/A **BM4:** N/A **BM5:** 13.6% **BM6:** N/A **BM7:** 53.4% to ED and 6.6% to non-ED.	**TM1:** >40%<50% **TM2:** 30.23 **TM3:** 34 FTE Clinical Advisors. **TM4:** 39 FTE operational Senior Clinical Advisors.21 FTE remote clinical triage. **TM5:** Hear & Treat increased by 2% by Q3 to (16.3%) and by Q4 to (17%). **TM6:** validation >5% **TM7:** tbc in Q2 after review.	**Q1:** Systems mapping complete. **Q2:** Phase 1 of creating a single clinical queue complete. **Q2:** Engagement sessions with staff established. **Q3:** Partnership model (Nimbus/Vocare) implemented, and contracts updated. **Q4:** Joint wellbeing approaches in place. **Q4:** Joint learning and recruitment plan developed.

Document Version Control

Version	Date	Document Author	Status	Description of Change
0.4	Jun 24	Natalie Tyrrell	D	Draft
0.5	20.6.24	Natalie Tyrrell	D	Develop an integrated clinical assessment service across 999 and 111 - Improve IUC KPI 4 (calls assessed by a Clinician/Clinical Advisor) metric target changed from above 65% to >40%<50% as per Mike Modder-Fitch email to PMO/P&D 20.6.24.
1.0	04/07/24	Catherine Taylor	F	Adam Leyland as SRO Develop the Future Operating Model. Issued for Business Plan 24/25 Monitoring
1.1	16/07/24	Natalie Tyrrell	F	CA title updated

This document is controlled.
If you would like to suggest amendments to this document, please contact the document author.

Trust Strategy Bold Ambition:	Our People		
Ambition Statement:	YAS will be a diverse and inclusive organisation with a culture of continuous improvement, where everyone feels valued, included, proud to work, and can thrive.		
YAS 2024/25 Business Plan Strategic Objectives:	To invest in our people to improve care and support delivery.		
Agreed Start Date:	01/04/2024	**Forecast End Date:**	31/03/2025
Assurance Reporting Committee:	People Committee	**Reporting Timeframe:**	Quarterly
Trust Strategy Outcome Measure:	• YAS will reduce sickness rates to better than the NHS average. • YAS will invest in developing our people, ensuring they have the skills, equipment and resources they need to deliver high quality care and services, now and in the future. • YAS will become a great place to work and volunteer, with staff survey engagement scores in the top quartile for the sector. • YAS will ensure all staff have a meaningful appraisal and career conversation each year. • YAS will value and improving equality, diversity, and inclusion of our people at all levels of the organisation, to reflect the population we serve and improve our progress towards Workforce Race and Disability Equality Standards and eliminating our Gender Pay Gap. • YAS will retain our Top 100 Apprenticeship Employer status and achieving outstanding Ofsted judgement for apprenticeship provision.		
Trust Enabling Plan:	• People Plan • YAS Together		
System Wide Alignment:	**Humber & North Yorkshire:**		
	West Yorkshire:		
	South Yorkshire:		
NHSE Operating Task:	Transform the way we deliver care and create strong foundations for the future.		
NHSE National Objective:	**Workforce:**	Improve the working lives of all staff and increase staff retention and attendance through systematic implementation of all elements of the People Promise retention interventions Provide sufficient clinical placements and apprenticeship pathways to meet the requirements of the NHS Long Term Workforce Plan	
	Use of resources:	Use resources to ensure workforce productivity.	

Priorities and Workstream	Executive Lead	Senior Responsible Officer	Outcome Measures: Metric Key Performance Indicator Definition	Outcome Measures: Baseline Key Performance Indicator 31st March 2024	Outcome Measures: Key Performance Indicator Target 31st March 2025	Key Milestones: Milestones and Delivery Quarter
Workforce Plans:	(4) YAS will strengthen the workforce within existing establishments, through improvements in recruitment, retention, training, staff support and sickness management across EOC, 999, 111 and PTS, with a particular focus on implementing the IUC change programme and the EOC change programme.					
Deliver the agreed workforce plan of 3,306 FTE across A&E Operations through delivery of recruitment and management of overtime.	Chief Operating Officer: Nick Smith	Associate Chief Operating Officer-Central Services: Jackie Cole	**M1:** Achieve A&E FTE workforce trajectories. **M2:** Recruitment of 72FTE Ambulance Care Assistants. **M3:** Recruitment of 240 FTE Ambulance Support Workers. **M4:** Recruitment of 252 FTE Paramedics. **M5:** Management of overtime to deliver overall workforce plan. **M6:** Reduce turnover supporting retention with HR.	**BM1:** N/A **BM2:** N/A **BM3:** N/A **BM4:** N/A **BM5:** N/A **BM6:** 6.3% turnover annualised average for 23/24.	**TM1:** Achieve A&E FTE substantive 3,202 workforce trajectories. **TM2:** 72FTE Ambulance Care Assistants. **TM3:** 240 FTE Ambulance Support Workers. **TM4:** 252 FTE Paramedics. **TM5:** 104 FTE overtime across the year, to flex depending on delivery of substantive workforce. **M6:** Retention/reducing turnover (with HR): A&E maintain 6.3% turnover	**Q1:** 999 FTE for Q1 delivered. –3,252 FTE YTD by Jun (3,131 substantive and 121 OT). **Q2:** 999 FTE for Q2 delivered. –3,287 FTE YTD by Sep (3,175 substantive and 112 OT). **Q3:** 999 FTE for Q3 delivered. –3,298 FTE YTD by Dec (3,193 substantive and 105 OT). **Q4:** 999 FTE for Q4 delivered. –3,306 FTE YTD by Mar (3,202 substantive and 104 OT) **Q4:** 3–5-year workforce plans for 999 (A&E) developed.
Deliver the agreed workforce plan of 247 FTE EMDs, 147 FTE Dispatch and 106 FTE clinical hub across EOC through delivery of recruitment and management of overtime.	Chief Operating Officer: Nick Smith	Associate Chief Operating Officer - Remote Patient Care: Julia Nixon	**M1:** Achieve EOC FTE workforce trajectories. **M2:** Recruitment of 120 FTE Emergency Medical Dispatchers. **M3:** Recruitment of 10 internal Dispatchers. **M4:** Recruitment of 39 FTE operational Senior Clinical Advisors and training of up to 21 A&E staff in remote clinical triage. **M5:** Reduce turnover supporting retention with HR.	**BM1:** N/A **BM2:** N/A **BM3:** N/A **BM4:** N/A **BM5:** 19% turnover annualised average for 23/24.	**TM1:** Achieve EOC FTE substantive 247 – EMD and 147 Dispatch workforce trajectories. **TM2:** 120 FTE Emergency Medical Dispatchers. **TM3:** 10 internal Dispatchers. **TM4:** 39 FTE operational Senior Clinical Advisors.21 FTE remote clinical triage. **M5:** Retention/reducing turnover (with HR): EOC maintain 19% turnover.	**Q1:** EOC FTE YTD delivered. – EMD – 239 FTE, Dispatch – 147 FTE, Clinical – 90 FTE. **Q2:** EOC FTE YTD delivered. – EMD – 246 FTE, Dispatch – 147 FTE, Clinical – 97 FTE. **Q3:** EOC FTE YTD delivered. – EMD – 251 FTE, Dispatch – 147 FTE, Clinical – 101 FTE. **Q4:** EOC FTE YTD delivered. – EMD – 247 FTE, Dispatch – 147 FTE, Clinical – 106 FTE. **Q4:** 3–5-year workforce plan for EOC developed.
Deliver the agreed workforce plan of 276 FTE Health Advisors and 90 FTE Clinical Advisors across 111 through delivery of recruitment and management of overtime.	Chief Operating Officer: Nick Smith	Associate Chief Operating Officer - Remote Patient Care: Julia Nixon	**M1:** Achieve IUC FTE workforce trajectories. **M2:** Recruitment of 372 FTE Health Advisors. **M3:** Recruitment of 34 FTE Clinical Advisors (which includes x16 international recruitment of nurses) **M4:** Reduce turnover supporting retention with HR.	**BM1:** N/A **BM2:** N/A **BM3:** N/A **BM4:** 29.1% turnover annualised average for 23/24.	**TM1:** Achieve IUC FTE substantive 476 – Health Advisors and 90 Senior Clinical Advisors workforce trajectories. **TM2:** 372 FTE Health Advisors. **TM3:** 34 FTE Clinical Advisors (which includes x16 international recruitment of nurses). **TM4:** Retention (with HR):IUC reduce by 2.5% to 26.6% turnover.	**Q1:** 111 FTE YTD delivered. – HA – 425 FTE, Clinical – 84 FTE. **Q2:** 111 FTE YTD delivered. – HA – 443 FTE, Clinical – 86 FTE. **Q3:** 111 FTE YTD delivered. – HA – 460 FTE, Clinical – 88 FTE. **Q4:** 111 FTE YTD delivered. – HA – 476 FTE, Clinical – 90 FTE. **Q4:** 3–5-year workforce plan for 111 (IUC) developed.
Deliver the agreed workforce plan of 471 FTE across PTS through delivery of recruitment and management of overtime .	Chief Operating Officer: Nick Smith	Managing Director of PTS: Chris Dexter	**M1:** Achieve PTS FTE workforce trajectories. **M2:** Recruitment of 112 FTE operational Ambulance Care Assistants. **M3:** Reduce turnover supporting retention with HR.	**BM1:** N/A **BM2:** N/A **BM3:** 10.9% turnover annualised average for 23/24.	**TM1:** Achieve PTS FTE substantive 465 workforce trajectories. **TM2:** 112 FTE operational Ambulance Care Assistants. **M3:** Retention/reducing turnover (with HR): PTS maintain 10.9% turnover.	**Q1:** PTS FTE YTD delivered. – 457 FTE YTD by Jun. **Q2:**PTS FTE YTD delivered. – 462 FTE YTD by Jun. **Q3:** PTS FTE YTD delivered. – 464 FTE YTD by Jun. **Q4:**PTS FTE for YTD delivered. – 465 FTE YTD by Jun. **Q4:** 3–5-year workforce plan for PTS developed.
Recruit 16 international nurses in four cohorts across 2024/25 for Senior Clinical Advisor roles in 111.	Chief Operating Officer: Nick Smith	Associate COO, Remote Patient Care: Julia Nixon	**M1:** Recruitment of x16 international nurses for Senior Clinical Advisor roles in 111.	**BM1:** N/A	**TM1:** X16 international nurses recruited for Senior Clinical Advisor roles in 111.	**Q1:** Recruitment of international nurses launched. **Q1:** First cohort English Language and NMC registration requirements passed. **Q2:** Second cohort passed. **Q2:** x8 nurse candidates interviewed and recruited. **Q2:** First cohort of OSCEs passed. **Q3:** First cohort NHS Pathways training complete. **Q3:** Second cohort of OSCEs passed. **Q3:** Third and fourth cohort passed. **Q3:** x4 nurse candidates recruited to start on the 4th Nov-24. **Q3:** First retention assessment complete. **Q4:** Second cohort NHS Pathways training complete. **Q4:** x4 nurse candidates recruited to start on the 13th Jan-25. **Q4:** Third and fourth cohort of OSCEs passed.
Implement IUC change programme.	Chief Operating Officer: Nick Smith	Associate COO, Remote Patient Care: Julia Nixon	**M1:** Achieve workforce targets for Health Advisors. **M2:** Achieve workforce targets for Clinical Advisors. **M3:** Reduce sickness absence in IUC - (WFM sickness and absence) **M4:** Meet Health Advisor recruitment trajectory. **M5:** Reduce Health Advisor turnover.	**BM1:** 412 FTE.(Substantive, excludes O/T). **BM2:** 81 FTE. **BM3:** Combined STS & LTS 15%. **BM4:** 31 FTE per month. **BM5:** 29.1% (annual average). **BM6:** 56%. **BM7:** Current 50% split **BM8:** 47.7%. **BM9:** 24%. **BM10:**	**TM1:** 476 FTE. **TM2:** 90 FTE. **TM3:** 4% reduction (annualised) from Q3 2024/25 (11%). **TM4:** Maintain average of 31 FTE per month. **TM5:** 26.6%. **TM6:** 74% (annualised average) Consistently above 80% from Q4 2024/25. **TM7:** 70/30% split from Q3 2024.	**Q1:** New rotas and Team Based Working implemented. **Q1:** New Career and Leadership Structure implemented. **Q1:** Leadership Development Programme for Team Leaders procured. **Q1:** Dashboard for metrics developed. **Q2:** Implementation of uniforms completed. **Q2:** Dashboard for performance management framework in place. **Q3:** Leadership Development Programme for Team Leaders commenced. **Q3:** Review, benefits realisation and closure of individual projects completed. **Q4:** Review, benefits realisation and closure of programme completed.

Priorities and Workstream	Executive Lead	Senior Responsible Officer	Outcome Measures: Metric Key Performance Indicator Definition	Outcome Measures: Baseline Key Performance Indicator 31st March 2024	Outcome Measures: Key Performance Indicator Target 31st March 2025	Key Milestones: Milestones and Delivery Quarter
			M6: Improve call answering to 80% by Q4. **M7:** Reduce Health Advisors recruited through agencies. **M8:** Productivity: Reduction in Abstractions. **M9:** Reduce Not Ready Reason Codes (NRRCs). **M10:** Improve Staff Survey Sections by >2%: E_1 Motivation M1 Thinking about Leaving PP1_2 Compassionate Leadership PP7_2 Line Management PP7_1 Team Working PP4 Safe and Healthy PP4 Heath and Safety climate PP4 Burnout **M11:** Improved Quality Indicators around: Patient Safety, Patient experience, Audit Outcomes, Training and CPD content and delivery.	Motivation 5.99 Thinking about leaving 5.80 Compassionate leadership 7.58 Line management 7.38 Teamworking 5.88 Safe and healthy 5.88 Health and safety climate 5.76 Burnout 4.37 **BM11:** Patient safety incidents (moderate or above) = 0.000675% from all calls answered. Patient incidents = 0.1%. Patient complaints = 0.019%. Patient compliments = 0.003%. Patient Survey = 80.5% satisfied with their care. Audits completed measuring self, routine, team leader: 0.8%. Trainees passing NHS Pathways = 83%.	**TM8:** 44.5% Q3 2024/25 onwards. **TM9:** Reduce to 20% increasing availability and improving response times from Q3 2024/25 onwards. **TM10:** Improvement of >2% over 2024-2026. **TM11:** Maintain or improve quality indicators for incidents, complaints and compliments. Patient Survey = 85% satisfied with their care Increase self, routine and team leader audits by 0.2% aiming for completed audits over 1% of all calls answered by the service. Maintain or improve 83%.	
Implement EOC change programme.	Chief Operating Officer: Nick Smith	Associate COO, Remote Patient Care: Julia Nixon	**M1:** Improve patient care - reduce mean call answer time and achieve KPIs. **M2:** Increased EOC management capacity at York site. **M3:** Reduction in sickness absence. **M4:** Increased levels of staff engagement. **M5:** Increased levels of morale. **M6:** Reduction in the number of HR issues: - Disciplinary - Issue resolution/DaW - Performance management.	**BM1:** 00:00.10 **BM2:**0 FTE. **BM3:** 8.61%. **BM4:** 5.84. **BM5:** 5.49. **BM6:** HR issues relating to: -Disciplinary = 4 -Issue resolution/DaW 8 + 3 = 11 -Performance management = 1 Total = 16	**TM1:** Improve call answering performance mean call answer to 2 secs (00:00.02)/ call answer above 80% by Q4. **TM2:** 1 FTE. **TM3:** Reduce by 0.5% to 8.1%. **TM4:** 6. **TM5:** 5.80. **TM6:** Reduce.	**Q1:** Job description review complete and approved. **Q1:** HR consultation process complete. **Q2/Q3:** EOC management re-structure implementation scoped and complete. **Q3/Q4:** Closure stage complete. **Q4:** Scope exclusions complete.
Deliver the Training Plan.	Director of People and Organisational Development: Amanda Wilcock	Associate Director of Education & Organisational Development (interim): Dawn Adams	**M1:** Deliver A&E Ambulance Support Worker training to meet Training Plan figures (includes emergency driver training). **M2:** Deliver A&E Paramedic Induction training. **M3:** Deliver A&E Associate Ambulance Practitioner (AAP) training. **M4:** Deliver A&E Ambulance Care Assistant (ACA) training (includes emergency driver training). **M5:** PTS Ambulance Care Assistant (ACA) training.	**BM1:** N/A **BM2:** N/A **BM3:** N/A **BM4:** N/A **BM5:** N/A	**TM1:** 100% A&E Ambulance Support Worker training requirement achieved. **TM2:** 100% of A&E Paramedic Induction training requirement achieved. **TM3:** 100% of A&E AAP training requirement achieved. **TM4:** 100% of A&E ACA training requirement achieved. **TM5:** 100% of PTS ACA training requirement achieved.	**Q1:** YTD Occupancy rate achieved (target 100%). **Q1:** Percentage of training required fulfilled. **Q2:** YTD Occupancy rate achieved (target 100%). **Q2:** Percentage of training required fulfilled. **Q3:** YTD Occupancy rate achieved (target 100%). **Q3:** Percentage of training required fulfilled. **Q3:** 2025/26 Training Plan completed and approved. **Q4:** YTD Occupancy rate achieved (target 100%). **Q4:** Percentage of training required fulfilled.
Improving Health, Wellbeing and Safety:	(5) YAS will improve the health, wellbeing and safety of staff with a particular focus on strengthening Mental Health and Wellbeing support, implementing the Sexual Safety Charter and the deterrence of violence and aggression including funding and extending the continued deployment of body-worn cameras.					
Reduce Trust-wide Sickness Absence by 0.5%.	Director of People and Organisational Development: Amanda Wilcock	Deputy Director of People & OD: Suzanne Hartshorne Head of Employee Health & Wellbeing: Mussarat Suleman	**M1:** Reduce Trust-wide sickness absence by 0.5%. **M2:** Improve the National Staff Survey results for morale to statistically significantly higher. **M3:** Feedback including improvements to National Staff Survey results for WDES. **M4:** Achieve 80% compliance with Empactis – callbacks, RTW meetings, staff supported through review stages. ~~**M5:** Case management system usage~~ – *converted to Q4 milestone* **M6:** Improve appraisal and career conversation compliance to 90%.	**BM1:** Trust Baseline 6.58%. - A&E – 5.8% YTD (5.84%) - EOC – 8.6% YTD (8.72%) - IUC – 11.5% YTD (11.44%) - PTS – 8.3% YTD (8.37%) - Other – 4.39% YTD (4.39%) **BM2:** Staff Survey: Morale 5.7 **BM3:** WDES Metric 8: - Staff with a long-term condition or illness responses: 616. - Staff with a long-term condition or illness: 68.83% (average 67.39%). **BM4:** Currently 12 hours for a call back (52.85%) and 72 hours for a RTW (currently 56.18%).	**TM1:** Reduce sickness by 0.5% Trust-wide to 6.08%. - A&E 5.3%. - EOC 8.1%, stretch 1% to 7.6%. - IUC to 10.5% (1% reduction). - PTS to 7.8%. - Other to 3.89%. **TM2:** Improve by 0.2 or achieve a statistically significantly higher score. **TM3:** Improve WDES score for Metric 8:" by 2% (target - 70.83%). **TM4:** 80%. ~~**TM5: Procured, implemented and cases loaded.**~~ **TM6:** 90%.	**Q1:** OEG Absence Reduction group and terms of reference refreshed with a focus on service lines and reducing sickness. **Q1:** Continued targeted and focused absence reduction including implementation of absence prevention approaches, including centralising workplace adjustments. **Q1:** Implementation of new Supporting Attendance Management Policy including leaders training. **Q2:** Completion of Supporting Attendance Policy training. **Q3:** Procurement of case management system. **Q4:** Reduction of sickness absence by 0.5% and to better than Ambulance Sector NHS average levels. **Q4:** Successful delivery of the annual Health and Wellbeing Plan. **Q4:** Case management system to ensure absence cases are accurately recorded and tracked through to completion commenced.

Priorities and Workstream	Executive Lead	Senior Responsible Officer	Outcome Measures: Metric Key Performance Indicator Definition	Outcome Measures: Baseline Key Performance Indicator 31st March 2024	Outcome Measures: Key Performance Indicator Target 31st March 2025	Key Milestones: Milestones and Delivery Quarter
				BM5: Not yet procured. **BM6:** 72.10 annualised average, 73.7 Mar-24.		**Q4:** Undertake Case Management procurement, dependent on procurement capacity.
Embed Body Worn Cameras.	Executive Director of Quality and Chief Paramedic: Dave Green	Deputy Director of Quality and Nursing: Clare Ashby	**M1:** Increase in the number of staff trained to utilise body-worn cameras. **M2:** Increase in the number of staff using body-worn cameras and reporting it on Datix. **M3:** Increase in the number of successful convictions as a result of using body-worn cameras. **M4:** Reduce the number of physical assaults as a consequence of body worn camera use.	**BM1:** 1,123 staff trained to use body-worn cameras. **BM2:** 98 reports on Datix with body-worn camera activated. **BM3:** 15 successful convictions as a result of using body-worn cameras. **BM4:** 16.5% physical assaults annualised average.	**TM1:** Increase by 10% to 1,235. **TM2:** Increase by 20% to 118. **TM3:** Increase by 20% to 18. **TM4:** Reduce by 0.5% to a 16%.	**Q2:** Extend body-worn camera licenses complete . **Q2:** Procure body-worn camera uniform fixtures complete. **Q2:** Review of training for body worn cameras complete. **Q4:** Review of equipment vs international usage complete. **Q4:** VPR Communications Plan implemented at operational levels.
Culture, Equality, Diversity and Inclusion:	(6) YAS will drive improvements in the culture of the organisation by implementing the NHS People Promise and the YAS Together programme, with a particular focus on leadership development, improving equality, diversity and inclusion, and creating a more open culture, where staff are well informed and are encouraged and supported to Speak Up.					
Implement YAS Together aligned to NHS People Promise exemplar.	Director of People and Organisational Development: Amanda Wilcock	Deputy Director of People & OD: Suzanne Hartshorne	**M1:** Improve appraisal and career conversation compliance to 90%. **M2:** Improve EOC and IUC contact centre turnover. **M3:** Reduce sickness by 0.5%. **M4:** NSS results to be in the upper quartile for the ambulance sector.	**M1:** 72.10 annualise average, 73.7 Mar-24. **M2:** EOC 19% turnover annualised average for 23/24. IUC 29.1% turnover annualised average for 23/24. **M3:** Trust Baseline 6.58%. - A&E – 5.8% YTD (5.84%) - EOC – 8.6% YTD (8.72%) - IUC – 11.5% YTD (11.44%) - PTS – 8.3% YTD (8.37%) - Other – 4.39% YTD (4.39%) **M4:** Above average for the ambulance sector.	**M1:** 90%. **M2:** EOC maintain 19% turnover. IUC reduce by 2.5% to 26.6% turnover. **M3:** Reduce sickness by 0.5% Trust-wide to 6.08%. - A&E 5.3%. - EOC 8.1%, stretch 1% to 7.6%. - IUC to 10.5% (1% reduction). - PTS to 7.8%. - Other to 3.89%. **M4:** NSS results to be in the upper quartile for the ambulance sector.	**Q1:** Retention data baseline and any data/information gaps, track progress and impact established. **Q1:** collective understanding of talent management and appraisal of YAS practices with all key stakeholders, including employee voice established. **Q1:** YAS Together engagement sessions across corporate areas to raise awareness complete. **Q1:** Launch and roll out Leadership behaviours complete. **Q2:** Recruitment reviewed and refreshed, and induction and onboarding based on evidence-based practices implemented. **Q2:** Roll out of succession planning tool across operational areas complete. **Q2:** Pilot shadowing and roadshows intervention within EOC developed. **Q3:** Career planning tools published and leaders upskilled to use these tools including coaching skills. **Q3:** YAS Together engagement sessions across operational areas complete. **Q4:** Learning and development resources curated and actively promoted, including apprenticeships, pathways and CPD. **Q4:** Evidence-based preceptorship frameworks and associated support implemented. **Q4:** Roll out of succession planning tool in corporate areas complete.
Embed equality, diversity and inclusion.	Director of People and Organisational Development: Amanda Wilcock	Head of Diversity and Inclusion: Nabila Ayub	**M1:** Increase feedback including improvements to National Staff Survey results for - Engagement - Morale - feeling valued - reasonable adjustments **M2:** Streamlined process for inclusive practice in recruitment. **M3:** Increase in compassionate leadership NSS scores.	**BM1:** - Engagement score = 6.0. - Morale score = 5.4. - Feeling valued 25.5%. - Reasonable adjustments 65.7%. **BM2:** Pockets of good practice. **BM3:** Compassionate leadership score = 6.87.	**TM1:** Increase NSS score/above sector average: - Engagement score =7.0. - Morale score = 6.4. - Feeling Valued increase by 1% to 26.5%. - Reasonable adjustments increase by 1% to 66.7%. **TM2:** Consistent approach across the Trust. **TM3:** Compassionate leadership score = 7.87.	**Q1:** Pilot of inclusive learning interventions for people leaders delivered and completed. **Q3:** Centralised workplace adjustments process to support staff living with disabilities developed. **Q3:** Robust plan committing to the NHSE anti-racism framework developed. **Q4:** Phase 2 of comprehensive review of end-to- end recruitment process and associated procedures with recommendations to improve inclusive recruitment continued. **Q4:** Improved staff engagement through Support Networks and EDI objectives for Board with support from NED Champions and Executive Sponsors.

Document Version Control

Version	Date	Document Author	Status	Description of Change
0.4	Jun 24	Natalie Tyrrell	D	Draft
1.0	04/07/24	Catherine Taylor	F	Issued for Business Plan 24/25 Monitoring
1.1	16/07/24	Natalie Tyrrell Catherine Taylor	F	DG & CA title updated Reduce Trust-wide sickness absence by 0.5% metric converted to Q4 milestone and case management procurement review and procurement milestones revised.

This document is controlled.
If you would like to suggest amendments to this document, please contact the document author.

Trust Strategy Bold Ambition:	Our Partners		
Ambition Statement:	YAS will be a collaborative, integral and influential partner across a joined-up healthcare network that works preventatively, reduces inequality and improves population health outcomes, supporting all our communities.		
YAS 2024/25 Business Plan Strategic Objective:	To collaborate with our partners to improve population health outcomes.		
Agreed Start Date:	01/04/2024	**Forecast End Date:**	31/03/2025
Assurance Reporting Committee:	Trust Board	**Reporting Timeframe:**	Quarterly
Trust Strategy Outcome Measure:	YAS will listen to staff, volunteers, patients, partners, and our communities to develop and deliver high quality care, which is continuously improving.		
Trust Enabling Plan:	Partnership enabling plan		
System Wide Alignment:	**Humber & North Yorkshire:**		
	West Yorkshire:		
	South Yorkshire:		
NHSE Operating Task:	Transform the way we deliver care and create strong foundations for the future.		
NHSE National Objective:	**Prevention and health inequalities:**	Continue to address health inequalities and deliver on the Core20PLUS5 approach, for adults and children and young people.	

Priorities and Workstream	**Executive Lead**	**Senior Responsible Officer**	**Outcome Measures**			**Key Milestones**	
			Metric Key Performance Indicator Definition	Baseline Key Performance Indicator 31st March 2024	Key Performance Indicator Target 31st March 2025	Milestone	Delivery Quarter
Partnership Working to Improve Response:	(8) YAS will further embed partnership working and system collaboration, with a particular focus on working with acute partners on handover delays and Place partners on appropriate clinical pathways for patients.						
Work with system partners to reduce hospital arrival to handover times.	Chief Operating Officer: Nick Smith	Directors of Partnerships and Operations: Jeevan Gill, Rachel Gillott & Adam Layland	**M1:** Reduced arrive to handover times.	**BM1:** Hull – 47:23 NY – 37:16 SY – 30:14 L/W – 19:43 B,C,K – 18:13	**TM1:** YAS – 23:58 Hull – 41:26 NY – 33:46 SY – 19:10 L/W – 19:41 B,C,K – 18:03	**Q1:** Actions in Place Plans delivered. **Q2:** Actions in Place Plans delivered. **Q3:** Actions in Place Plans delivered. **Q4:** Actions in Place Plans delivered.	
Increase where appropriate pathways and improve utilisation.	Executive Medical Director: Dr Julian Mark & Chief Operating Officer: Nick Smith	Clinical Pathways Manager: Derek Hatley & Directors of Partnerships and Operations: Jeevan Gill, Rachel Gillott & Adam Layland & Associate Chief Operating Officer: Julia Nixon	**M1:** Increase capability of understanding appropriate conveyance vs inappropriate conveyance using data. **M2:** Optimise availability of Push pathways regionally. **M3:** Optimise availability of current pathways.	**BM1:** Manual audit. **BM2:** Gaps in falls response provision, GP CAS and MH pathways. **BM3:** N/A	**TM1:** Data dashboard implemented to provide estimation of pathways' effectiveness and accurate patient flow. **TM2:** Full MH Push coverage; optimised falls response and GP CAS pathways available. **TM3:** TBC following dashboard creation.	**Q1:** Recruitment of Pathways Coordinator and clinical data analyst (within Clinical budget) complete. **Q1:** Review of current pathway and utilisation, including Push complete. **Q1:** Review of what is hindering reporting on pathways complete. **Q2:** Training package developed on clinical decision making and safe referrals. **Q2:** Optimising utilisation of current pathways, including PUSH commenced and ongoing. **Q2:** Development of new pathways with system partners following the review in Q1 commenced. **Q2:** Robust pathway reporting mechanisms to share with areas established. **Q3:** Actions identified in Q2 to improve utilisation reviewed and implemented. **Q3:** Any blockers and remedial actions identified. **Q4:** Development of pathways data dashboard to track themes/trends complete. **Q4:** Ability to provide high-quality intelligence to YAS senior leadership and system partners embedded. **Q4:** Evaluation of the training package complete.	

Embed the Mental Health and Learning Disabilities Programme.	Executive Director of Quality and Chief Paramedic: Dave Green	Lead Nurse - Urgent Care: Lesley Butterworth	**M1:** Increase in utilisation of ambulance specialist Mental Health response as the sole response to mental health incidents. **M2:** Decrease frontline DCA allocation to mental health incidents. **M3:** Implement PUSH model for local Mental Health Services to respond to lower acuity 999 calls. **M4:** Increase staff trained in Mental Health awareness. **M5:** Increase positive feedback received from patients with learning disabilities: "Do you have more confidence in accessing Ambulance Services". **M6:** Increase staff (trust-wide) receiving Oliver McGowen training (e-learning and classroom).	**BM1:** MH specialist resource 0%. **BM2:** DCA resource 100%. **BM3:** 2/10 MH Services implementing MH PUSH Model. **BM4:** 33% of all staff Trust-wide. **BM5:** N/A **BM6:** N/A	**TM1:** Increase to 20%. **TM2:** Decrease by 80%. **TM 3:** 10/10 MH Services implementing MH PUSH model. **TM4:** 66% of all staff Trust-wide. **TM5:** 80% positive feedback. **TM6:** E Learning: 33%, Classroom Learning: 10%.	**Q1:** Training Trio established to deliver webinar and face to face Oliver McGowen training complete. **Q2:** Implementation of remaining MHRVs (increase from 6 to 9) complete. **Q2:** Recruitment of 9 SPMH complete. **Q2:** Handover of MH PUSH model to EOC navigators complete. **Q2:** Recruitment of internal MH facilitators complete. **Q3:** MH programme completed into BAU.

Version	Date	Document Author	Status		Description of Change
0.4	Jun 24	Natalie Tyrrell	D		Draft
1.0	04/07/24	Catherine Taylor	F		Issued for Business Plan 24/25 Monitoring
1.1	16/07/24	Natalie Tyrrell	F		DG title updated

Trust Strategy Bold Ambition:	Our Planet and Pounds		
Ambition Statement:	YAS will be a responsible and sustainable organisation in the use of our financial and physical resources, reducing our environmental impact and ensuring the most effective use of all our resources.		
YAS 2024/25 Business Plan Strategic Objective:	To invest in the infrastructure and resources to improve the effectiveness of direct delivery.		
Agreed Start Date:	01/04/2024	**Forecast End Date:**	31/03/2025
Assurance Reporting Committee:	Finance & Performance Committee	**Reporting Timeframe:**	Quarterly
Trust Strategy Outcome Measure:	• YAS will work towards all new ambulances being zero emission by 2030 and become the first net zero emissions ambulance Trust. • YAS will use our resources wisely and ensure value for money. • YAS will ensure decisions are informed by evidence, research, data, and intelligence. • YAS will develop and deliver improvements and innovation. • YAS will provide cutting edge services by establishing new digitally enabled ways of working to optimise patient care and services including automation, AI and innovation.		
Trust Strategy Enabling Plan:	• Sustainable Services Plan		
System Wide Alignment:	**Humber & North Yorkshire:**		
	West Yorkshire:		
	South Yorkshire:		
NHSE Operating Task:	Transform the way we deliver care and create strong foundations for the future.		
NHSE National Objective:	**Use of resources:**	Deliver a balanced net system financial position for 2024/25. Reduce agency spending across the NHS, to a maximum of 3.2% of the total pay bill across 2024/25. Use resources efficiently. Use digital and data resources to support integration and service transformation.	

Priorities and Workstream	**Executive Lead**	**Senior Responsible Officer**	**Outcome Measures**			**Key Milestones**
			Metric Key Performance Indicator Definition	**Baseline Key Performance Indicator** 31st March 2024	**Key Performance Indicator Target** 31st March 2025	**Milestone & Delivery Quarter**
Effective use of Resources, Efficiencies and Value for Money:	(8) YAS will deliver a balanced break-even financial plan and drive more effective use of resources, through implementing a structured productivity and cost improvement programme.					
Maximise Organisational Efficiencies to deliver Trust wide efficiency target	Deputy Chief Executive: Marc Thomas – Exec lead for Productivity Improvements & Executive Director of Finance: Kathryn Vause – Exec lead for Financial Plan	Louise Engledow	**M1:** Achieve a minimum of 1.1% recurrent CIP savings across all budgets. **M2:** Achieve vacancy factor 1.8% to operational budgets and 1% to non-operational budgets - NB this is tracked through People Plan	**BM1:** TBC. **BM2:** TBC.	TM1: 1.1% minimum recurrent CIP target. TM2: 1.8% to operational budgets and 1% to non-operational budgets.	**Q1:** YAS and Departmental CIP targets agreed (agreed in June) **Q1:** OEG lead arrangements, OEG's ToR and Membership confirmed. – (agreed marc to lead) **Q2:** Develop process to identify efficiencies and consolidate into single CIP Tracker commenced. **Q2:** OEG agreement for saving ideas to progress. OEG to identify schemes requiring support. **Q2:** Departmental efficiency delivery plans developed and reported to OEG. **Q3:** FY25/26 CIP Ideas submitted into FY25/26 Business Planning process. **Q4:** 25/26 CIP targets / plans agreed. **Q4:** Report on outcome of 24/25 CIP programme complete.
Implement Non-Emergency Patient Transport Service (PTS) Eligibility.	Chief Operating Officer: Nick Smith	Managing Director of PTS: Chris Dexter	*2024-2025 based on new go-live timescales:* **M1:** Agreement of final criteria from x3 ICBs. (dependency with ICBs), by Q3. **M2:** Agreement and completion of comms, engagement and go-live date by Q3. **M3:** By Q4 update modelled efficiency figures of £1,950,203.52 based on agreed criteria and go-live date. **M4:** WTE Band 3 Call Handlers recruitment target increased by Q4.	*2024-2025 based on new go-live timescales:* **BM1:** No agreement of final criteria from x3 ICBs. **BM2:** N/A **BM3:** £1,950,203.52 **BM4:** 51.2.	*2024-2025 based on new go-live timescales:* **TM1:** Agreement of final criteria from x3 ICBs. **TM2:** Comms, engagement and go-live date agreed. **TM3:** Reviewed efficiency figures by Q4. **TM4:** 58.8 WTE by Q4.	*Timescales are dependent on ICB determined go-live date and therefore subject to change.* **Q3:** NHSE criteria translated into questions and adopted by the x3 ICBs complete. **Q3:** Signposting Process Approved. **Q3:** Single Robust Appeal process approved. **Q3:** Funding requirements identified, and funding agreed. **Q3:** Go Live dates agreed. **Q3/4:** Phase plan for realising the recurrent efficiency savings, as a result of reduced activity complete. **Q3/4:** Communications and engagement delivered. **Q4:** Staff Recruitment completed. **Q4**: YAS Staff Familiarisations delivered. **Q4:** Acute Trust Familiarisation delivered.

Priorities and Workstream	Executive Lead	Senior Responsible Officer	Outcome Measures: Metric Key Performance Indicator Definition	Outcome Measures: Baseline Key Performance Indicator 31st March 2024	Outcome Measures: Key Performance Indicator Target 31st March 2025	Key Milestones: Milestone & Delivery Quarter
			2025-2026 Metrics based on new go-live timescales: **M1:** Post implementation, achieve 30% reduction of SC/W1 (standard car journey/wheelchair with 1 ambulance) journey no longer eligible. (Excluding In Centre Haemodialysis (renal) journeys). **M2:** Reduce taxi spend by £1,950,203.52. **M3:** Reduce standard car (SC) activity figures (actual journeys) for SC mobility patients (excluding patients travelling for renal dialysis). **M4:** Reduce escort % of total delivered journeys. **M5:** Post full recruitment and implementation of eligibility, reduce WTE Band 3 call handler establishment. **M6**: No reduction in Patient Satisfaction for eligible patients.	*2025-2026 Metrics based on new go-live timescales:* **BM1:** Monthly Average for each area = North: 7,941 West: 10,160 South: 6,389 **BM2:** Taxi Spend = £6,842,525.35. **BM3:** SC activity figures (actual journeys) average 17,525per month. **BM4:** 22.3%. **BM5:** 58.8 WTE. **BM6:** Overall: 94.1% (Very Good 75%/Good 19.1%).	*2025-2026 Metrics based on new go-live timescales:* **TM1:** North: Reduce by 2,383 to 5,558. West: Reduce by 3,048 to 7,112. South: Reduce by 1,918 to 4471. **TM2:** Taxi spend £4,892,321.35 FYE. **TM3:** SC activity figures (actual journeys) average 13,481 per month. **TM4:** Reduce by 18%. **TM5:** 48.8 WTE. **TM6:** No reduction.	*2025-2026 Milestones based on new go-live timescales:* **Q1 2025/26:** Area 1 Go Live achieved. **Q1 2025/26:** Area 2 Go Live achieved. **Q1 2025/26:** Area 3 Go live achieved. **Q2 2025/26:** Review and evaluation complete. **Q2 2025/26:** Review of benefits and Metrics complete. **Q4 2025/26:** Project closure complete.
Optimise Fleet Availability & Performance:	(9) YAS will strengthen staffing and vehicle availability by investing further in the ambulance fleet and fleet management support, increasing the numbers and reducing the average age of vehicles, and reducing environmental impact through telematics systems.					
Increase fleet numbers to 512 DCAs and reduce VOR to achieve 82% vehicle availability. To be reviewed 17/7/24	Executive Director of Finance: Kathryn Vause	Director of Fleet & Estates: Glen Adams	**M1:** Achieve min 82% vehicle availability at Trust level. **M2:** Recruit to 11 fleet vacancies. **M3:** Delivery and rollout of new vehicles.	**BM1:** Vehicle availability: 82%. **BM2:** 11 vacant posts **BM3:** 442 DCA vehicles in fleet.	**TM1:** min 82% vehicle availability. **TM2:** 11 vacancies recruited to. **TM3:** 512 DCA vehicles in fleet. –	**Q1:** RRP for B5 and B6 technical staff complete. **Q2:** Recruitment plan complete. **Q2-3:** 61 new (additional) vehicles to be delivered to attain 512 target. **Q2-3** Commence recruitment. **Q3:** Consultation process for fleet restructure complete. **Q3:** Fleet business partners to support communication and engagement with service lines and ownership in area of VOR appointed. **Q4:** Staff in post, induction and training complete. **Q4:** 73 replacement vehicles to allow decommissioning of older vehicles and improve VOR rates. **Q4:** Restructure process complete (continue with onboarding 25/26). **Q4:** Commence implementation plans to deliver accident reduction and avoidable incidents in 2025/26.
Introduce in-vehicle telematics to the A&E, PTS and Support Service Vehicle Fleet to increase productivity and efficiency and reduce the trust's carbon footprint.	Executive Director of Finance: Kathryn Vause	Director of Fleet & Estates: Glen Adams	**M1:** Deliver £512K efficiency savings based on 10% fuel reduction 10% accident reduction following successful installation and roll out	**BM1: £0**	**TM1:** £512K efficiency savings (full year estimate)	**Q2:** Strategy report sign off F&P (23/7/24) Q2: Board approval (25/7/24) Q2: Publish tender on YPO portal (29/7/24). Q2: Evaluation of Tenders (29/8/24-5/9/24). Q2: F&P and Board approval (24&26/9/24). Q3: Contract award (8/10/24). **Q3:** Project planning phase to commence. **Q3:** Contract start date (14/10/24). Q3: Commence Phase 1 implementation and continue to develop roll out plans. **Q4:** Commence benefit review and reporting metrics for inclusion in 25/26 Business Planning process.

Document Version Control

Version	Date	Document Author	Status	Description of Change
0.4	Jun 24	Natalie Tyrrell	D	Draft
0.5	2/7/24	Natalie Tyrrell/Catherine Taylor	D	CIP M2 metric changed Achieve a minimum of 1.1% (instead of 1%) recurrent CIP targets across all budgets.
0.6	16/7/24	Catherine Taylor	D	Revisions to Organisational Efficiencies; Increase Fleet and Telematics following meetings with Kathryn Vause/Gavin Austin and email update from Glen Adams.

1.0	17/7/24	Gav Austin/Catherine Taylor	F	Revisions to Vehicle Availability and Telematics metrics and milestones, meeting with Kathryn Vause, Glen Adams, Gavin Austin 17/7/24
This document is controlled. If you would like to suggest amendments to this document, please contact the document author.				

Appendix B Business Plan Priorities: Key Workstreams and Measures

The key workstreams and high-level measures to deliver the 9 annual business plan priorities are detailed below.

For Our Patients in 2024-25 YAS will focus on:

1. Improve Response including Category 2:

YAS will improve ambulance and 999 and 111 call **response** times, particularly **Category 2 ambulance response**, by strengthening staffing and vehicle availability and deployment, by working intensively with acute partners to reduce Emergency Department (ED) handover times and by strengthening collaboration with Place partners to deliver more care remotely, in people's own homes and closer to home, utilising analysis of clinical and population health data, so that only where it is the best option for the patient are they conveyed to ED.

Manage Demand:

- Increase Hear and Treat rates from 13.6% to 16.3%
- Reduce avoidable conveyance rates
- Work with system partners to develop and increase access to appropriate alternative pathways - see priority 7
- Appropriate management of Health Care Professional calls:
  - Reduce the proportion of HCP responses by 1% Trust-wide from 12.3%.

Manage Capacity:

- Achieve 2024-25 Workforce Plan: Trajectories, Recruitment and Retention – see priority 4
- Achieve 0.5% Sickness Reduction in operational service lines – see priority 5
- Maximise on shift availability by increasing resource availability from an overall Trust-wide 21% to 23%
- Optimise use of Community First Responders from 17924 hours to 20000 hours
- Optimise appropriate deployment of Specialist Paramedics Urgent Care (SPUCs):
  - Increase the proportion of Category 3 calls vs total Category 1 and 2 calls SPUCs attend by 10% from 56%
  - Decrease conveyance rates of SPUCs by 5% from a Category 2 baseline of 50.7%, Category 3 baseline of 23.5% and Category 4 baseline of 15%

Maximise Efficiency:

- Reduce crew clear times by 10%: YAS average 20min 30secs (Humber 18:04; North Yorkshire 18:48; South Yorkshire 16:48, Leeds and Wakefield 22:50, Bradford, Calderdale and Kirklees 24:01)
- Improve productivity around meal break management by increasing compliance with meal break arrangements from 42% Trust-wide to at least 50%.

- Maximise the efficiency of clinical decision making to reduce on-scene times from 30 minutes conveyed or 60 minutes non-conveyed on scene to target to be confirmed after Q2.
- Work with system partners to improve Arrival to Handover times - see priority 7
- Improve category 2 response, by developing a future operating model

2. Strengthen Quality and Safety:

YAS will improve **quality and safety** through strengthening Quality Governance (including complaint handling) and medicines management, embedding the Patient Safety Incident Response Framework (PSIRF), implementing Clinical Supervision for all front-line staff, and evolving Quality Improvement (QI) to embed it culturally across the Trust. PSIRF

- Reduce the number of patient incidents by 5% from baseline (2023/24 baseline 33,736 incidents), through the introduction of PSIRF with a focus on incident reduction across key areas:
  - Care for patients that have fallen or been injured whilst in our care, 5% reduction from baseline (2023/24 baseline 319)
  - On-scene decision making incidents, 5% reduction from baseline (2023/24 baseline 248)
  - EOC (999) telephony issues, 5% reduction from baseline (2023/24 baseline 452)
  - IUC (111) telephony issues, 5% reduction from baseline (2023/24 baseline 573)
- Increase number of staff trained in QI Methodology: Introduction -1750, Foundation - 90, QI leader – 32
- Increase clinical supervision: 100 facilitators trained by Q3, 40% of frontline staff offered CS session by quarter four
- Improve medicine governance by reducing out of date medicines incidents by 25% to (target tbc) and achieve 100% compliance in controlled drug adherence

3. Deliver an Integrated Clinical Assessment Service:

YAS will invest further in developing **integrated clinical assessment** across 999 and 111, streamlining triage and care navigation processes to ensure patients get the most appropriate care at the earliest point in their journey. YAS will deliver this by aligning systems, expanding multi-disciplinary clinical capacity and support for clinical staff, and working closely with each of our 15 Places to develop consistent pathways into Place-based care coordination services.

- Improve IUC KPI 4 (calls assessed by a Clinician/Clinical Advisor) from 40.6% to above 65% - see also priority 1 and 4

For Our People in 2024-25 YAS will focus on:

4. Deliver Workforce Plans:

YAS will strengthen the **workforce** within existing establishments, through improvements in recruitment, retention, training, staff support and sickness management across EOC, 999, 111 and PTS, with a particular focus on implementing the IUC change programme and the EOC change programme.

- Achieve 2024-25 Workforce Plan:

A&E Operations Workforce Recruitment & Retention

- Achieve A&E FTE workforce trajectories: Substantive 3202, Overtime 104
- Achieve A&E FTE Recruitment: 240 Ambulance Support Workers, 72 Ambulance Care Assistants, 252 Paramedics
- Retention/reducing turnover (with HR): maintain 6.3% turnover

Remote Patient Care (EOC & IUC) Workforce Recruitment & Retention

- Achieve EOC and IUC FTE workforce trajectories: (EOC) 247 EMD, 147 Dispatch, 106 Clinical Advisors, (IUC) 476 Health Advisors, 90 Senior Clinical Advisors
- Achieve EOC and IUC FTE Recruitment: (EOC) 120 EMD, 10 Dispatchers, 39 Senior Clinical Advisors (train 21 A&E staff in Remote Clinical Assessment), (IUC) 372 Health Advisors, 34 Senior Clinical Advisors (inclusive of 16 International Recruits)
- Retention (with HR): EOC maintain 19% turnover; IUC reduce by 2.5% to 26.6% turnover

PTS Workforce Recruitment & Retention

- Achieve PTS FTE workforce trajectories: Substantive 465
- Achieve PTS FTE Recruitment: 112 Ambulance Care Assistants
- Retention (with HR) maintain 10.9% turnover

- Implement IUC Improvements including:
  - Achieve KPIs, including improve call answering performance to 74% full year and above 80% by Q4;
  - Reduce Not Ready Reason Codes from 24% to 20% increasing availability and improving response times
  - Reduce agency use from 50% to 30%

- Implement EOC Improvements including:
  - Achieve KPIs, including improve call answering performance Mean Call Answer to 2 secs/ call answer above 80% by Q4
  - Increase Hear and Treat from 13.6% to 16.3% full year

- Implement Training Plans:
  - Achieve 100% training requirements
  - Achieve 100% YTD occupancy rate achieved

5. Improve Health, Wellbeing and Safety:

YAS will improve the **health, wellbeing and safety** of staff with a particular focus on strengthening Mental Health and Wellbeing support, implementing the Sexual Safety Charter and the deterrence of violence and aggression including funding and extending the continued deployment of body-worn cameras.

- Violence Prevention/Reduction:
  - Embed Body Worn Cameras: Increase the numbers of staff trained to use body worn cameras by 10% from 1123 to 1235. Increase the numbers of staff using and reporting body worn camera use on Datix by 20% from 100 to 120
  - Reduction in physical assaults from 16.5% by 0.5% to 16%

- Reduce Trust-wide Sickness Absence by 0.5%
  - A&E Operations: by 0.5% to 5.3%
  - Remote Patient Care: EOC by 0.5% to 8.1% with a stretch 1% target 7.6%; IUC reduce by 1% to 10.5%
  - PTS: by 0.5% to 7.8%

- Improve appraisal and career conversation compliance to 90%

- Implement Mental Health First Aid Training

6. Culture, Equality, Diversity and Inclusion:

YAS will drive improvements in the **culture** of the organisation by implementing the NHS People Promise and the YAS Together programme, with a particular focus on leadership development, improving **equality, diversity and inclusion**, and creating a more open culture, where staff are well informed and are encouraged and supported to Speak Up.

- Engage in the NHS People Promise, by being an exemplar site
- Implement YAS Together including leadership development and talent management
- Embed Equality, Diversity and Inclusion

For Our Partners in 2024-25 YAS will focus on:

7. Partnership working to improve response:

YAS will further embed **partnership working** and **system collaboration**, with a particular focus on working with acute partners on handover delays and Place partners on appropriate clinical pathways for patients.

- Work with system partners to reduce hospital arrival to handover times: YAS average 23min 58sec (Humber 41:26; North Yorkshire 33:46; South Yorkshire 19:10; Leeds and Wakefield 19:41; Bradford, Calderdale, Kirklees 18:03)
- Work with system partners to develop and increase access to appropriate pathways
- Embed the Mental Health and Learning Disabilities Programme:
  - Increase in utilisation of ambulance specialist Mental Health response as the sole response to mental health incidents from 0% to 20%
  - Decrease DCA allocation to mental health incidents from 100% to 80%.
  - Number of YAS staff receiving Oliver McGowen training (E learning 33% classroom 10% of all staff)

For Our Planet and Pounds in 2024-25 YAS will focus on:

8. Effective use of Resources, Efficiencies and Value for Money:

YAS will deliver a **balanced break-even financial plan** and drive more effective use of resources, through implementing a structured **productivity and cost improvement** programme.

- Maximise Organisational Efficiencies to deliver Trust wide efficiency target of 5.2%
- Implement Non-Emergency Patient Transport Service (PTS) Eligibility leading to:
  - Reduce taxi spend by £1,950,203.52 from spend in 2023/24 of £6,842,525.35 to a target of £4,892,321.35 full year effect in 2024-25.
  - Reduce standard car (SC) activity figures (actual journeys) from 17,525 per month average to 13,481 per month average for SC mobility patients (excluding patients travelling for renal dialysis)

9. Optimise fleet availability & performance:

YAS will strengthen staffing and vehicle availability by investing further in the **ambulance fleet** and fleet management support, increasing the numbers and reducing the average age of vehicles, and reducing environmental impact through telematics systems.

- Implement the Fleet Plan to support availability to 82% (reducing Vehicle Off Road, VOR to 18%) and improve Category 2 performance
- Increase fleet numbers to target of 512 Double Crewed Ambulances (DCAs)
- Implement Telematics system

Meeting Title: Board of Directors (Public)
Meeting Date: 25 July 2024
Agenda Item 3.1

Report Title	**Corporate Risk Report**
Author (name and title)	David O'Brien, Director of Corporate Services and Company Secretary Levi MacIness, Risk and Assurance Manager
Accountable Director	David O'Brien, Director of Corporate Services and Company Secretary
Previous committees/groups	Risk and Assurance Group: June 2024, July 2024 People Committee: 09 July 2024 Quality Committee: 18 July 2024 Finance and Performance Committee: 23 July 2024
Recommended action(s) Approval, Assurance, Information	Assurance
Purpose of the paper	To provide an update to the Board of Directors on material changes to corporate risks since the previous risk report (30 May)
Recommendation(s)	The Board of Directors notes the position regarding corporate risks.

Executive summary (overview of main points)

1. Four new corporate risks have been opened:

- Risk 610: National Minimum Wage (moderate risk)
- Risk 637: Industrial action by General Practitioners (high risk)
- Risk 639: Employment checks for Student Paramedics (moderate risk)
- Risk 640: Procurement Act 2023 (moderate risk)

2. Three risks have been reduced in score but remain on the Corporate Risk Register:

- Risk 187: Cumulative effect of moving and handling (moderate risk)
- Risk 433: EOC Workforce capacity (moderate risk)
- Risk 588: Visas & Immigration (moderate risk)

3. Two risks have been de-escalated from the Corporate Risk Register.

- Risk 360: Facilities at Manor Mill for the Hazardous Area Response Team
- Risk 452: Management of Safeguarding Allegations

4. Four corporate risks have been closed:

- Risk 404: Clinical Effectiveness
- Risk 447: Safeguarding Team capacity
- Risk 549: C1 Driver training for recruits
- Risk 578: Job evaluation process

The Corporate Risk Register has been issued as part of the pack of supporting material for this meeting.

Strategic ambition(s) this supports Provide brief bullet point details of link to Trust strategy	Our Patients	All priorities
	Our People	All priorities
	Our Partners	All priorities
	Our Planet and Pounds	All priorities
Link with the BAF Include reference number (board and level 2 committees only)		All BAF strategic risks

Board of Directors (Public)
25 July 2024
Corporate Risk Report

1. PURPOSE

1.1 This paper:

- Reports recent material changes to the Corporate Risk Register
- Highlights any areas of reported emerging risk.

1.2 This risk report is prepared as part of the quarterly cycle of risk reporting and assurance for the Trust Board.

2.0 CONTEXT

2.1 Risk is inherent in all Trust activities. Risk management is everybody's business. Failure to manage risk well could lead to harm to patients, staff or others, loss or damage to the Trust's reputation and assets, financial loss, and potential for complaints, litigation, and adverse publicity. Effective risk management is essential at all levels and across all activities of the organisation to support safe and high-quality service delivery and pro-active planning for Trust development.

2.2 An important element of the Trust's risk management arrangements is regular reporting to governance bodies and management groups, including the Board and its committees, of current corporate risks, changes in corporate risk exposures, and areas of emerging corporate risk.

3.0 CORPORATE RISKS

3.0.1 The Corporate Risk Register is reviewed by the Risk and Assurance Group (RAG) monthly. It comprises all risks that have a current risk score of **12 or above** (based on the criteria found in the Trust's risk evaluation matrix).

3.0.2 The Corporate Risk Register for July 2024 is issued separately as supporting material for this meeting. Note that as part of an exercise to disaggregate several A&E Operations risks into the three ICB areas some operational risks have been removed from the Corporate Risk Register and are held in a separate A&E Operations risk register. Those disaggregated risks that meet the criteria for a corporate risk will be re-introduced to the corporate reports in the next reporting cycle.

3.0.3 The greatest individual corporate risks are as follows:

1. Hospital Handover (25, high risk)

This risk has been disaggregated to reflect the position in different operational areas. The highest risk is found in North and East.

- Hospital Handover – South (20, high risk)
- Hospital Handover – N&E (25, high risk)
- Hospital Handover – West (10, moderate risk)

3.1 NEW CORPORATE RISKS

3.1.1 Four new corporate risks have been opened:

- Risk 610: National Minimum Wage – Staff on salary sacrifice remunerated under legal minimum (12, moderate risk)
- Risk 637: Industrial action by General Practitioners (high risk, score to be finalised)
- Risk 639: Employment checks for Student Paramedics (12, moderate risk)
- Risk 640: Procurement Act 2023 (12, moderate risk)

3.1.2 **Appendix A** presents more detailed information about these risks.

3.2 RISKS REDUCED BUT REMAINING ON THE CORPORATE RISK REGISTER

3.2.1 Three risks have been reduced in score but remain on the Corporate Risk Register:

- Risk 187: Cumulative effect of repeated moving and handling (reduced from 15 to 12, moderate risk)
- Risk 433: EOC Workforce capacity (reduced from 20 to 12, moderate risk)
- Risk 588: Visas & Immigration (reduced from 15 to 12, moderate risk)

3.2.2 **Appendix B** presents more detailed information about the above risks.

3.3 RISKS DE-ESCALATED FROM THE CORPORATE RISK REGISTER

3.3.1 Two risks have been de-escalated from the Corporate Risk Register. These remain open and are managed via local risk registers:

- Risk 360: Facilities at Manor Mill for the Hazardous Area Response Team (reduced from 12 to 6, low risk)
- Risk 452: Management of Safeguarding Allegations (reduced from 16 to 8, low risk)

3.3.2 **Appendix C** presents more detailed information about these risks.

3.4 CLOSED RISKS

3.4.1 Four corporate risks have been closed:

- Risk 404: Clinical Effectiveness
- Risk 447: Safeguarding Team capacity
- Risk 549: C1 Driver training for recruits
- Risk 578: Job evaluation process

3.4.2 **Appendix D** presents more detailed information about these closed risks

4.0 FINANCIAL IMPLICATIONS

4.1 This report has no direct financial implications.

5.0 RISK

5.1 Failure to identify and manage operational risks in a timely and appropriate manner could prevent service lines and support functions from achieving their objectives.

5.2 Failure to demonstrate suitably robust and effective risk management arrangements could have an adverse impact on the Trust's reputation and could attract regulatory attention.

6.0 RECOMMENDATIONS

6.1 The Board is asked to note the position regarding corporate risks.

David O'Brien
Director of Corporate Services and Company Secretary

Levi MacInnes
Risk and Assurance Manager

July 2024

APPENDIX A: NEW CORPORATE RISKS

NEW CORPORATE RISK 1		
Reference	610	
Title	National Minimum Wage	
Committee	People Committee	
Directorate	People and Organisational Development	
Business Area	Human Resources	
Risk Owner	Suzanne Hartshorne, Deputy Director of People & OD	
BAF Links	Strategic Risk 6: Workplace culture Strategic Risk 7: Recruitment and retention	
Context	The increase in National Minimum Wage effective from 01 April 2024 has resulted in some staff who participate in salary sacrifice schemes receiving a level of pay that is below the National Minimum Wage. There is a risk of HMRC penalties, legal process and potential prosecutions.	

Opening Score	Current Score	Target Score
12 (Moderate Risk)	12 (Moderate Risk)	3 (Low Risk)

FULL RISK DESCRIPTION		
WHAT	If…	A solution cannot be found to ensure staff are paid at or above National Minimum Wage
	Then…	The Trust might be subject to legal action from staff
SO WHAT	Resulting in…	Potential fines and reputational issues.
WHAT NEXT	Key Mitigation Actions	The Trust is seeking legal advice to explore all options moving forwards. Options will be presented to TEG for approval with a view to ensure actions are taken as soon as possible.

NEW CORPORATE RISK 2		
Reference	637	
Title	Industrial action by General Practitioners	
Committee	Finance and Performance Committee	
Directorate	Chief Operating Officer	
Business Area	A&E Operations	
Risk Owner	Jackie Cole, Associate Chief Operating Officer – Central Services	
BAF Links	Strategic Risk 1: Timely response Strategic Risk 2: Access to appropriate care	
Context	Potential risk has been identified following GP's balloting for industrial action. A wider risk-assessment is being undertaken to support mitigating actions in the event of industrial action, which would result in significant potential harm to patients. This is considered to be a high risk. However the finalised risk score is yet to be confirmed.	

Opening Score	Current Score	Target Score
tbc (High Risk)	tbc (High Risk)	5 (Low Risk)

FULL RISK DESCRIPTION		
WHAT	If…	General Practitioners across the whole of Yorkshire and Humber take industrial action as planned
	Then…	There will be a potential increase in demand into 999 and IUC, a reduction in alternative pathways, and a reduction in direct access to GPs.
SO WHAT	Resulting in…	Patient harm due to delays to call handling, clinical triage and assessment, and response as a result of increased demand and reduced alternative pathways.
WHAT NEXT	Key Mitigation Actions	Mitigating plans to be established by all operational functions. Review at Operational Resilience Oversight Group to ensure that business continuity plans and other tactical plans are in place to manage an increase in demand, the reduction in alternate pathways and the reduced access to GPs.

NEW CORPORATE RISK 3		
Reference	639	
Title	Employment checks for student paramedics	
Committee	People Committee	
Directorate	People and Organisational Development	
Business Area	Human Resources	
Risk Owner	Suzanne Hartshorne, Deputy Director of People and OD	
BAF Links	Strategic Risk 7: Recruitment and retention	
Context	It has been identified that the Trust is required to conduct internal checks for student paramedics in addition to the checks already undertaken by the universities. Approximately 600 student paramedics have been identified as not having had internal employment checks and the Trust is in breach of contract as a result.	

Opening Score	Current Score	Target Score
12 (Moderate Risk)	12 (Moderate Risk)	(Low Risk)

FULL RISK DESCRIPTION		
WHAT	If…	The Trust does not comply with the terms of the NHS England contract regarding employment checks for student paramedics
	Then…	The Trust will be in breach of contract
SO WHAT	Resulting in…	The potential withdrawal of our permissions to train students, which will reduce our paramedic recruitment pipeline with implications for patient safety due to gaps in rotas.
WHAT NEXT	Key Mitigation Actions	Actions to mitigate the risk to be determined for existing staff (approximately 600 student paramedics). New staff will have necessary checks conducted moving forward.

NEW CORPORATE RISK 4		
Reference	640	
Title	Procurement Act 2023	
Committee	Finance and Performance Committee	
Directorate	Finance	
Business Area	Procurement	
Risk Owner	Matt Barker, Head of Procurement and Logistics	
BAF Links	Strategic Risk 12: Wise use of revenue resource / value for money Strategic Risk 13: Wise use of capital resource / value for money	
Context	In October 2024 a new Procurement Act will replace the existing Public Contracts Regulations. This presents a potential risk to the Trust regarding the new requirements of early transparency notices on any procurement with a value in excess of £30k.	

Opening Score	Current Score	Target Score
12 (Moderate Risk)	12 (Moderate Risk)	4 (Low Risk)

FULL RISK DESCRIPTION		
WHAT	If…	The Trust does not meet the Procurement Act 2023 requirements to be enforced from October 2024
	Then…	The Trust will be non-compliant with in respect of the new regulations
SO WHAT	Resulting in…	Potential challenge from suppliers, legal action, financial penalties and reputational risk.
WHAT NEXT	Key Mitigation Actions	Requirements of the Act includes additional reporting, continual commercial awareness training and ten modules of training for the procurement team. The training is underway within the team in preparation for the Act introduction however actions for the wider Trust are still to be identified.

APPENDIX B: CORPORATE RISKS THAT HAVE REDUCED BUT REMAIN ON THE CORPORATE RISK REGISTER

Ref	Title	Area	WHAT	SO WHAT	Change		Rationale	WHAT NEXT
					From	To		
187	Cumulative effect of repeated moving and handling	Quality	IF the Trust does not consider the frequency, weight and forces involved in moving and handling tasks THEN staff may experience the cumulative effect of repeated actions	RESULTING IN musculoskeletal injury.	15	12	The Moving and Handling SME is now in post and progress has been made against the workplan. Actions identified and delivered with improvements reported.	Appetite/Target: 2 Review of training and collaborative working with the Health and Safety Executive and the National Ambulance Risk and Safety Forum.
433	EOC Workforce Capacity	EOC	IF there are sustained increases in call volume, duplicate calls and failure to meet requirements for staffing numbers THEN EOC staff will not be able to allocate resources in a timely manner	RESULTING IN delayed response times to answer and respond to emergency calls with potential for harm to patients	20	12	Workforce grown substantially with sustained improvements with a mean of 3-5 seconds for call answer. Short periods of pressure remain and response plans in place. Trajectory of improvement on track and continuation of recruitment.	Appetite/Target 4 Continuous recruitment to meet demand. The risk remains on the corporate risk register.
588	Visas & Immigration	People & OD	IF the Trust does not have systems and processes in place to robustly manage non-UK residents THEN the Trust could face significant reputation as well as financial penalties	RESULTING in the withdrawal of our UKVI license to be able to sponsor international applicants	15	12	No further investigation from Home Office. All personnel files have been reviewed and employees are being contacted where information is missing. Process in place to capture details for new staff.	Appetite/Target 3 The risk remains on the corporate risk register with a view to close upon all records reviews completed.

APPENDIX C: RISKS THAT HAVE BEEN DE-ESCALATED FROM THE CORPORATE RISK REGISTER

Ref	Title	Area	WHAT	SO WHAT	Change		Rationale	WHAT NEXT
					From	To		
360	Facilities at Manor Mill for the Hazardous Area Response Team (HART)	A&E Central Services	IF there continues to be a lack of storage facility and room availability at Manor Mill for the Hazardous Area Response Team, THEN personal protective equipment will continue to be stored in the garage area and some capabilities will be unable to be delivered	RESULTING IN a lack of national compliance against the National Ambulance Resilience Unit (NARU) standards	12	8	Modular storage facilities constructed within the garage for HART equipment.	Appetite/Target 4 The risk will be managed via the local risk register, with a view to closure
452	Management of Safeguarding Allegations.	Safeguarding	IF the management of safeguarding allegations against staff is inconsistent due to a lack of a standardised process THEN potential failure to identify and escalate incidents and concerns may exist	RESULTING IN the Trust being unable to give assurance that it is meeting its statutory obligations as a provider Trust, and delay in making timely risk assessments and action plans which will affect the safety of staff and patients.	16	8	Rapid Process Improvement Workshop (RPIW) held with HR and Safeguarding teams and process reported to be more robust and consistent at 90-day outturn report.	Appetite/Target 4 Policy to be updated and ongoing monitoring underway as this is reported on the internal audit action plan. The risk will be managed via the local risk register, with a view to closure.

APPENDIX D: CORPORATE RISKS THAT HAVE BEEN CLOSED

Ref	Title	Area	WHAT	SO WHAT	Change		Rationale	WHAT NEXT	
					From	To			
404	Clinical Effectiveness	Medical	IF the Head of Clinical Effectiveness function is not filled THEN there is a lack of representation at National Clinical Quality Group and a lack of capacity to develop and maintain the clinical audit plan and respond to the emerging needs of the organisation	RESULTING IN an inability to influence the development of relevant clinical quality indicators, an inability to provide assurance to the Board and wider stakeholders on the delivery of safe and effective healthcare and an adverse effect on our ability to continuously improve clinical care.	12	3>	Role appointed to with a start date of 1st July 2024.	Appetite/Target Risk closed	3
447	Capacity within the Safeguarding team to deliver core statutory requirements.	Safeguarding	IF the capacity of the safeguarding team remains as it is and if the increased service demand around statutory reviews, child deaths and social care enquiries for section 42 and section 47 remains THEN potential failure to meet these requirements will exist	RESULTING IN the Trust being unable to give assurance that it is meeting its statutory safeguarding obligations as a provider Trust, and will result in a delay in providing information and professional analysis and opinion to multi agency partners, with potential implications for patient safety and staff wellbeing	12	4>	New team members now in post and fully functional following a period of induction. At capacity to deliver workstreams effectively.	Appetite/Target Risk closed	4

Ref	Title	Area	WHAT	SO WHAT	Change		Rationale	WHAT NEXT	
					From	To			
549	C1 Driver training for recruits	A&E Ops	IF there is a delay to candidates getting their C1 provisional license THEN they cannot be booked onto a clinical training course and start employment with YAS	RESULTING in not delivering the required staffing levels for A&E Operations this year (2023/24) which in turn will contribute to delayed response times for patients.	12	4>	No longer issues with DVLA processing C1 provisional licenses therefore risk to be closed. Ongoing delivery of driver training ongoing via Academy.	Appetite/Target Risk Closed	4
578	Job Evaluation Process	People & OD	IF the job evaluation process is not efficient and achieving intended aims THEN decisions cannot be made in a timely manner and the Trust will continue to experience delays in recruitment and structural changes	RESULTING IN roles remaining unfilled, creating gaps in capacity with impact to operational activities. Potential risk to regulatory compliance, patient safety and reputational damage.	12	4>	Significant improvement to JE process following work with trade unions. Backlog now cleared and work to ensure consistency will continue.	Appetite/Target Risk closed	4

Meeting Title: Board of Directors (in Public)
Meeting Date: 25 July 2024
Agenda Item: 3.2

Report Title	**Board Assurance Framework**
Author (name and title)	David O'Brien, Director of Corporate Services and Company Secretary
Accountable Director	David O'Brien, Director of Corporate Services and Company Secretary
Previous committees/groups	Board Strategic Forum: 29 February, 20 June Audit and Risk Committee: 16 April Quality Committee, 21 May, 18 July Finance and Performance Committee, 23 July People Committee, 09 July
Recommended action(s) Approval, Assurance, Information	Approval
Purpose of the paper	This paper presents the new Board Assurance Framework that has been developed to align with the Trust Strategy 2024-29
Recommendation(s)	The Trust Board: 1. Notes the new set of strategic risks aligned to the Trust Strategy 2024-29 2. Notes that the Board Assurance Framework is a live document and will continue to evolve. 3. Supports the intention to hold a session on the Board's strategic risk appetite later in 2024/25. 4. Notes the key issues identified in Section 7 of this report, particularly those relating to the need to strengthen elements of the Trust's governance and assurance framework. 5. Approves the new Board Assurance Framework to go live, subject to final adjustments as required, with reporting to commence in September 2024.

To align with its new strategy the Trust has developed a new set of strategic risks and a new Board Assurance Framework based on the four new bold ambitions and the priorities linked to these. As part of this process the Trust has reviewed and updated the content and format of the Board Assurance Framework.

The new strategic risks were approved by the Trust Board at its meeting in Public on 30 May 2024 and subsequently refined at a Board Strategic Forum session on 20 June 2024.

The new Board Assurance Framework is presented at Appendix 2. Although some content is subject to adjustment and final confirmation, the framework is substantially complete (as far as a 'live' document such as the BAF is ever complete) and is in a position to be adopted by the Board.

The Board Assurance Framework sets out Executive Director ownership and Committee oversight arrangements for each of these risks and the associated priority actions. Most of the priority actions for 2024/25 are either previously agreed business plan deliverables or are actions taken from other agreed plans. The actions tend to focus on strengthening the controls around each risk, however there are some notable examples that are actions to strengthen the assurance arrangements. For a small number of strategic risks the priority actions for 2024/25 require further work to finalise, and some actions may change during the year in response to changes in the nature of the risks facing the Trust.

The BAF includes a high-level 'assurance map' for each strategic risk to indicate the main sources of assurance and the schedule of assurance reporting to key governance bodies. The assurance maps also provide an indication of recent ratings received via external assurance sources where these are available.

Formal BAF reporting to TEG, Committees and Board will commence from September. A schedule of reporting for the remainder of 2024/25 is attached at Appendix 1. Prior to that, all risk scores will be re-assessed to ensure that the starting position properly reflects risk exposures facing the Trust as it heads into the autumn and winter period.

The BAF is a live document and will continue to flex and evolve in line with the operating environment of the Trust.

Strategic ambition(s) this supports Provide brief bullet point details of link to Trust strategy	Our Patients	All strategic priorities
	Our People	
	Our Partners	
	Our Planet and Pounds	
Link with the BAF Include reference number (board and level 2 committees only)		All BAF strategic risks

Board of Directors (in Public)
25 July 2024
Board Assurance Framework
Director of Corporate Services and Company Secretary

1. PURPOSE

1.1 This paper presents a provisional draft of the new Board Assurance Framework that has been developed to align with the Trust Strategy 2024-29.

2.0 CONTEXT

2.1 Risk is inherent in all Trust activities. Risk management is everybody's business. Failure to manage risk well could lead to harm to patients, staff or others, loss or damage to the Trust's reputation and assets, financial loss, and potential for complaints, litigation, and adverse publicity.

2.2 Effective risk management is essential at all levels and across all activities of the organisation to support safe and high-quality service delivery and pro-active planning for Trust development.

2.3 The Board Assurance Framework represents ownership by the Board of the key risks to the achievement of the organisation's strategic objectives.

3.0 2023/24 BOARD ASSURANCE FRAMEWORK

3.1 The Board Assurance Framework (BAF) presents the key areas of strategic risk associated with the Trust's ambitions. It also sets out the key control and assurance developments required to mitigate these risks, and the most important actions associated with these.

3.2 The Trust has adopted a new strategy for the period 2024-29, based around four strategic 'bold ambitions':

- Our Patients
- Our People
- Our Partners
- Our Planet and Pounds

3.3 To align with this strategy the Trust has developed a new set of strategic risks based on these four bold ambitions, and, subsequently, a new Board Assurance Framework. As part of this process the Trust has reviewed and updated the content and format of the Board Assurance Framework.

4.0 2024/25 STRATEGIC RISKS

4.1 The new strategic risks were approved by the Trust Board at its meeting in Public on 30 May 2024 and subsequently refined at a Board Strategic Forum session on 20 June 2024. These are as follows:

1. Our Patients

- Ability to deliver a timely response to patients.
- Ability to provide patients with access to appropriate care.
- Ability to support patient flow across the healthcare system.
- Ability to strengthen quality governance and medicines management.
- Ability to develop and maintain effective emergency preparedness, resilience, and response arrangements.

2. Our People

- Ability to develop and sustain an open and positive workplace culture.
- Ability to support staff health and well-being effectively.
- Ability to deliver and sustain improvements in recruitment and retention.
- Ability to deliver and sustain improvements in leadership and staff training and development.

3. Our Partners

- Ability to act as a collaborative, integral, and influential system partner.
- Ability to collaborate effectively to improve population health and reduce health inequalities.

4. Our Planet and Pounds

- Ability to secure sufficient revenue resources and use them wisely to ensure value for money.
- Ability to secure sufficient capital resources and use them wisely to ensure value for money.
- Ability to deliver safe and effective digital technology developments and cyber security arrangements.
- Ability to act responsibly and effectively in response to climate change.

4.2 The Board Assurance Framework sets out Executive Director ownership and Committee oversight arrangements for each of these risks.

5.0 BOARD ASSURANCE FRAMEWORK

5.1 The new Board Assurance Framework is presented at Appendix 2. Although some content is subject to adjustment and final confirmation, the framework is substantially complete (as far as a 'live' document such as the BAF is ever complete) and is in a position to be adopted by the Board.

5.2 For each strategic risk there are four pages of assurance information:

Page 1: Summary description of the risk, with risk scores, priority areas of development to strengthen controls and / or assurance relating to the risk, and priority actions for 2024/25 to achieve this.

Page 2: Fuller description of the risk, presented in terms of the both the established 'If... Then... Resulting In' risk articulation and the 'What?...So What?...What Next?' assurance questions. This page also includes an indication of risk appetite and a diagrammatic representation of key assurance flows.

Page 3: Sets out links to other strategic and corporate risks, the key internal and external controls, and the key sources of assurance (based on the three lines of assurance model)

Page 4: A high-level assurance map for each strategic risk to indicate the main schedule of assurance reporting to key governance bodies and a summary of outcomes from assurance processes.

5.3 Generally speaking, for assurance purposes only first page for each risk will be routinely reported to governance bodies. That page contains the key information about delivery of mitigation actions and the impact of this on risk exposures. However the whole framework document will be circulated with the supporting documents for each Board meeting and will be routinely available to the Audit and Risk Committee.

5.4 Most of the priority actions for 2024/25 are either previously agreed business plan deliverables or are actions taken from other agreed plans. The actions tend to focus on strengthening the controls around each risk, however, there are some actions to strengthen the assurance arrangements. For a small number of strategic risks the priority actions for 2024/25 require further work to finalise. Some actions might change during the year in response to changes in the nature of the risks facing the Trust.

5.5 The risk appetite statements for each strategic risk are drawn from the existing Board's Statement of Risk Appetite. This statement was last approved in early 2023/24 and although it remains applicable it should be reviewed and updated. It is proposed to run a session on the Board's strategic risk appetite during a Board Strategic Forum later in 2024/25 (date to be confirmed).

6.0 ASSURANCE MAPPING

6.1 The BAF includes a high-level assurance map for each strategic risk to indicate the main sources of assurance (based on the 'three lines' assurance model) and the schedule of assurance reporting to key governance bodies. The assurance maps also provide an indication of recent ratings received via third line / external assurance sources where these are available.

6.2 Assurance mapping is a complex undertaking, and few NHS trusts attempt it (for instance, 360 Assurance have confirmed that across their client base few Trusts

have undertaken it). With this in mind, the Board should note that for some risks the assurance mapping remains work in progress and will continue to evolve.

6.3 Although the assurance mapping work in YAS is incomplete and not fully mature, the exercise has delivered value by identifying or confirming opportunities to strengthen the Trust's governance and assurance framework (see 7.1.3 below).

7.0 KEY POINTS FROM THE BAF

7.1 From the work to date on the new BAF the Board should note the following key points:

7.1.1 Two priority actions relating to financial risk are complete. These are the actions to develop an approved revenue plan for 2024/45 (Strategic Risk 12) and to develop an approved Capital Plan for 2024/25 (Strategic Risk 13).

7.1.2 The content for Risk 11 (Health Inequalities) is the least developed to date. The Board held a session on health inequalities on 20 June and this confirmed that the Trust has strong appetite for and commitment to this agenda. Further work is required to define the Trust's role regarding health inequalities and how it can best support system-wide work relating to this. The supporting material for Risk 11 will be developed as the Trust's position on health inequalities evolves. For now, however, the Trust does have a Health Inequalities Action Plan for 2024/25 and key actions from this have been incorporated into the BAF.

7.1.3 The assurance mapping exercise has confirmed or identified the following areas for development in the Trust's assurance framework:

- Risk 12: Revenue Resources and Value For Money – the Trust has recognised that there is an opportunity to improve the governance and assurance arrangements regarding the planning and delivery of in-year efficiency savings and longer-term productivity gains. This is being progressed via the Organisational Efficiency Group chaired by the Deputy Chief Executive.

- Risk 14: Digital Technology and Cyber Security – the Trust has recognised that the role and presence of a mature governance body to provide oversight and assurance regarding digital and cyber work is under-developed. There is an opportunity to develop more visible executive management flows through to TEG and clearer assurance flows through to the Finance and Performance Committee. The actions for Risk 14 include the establishment of a new governance group to address this.

- Risk 15: Action in Response to Climate Change – the Trust has recognised that the role and presence of a mature governance body to provide oversight and assurance regarding net zero and sustainability is under-developed. There is an opportunity to develop more visible executive management flows through to TEG and clearer assurance flows through to the Finance and Performance Committee. The actions for Risk 15 include the establishment of a new governance group to address this.

- In the first line of assurance a systematic approach to reporting from services to governance bodies via the Trust's new Performance Management Framework is under consideration.

- Further work is required on the third line assurance mapping in order to confirm the key sources of external assurance received by the Trust, which governance groups these sources of assurance are reported to, and what these sources of assurance tell the Trust regarding its system of governance, risk management and internal control.

7.1.4 The BAF is a live document and will continue to flex and evolve in line with the operating environment of the Trust.

7.1.5 Formal BAF reporting to TEG, Committees and Board will commence from September. A schedule of reporting for the remainder of 2024/25 is attached at Appendix 1.

7.1.6 As part of their Head of Internal Audit Annual Opinion work for 2024/25, 360 Assurance will carry out a separate internal audit review of the Board Assurance Framework. A draft Terms of Reference has been issued for this review.

8.0 FINANCIAL IMPLICATIONS

8.1 This report has no direct financial implications.

9.0 RISK

9.1 Failure to identify and manage strategic risks in a timely and appropriate manner could prevent the Trust from achieving its strategic objectives.

9.2 Failure to identify and manage operational risks in a timely and appropriate manner could prevent service lines and support functions from achieving their objectives.

9.3 Failure to demonstrate suitably robust and effective risk management arrangements could have an adverse impact on the Trust's reputation and could attract regulatory attention.

10.0 RECOMMENDATIONS

10.1 The Trust Board:

1. Notes the new set of strategic risks aligned to the Trust Strategy 2024-29.
2. Notes that the Board Assurance Framework is a live document and will continue to evolve.
3. Supports the intention to hold a session on the Board's strategic risk appetite later in 2024/25.

4. Notes the key issues identified in Section 7 of this report, particularly those relating to the need to develop elements of the Trust's governance and assurance framework.
5. Approves the new Board Assurance Framework to go live, subject to final adjustments as required, with reporting to commence in September 2024.

11. SUPPORTING INFORMATION

Appendix 1: Board Assurance Framework: 2024/25 Reporting Schedule

Appendix 2: Board Assurance Framework 2024-25

David O'Brien
Director of Corporate Services and Company Secretary

July 2024

APPENDIX 1:

BOARD ASSURANCE FRAMEWORK – REPORTING SCHEDULE Q2-Q4, 2024-25

	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr
TEG	04		05		15		05	
Quality Committee	19		21		16		20	
Finance and Performance Committee	24		26		28		25	
People Committee	10		19		21		18	
Audit and Risk Committee			12		21			tbc
Board of Directors (in Public)	26		28		30		27	

APPENDIX 2

NHS
Yorkshire
Ambulance Service
NHS Trust

Board Assurance Framework 2024/25

Provisional Pre-Approval Draft
Version 0.9: July 2025

DOCUMENT CONTROL INFORMATION

Document name	**BOARD ASSURANCE FRAMEWORK**
Version	0.9
Responsible Committee	Board of Directors
Responsible Director	Director of Corporate Services and Company Secretary
Document Owner (title)	Director of Corporate Services and Company Secretary
Document Lead (title)	Director of Corporate Services and Company Secretary
Approved By	Board of Directors
Date Approved	25 July 2025 (tbc)
Review Date	tbc
Equality Impact Assessed (EIA)	Not applicable
Protective Marking	Not Protectively Marked

DOCUMENT CONTROL INFORMATION

Version	Date	Author	Status (A/D)	Description of Change(s)
0.9	**July 2024**	**David O'Brien**	**D**	New Board Assurance Framework to align with the Trust Strategy 2024-29
Document Status		A = Approved / **D = Draft**		
Document Author		**David O'Brien** Director of Corporate Services and Company Secretary		
This document is controlled in accordance with the Management of Procedural Documents Policy. If you would like to suggest amendments to this document, please contact the document author.				

Associated Policies and Procedural Documents

External Documents

NHS Code of Governance (2023)

CQC Well-Led Framework

Trust Documents

Trust Standing Orders

Corporate Governance Guide: The Board of Directors

Committee Terms of Reference

Risk Management Policy

Risk and Assurance Strategic Framework

STRATEGIC RISKS 2024/25

Strategy Objective: Bold Ambition	Strategic Risk: The Trust is unable to...	
Our Patients	1	Deliver a timely response to patients
	2	Provide access to appropriate care
	3	Support patient flow across the urgent and emergency care system
	4	Strengthen quality governance and medicines management to develop a culture of improvement, safety, and learning.
	5	Develop and maintain effective emergency preparedness, resilience, and response arrangements.
Our People	6	Develop and sustain an open and positive workplace culture
	7	Support staff health and well-being effectively
	8	Deliver and sustain improvements in recruitment and retention.
	9	Develop and sustain improvements in leadership and staff training and development.
Our Partners	10	Act as a collaborative, integral, and influential system partner.
	11	Collaborate effectively to improve population health and reduce health inequalities.
Our Planet and Pounds	12	Secure sufficient revenue resources and use them wisely to ensure value for money.
	13	Secure sufficient capital resources and use them wisely to ensure value for money.
	14	Deliver safe and effective digital technology developments and cyber security arrangements.
	15	Act responsibly and effectively in response to climate change.

BOARD ASSURANCE FRAMEWORK						
Bold Ambition	**Our Patients**					
Strategic Risk	**1**	**Timely Response**				
Lead Committee	Finance and Performance Committee					
Lead Director	Nick Smith, Chief Operating Officer					
Risk Score	2024/25 Q1	16	2024/25 Q2		Trend	
WHAT	If the Trust is unable to provide patients with a timely response.					
SO WHAT	It could fail deliver care to patients whenever and wherever they need it.					
WHAT NEXT	Key mitigation actions to strengthen key controls and / or assurance for this risk:					
A	Control: Improve demand management – increase Hear and Treat rates					
B	Control: Increase resource capacity – on-shift availability; fleet availability					
C	Control: Increase efficiency and productivity - crew clear times; on-scene times					

Priority Actions		Executive Lead	Due Date	Delivery Status
A1	Increase Hear and Treat rates from 13.6% to 17%	Nick Smith	31/03/25	
B1	Increase on-shift resource availability from 21% to 23%	Nick Smith	31/03/25	
B2	Achieve targets for delivery and rollout of DCA fleet: increase DCA fleet to 512	Kathryn Vause	31/03/25	
B3	Deliver the fleet availability target of 82% in all geographical areas	Kathryn Vause	31/03/25	
C1	Reduce crew clear times by 10%	Nick Smith	31/03/25	
C2	Appropriately reduce on-scene times (target tbc at Q2)	Nick Smith	31/03/25	

IMPACT	Timescale	Q1	Q2	Q3	Q4
	Forecast Risk	16	16	20	16
	Actual Risk	16			

Comments	Key mitigations also include workforce capacity (see Strategic Risk 8) and hospital handover (see Strategic Risks 3 and 11)

FULL RISK DESCRIPTION		
Bold Ambition	**Our Patients**	
Strategic Risk	**1**	**Timely Response**
WHAT	IF the Trust is unable to...	Provide patients with a timely response.
	THEN the Trust could…	Fail to provide patients with sufficiently fast access to care. Fail to deliver the national, regional, and local performance targets for 999, NHS 111 and the Patient Transport Service (PTS).
SO WHAT	RESULTING IN…	It could fail to deliver care to patients whenever and wherever they need it.
Risk Appetite	LOW	The Trust has a **low** appetite for risk relating to patient safety. The Trust has a **low** appetite for risk relating to effectiveness of care. The Trust has a **low** appetite for risk relating to patient experience.

RISK GOVERNANCE AND ASSURANCE	
Board Assurance Committee	Finance and Performance Committee
TEG Reporting Committee	Operational Leadership
Key Governance and Assurance Flows	

Assurance Flows to:

----- Finance and Performance Committee

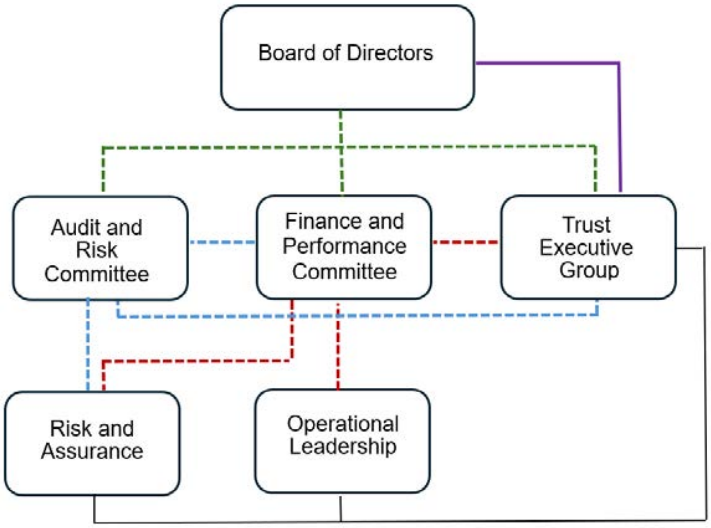
----- Audit and Risk Committee

----- Trust Board

Executive Management Flows to:

— Trust Executive Group

— Trust Board



ASSOCIATED RISKS, CONTROLS AND ASSURANCE

Bold Ambition	**Our Patients**	
Strategic Risk	**1**	**Timely Response**
Links to other Strategic Risks	2	Access to Appropriate Care
	3	Patient Flow
	8	Recruitment and Retention
	10	Influential and Collaborative System Partner

RELATED CORPORATE RISKS

Moderate Risks	High Risks
Risk 30: Demand (N&E) (12) Risk 387: Unable to Recruit Health Advisers (12)	Risk 627: Operational Performance (South) (20) Risk 616: Operational Performance (West) (15) Risk 603: Operational Performance (N&E) (16) Risk 629: Fleet Availability (N&E) (16) Risk 54: Clinical Capacity in IUC (20) Risk 564: Right Care Right Person (16) Risk 500: No Triage System - EOC Cyber Attack (15) Risk 509: EOC Duplicate Calls (15) Risk 625: Industrial Action by GPs (25)

KEY CONTROLS

Internal Controls	External Controls

Trust Strategy 2024-29: ‘Our Patients’ Trust Business Plan 2024-25 Trust Governance Arrangements Operational Plans Trust Policies and Procedures Training and Professional Standards Demand and Capacity Planning, including REAP Seasonal Plan Recruitment and Retention Plans Capital Plan (Fleet Capacity)	Regional Ambulance Contract Patient Transport Service Contracts National Strategies, Plans and Policies ICB Strategies and Plans National Performance Targets Patient Safety Incident Response Framework

KEY SOURCES OF ASSURANCE		
First Line	Second Line	Third Line
Regional Operations Centre EOC Management IUC Management PTS Management CBU Management Groups Directorate Management Groups Operational Leadership Group TEG	Performance Management Framework Business Plan Delivery Reports Risk and Assurance Group Clinical Governance Group Patient Safety Learning Group Resilience Governance Group BI Performance Assurance Reports	Internal Audit External Audit CQC Assurance NHSE Oversight Framework National datasets Coroners’ Inquests

HIGH-LEVEL ASSURANCE MAP														
Bold Ambition	**Our Patients**													
Strategic Risk	**1**	**Timely Response**												
KEY ASSURANCE FLOWS		Finance and Performance Committee (FPC)				Audit and Risk Committee				Trust Board				
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
1st Line	Operational Assurance Highlight Report													
	Operations Performance Report													
	Integrated Performance Report													
	Service / Issue Deep Dives													
2nd Line	FPC Chair's AAA Report													
	FPC Risk Assurance Report													
	FPC Annual Report													
	FPC BAF and Risk Report													
	Trust BAF and Risk Report													
	Business Plan Progress Report													
	System Partnership Reports													
	PSIRF Reporting													
3rd Line	National Datasets													
	NHSE / CQC Oversight													

Aspects of this risk about which the Trust is **not** assured		Recent Third Line Assurance Outcomes	24/25	NHSE Oversight Framework	2
			23/24	IA: Hear and Treat Data Quality	Sig
			23/24	NHSE Oversight Framework	2
			22/23	A&E Ops Risk Management	Lim

BOARD ASSURANCE FRAMEWORK

Bold Ambition	**Our Patients**					
Strategic Risk	**2**	**Access to Appropriate Care**				
Lead Committee	Quality Committee					
Lead Director	Nick Smith, Chief Operating Officer; Julian Mark, Executive Medical Director					
Risk Score	2024/25 Q1	16	2024/25 Q2		Trend	
WHAT	If the Trust is unable to provide effective triage and care navigation to make best use of alternative care pathways.					
SO WHAT	It could fail to deliver the most clinically appropriate response for every patient, whenever and wherever they need it.					
WHAT NEXT	Key mitigation actions to strengthen key controls and / or assurance for this risk:					
A	Control: Develop integrated clinical assessment across 999 and 111.					
B	Control: Increase the availability of alternative care pathways and improve utilisation of these.					

Priority Actions		Executive Lead	Due Date	Delivery Status
A1	Increase 111 clinical capacity: 34 FTE Clinical Advisors and 39 FTE Senior Clinical Advisors	Nick Smith	31/05/25	
A2	Complete Phase 1 of creating a single clinical queue	Nick Smith	30/06/24	
A3	Increase Category 2 Segmentation	Nick Smith	31/03/25	
A4	Reduce conveyance to Emergency Departments (target tbc)	Nick Smith	31/03/25	
B1	Develop new pathways with system partners following a review of pathways and utilisation	Nick Smith Julian Mark	31/12/24	
B2	Data dashboard implemented to show patient flow and pathways effectiveness	Nick Smith Julian Mark	31/03/24	

IMPACT	Timescale	Q1	Q2	Q3	Q4
	Forecast Risk	16	16	16	12
	Actual Risk	16			

Comments	

FULL RISK DESCRIPTION		
Bold Ambition	**Our Patients**	
Strategic Risk	**2**	**Access to Appropriate Care**
WHAT	IF the Trust is unable to...	Provide effective triage and care navigation to make best of use alternative care pathways.
	THEN the Trust could…	Fail to reduce inappropriate conveyances. Fail to meet the clinical needs of patients. Fail to support efficient and effective patient flow across the urgent and emergency care system.
SO WHAT	RESULTING IN…	Failure to deliver the most clinically appropriate response for every patient, whenever and wherever they need it.
Risk Appetite	LOW	The Trust has a **low** appetite for risk relating to patient safety. The Trust has a **low** appetite for risk relating to effectiveness of care. The Trust has a **low** appetite for risk relating to patient experience.

RISK GOVERNANCE AND ASSURANCE	
Board Assurance Committee	Quality Committee
TEG Reporting Committee	Clinical Governance
Key Governance and Assurance Flows	

Assurance Flows to:

----- Quality Committee

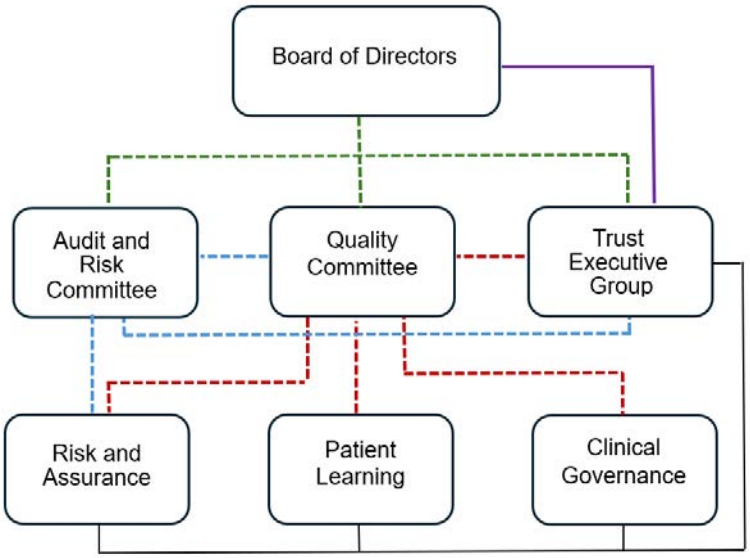
----- Audit and Risk Committee

----- Trust Board

Executive Management Flows to:

— Trust Executive Group

— Trust Board



ASSOCIATED RISKS, CONTROLS AND ASSURANCE

Bold Ambition	**Our Patients**	
Strategic Risk	**2**	**Access to Appropriate Care**
Links to other Strategic Risks	1	Timely Response
	3	Patient Flow
	4	Safety, Quality and Clinical Governance
	10	Influential and Collaborative System Partner

RELATED CORPORATE RISKS

Moderate Risks	High Risks
Risk 367: Unable to Recruit Health Advisers (12) Risk 58: Culture and Retention in IUC (12) Risk 40: Non-Conveyance Decisions (12) Risk 357: Maternity Care (12)	Risk 647: Industrial Action by GPs (25) Risk 623: Hospital Handover (South) (20) Risk 602: Hospital Handover (N&E) (25) Risk 627: Operational Performance (South) (20) Risk 616: Operational Performance (West) (15) Risk 603: Operational Performance (N&E) (16) Risk 54: Clinical Capacity in IUC (20) Risk 500: No Triage System - EOC Cyber Attack (15) Risk 564: Right Care, Right Person (16)

KEY CONTROLS

Internal Controls	External Controls

Trust Strategy 2024-29: ‘Our Patients’ Trust Business Plan 2024-25 Trust Governance Arrangements Operational Plans Trust Policies and Procedures Recruitment and Retention Plans Training and Professional Standards IUC Case for Change Integrated Clinical Assessment	Regional Ambulance Contract Patient Transport Service Contracts National Strategies, Plans and Policies ICB Strategies and Plans National Performance Targets Patient Safety Incident Response Framework Place Partnerships Provider Collaboratives

KEY SOURCES OF ASSURANCE		
First Line	Second Line	Third Line
EOC Management IUC Management PTS Management CBU Management Groups Directorate Management Groups Operational Leadership Group TEG	Performance Management Framework Business Plan Delivery Reports Risk and Assurance Group Clinical Governance Group Patient Safety Learning Group BI Performance Assurance Reports PMO Programme Assurance	Internal Audit External Audit CQC Assurance NHSE Oversight Framework National datasets Coroners’ Inquests

HIGH-LEVEL ASSURANCE MAP

Bold Ambition	**Our Patients**	
Strategic Risk	**2**	**Access to Appropriate Care**

KEY ASSURANCE FLOWS		Quality Committee				Audit and Risk Committee				Trust Board			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
1st Line	Clinical and Quality Highlight Report												
	Operational Assurance Highlight Report												
	Integrated Performance Report												
	Quality Committee Dashboard												
	Service / Issue Deep Dives												
	Quality and Safety Briefing												
2nd Line	Quality Committee Chair's AAA Report												
	Quality Committee Risk Assurance Report												
	Quality Committee Annual Report												
	Quality Committee BAF and Risk Report												
	Trust BAF and Risk Report												
	Business Plan Progress Report												
	System Partnership Reports												
	PSIRF Reporting												
	System Partnership Reports												
3rd Line	National Datasets												
	NHSE / CQC Oversight												

Aspects of this risk about which the Trust is **not** assured		Recent Third Line Assurance Outcomes	24/25	NHSE Oversight Framework 2
			23/24	NHSE Oversight Framework 2

BOARD ASSURANCE FRAMEWORK						
Bold Ambition	**Our Patients**					
Strategic Risk	**3**	**Patient Flow**				
Lead Committee	Finance and Performance					
Lead Director	Nick Smith, Chief Operating Officer					
Risk Score	2024/25 Q1	16	2024/25 Q2		Trend	
WHAT	If the Trust is unable to support patient flow through the health and care system effectively					
SO WHAT	It could fail to meet the needs of an efficient and productive urgent and emergency care system.					
WHAT NEXT	Key mitigation actions to strengthen key controls and / or assurance for this risk:					
A	Control: Patient flow to hospitals - reduce conveyance to Emergency Departments					
B	Control: Patient flow at hospitals - work with partners to reduce hospital arrival to handover times					
C	Control: Patient flow from hospitals - support timely patient discharge.					

Priority Actions		Owner	Due Date	Delivery Status
A1	Increase Hear and Treat rates from 13.6% to 17%	Nick Smith	31/03/25	
A2	Reduce conveyance to Emergency Departments (target tbc)	Nick Smith	31/03/25	
B1	Reduce arrive to handover times in all five CBU areas	Nick Smith	31/03/25	
B2	Reduce overall average arrive to handover time to below 24 mins	Nick Smith	31/03/25	
C1	Achieve performance targets to support timely patient discharge.	Nick Smith	31/03/25	

IMPACT	Timescale	Q1	Q2	Q3	Q4
	Forecast Risk	16	16	16	12
	Actual Risk	16			

Comments	

FULL RISK DESCRIPTION		
Bold Ambition	**Our Patients**	
Strategic Risk	**3**	**Patient Flow**
WHAT	IF the Trust is unable to...	Support patient flow through the health and care system effectively
	THEN the Trust could…	Fail to support seamless integration of services to provide joined-up care that is coordinated across the health and care system. Fail to deliver a timely and appropriate response for all patients.
SO WHAT	RESULTING IN…	Failure to support an efficient and productive urgent and emergency care service that delivers effective care and a positive patient experience.
Risk Appetite	LOW	The Trust has a **low** appetite for risk relating to patient safety. The Trust has a **low** appetite for risk relating to effectiveness of care. The Trust has a **low** appetite for risk relating to patient experience.

RISK GOVERNANCE AND ASSURANCE	
Board Assurance Committee	Finance and Performance Committee
TEG Reporting Committee	Operational Leadership
Key Governance and Assurance Flows	

Assurance Flows to:

----- Finance and Performance Committee

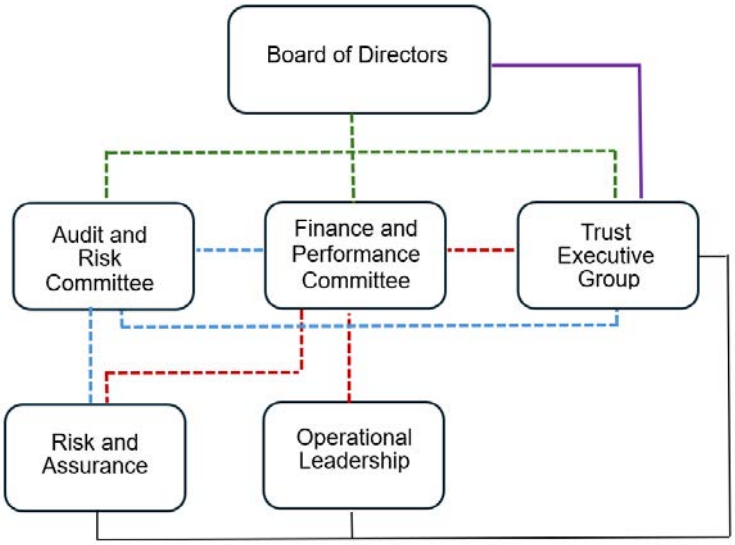
----- Audit and Risk Committee

----- Trust Board

Executive Management Flows to:

— Trust Executive Group

— Trust Board



ASSOCIATED RISKS, CONTROLS AND ASSURANCE

Bold Ambition	**Our Patients**	
Strategic Risk	**3**	**Patient Flow**
Links to other Strategic Risks	1	Timely Response
	2	Access to Appropriate Care
	4	Safety, Quality and Clinical Governance
	10	Influential and Collaborative System Partner

RELATED CORPORATE RISKS

Moderate Risks	High Risks
Risk 367: Unable to Recruit Health Advisers (12) Risk 58: Culture and Retention in IUC (12) Risk 40: Non-Conveyance Decisions (12) Risk 357: Maternity Care (12) Risk 559: PTS Contracts (12)	Risk 647: Industrial Action by GPs (25) Risk 623: Hospital Handover (South) (20) Risk 602: Hospital Handover (N&E) (25) Risk 627: Operational Performance (South) (20) Risk 616: Operational Performance (West) (15) Risk 603: Operational Performance (N&E) (16) Risk 54: Clinical Capacity in IUC (20) Risk 500: No Triage System - EOC Cyber Attack (15)

KEY CONTROLS

Internal Controls	External Controls

Trust Strategy 2024-29: ‘Our Patients’ Trust Business Plan 2024-25 Trust Governance Arrangements Operational Plans Trust Policies and Procedures Demand and Capacity Planning Seasonal Plan Recruitment and Retention Plans Capital Plan (Fleet Capacity) IUC and EOC Change Programmes Integrated Clinical Assessment	Regional Ambulance Contract Patient Transport Service Contracts National Strategies, Plans and Policies ICB Strategies and Plans National Performance Targets Patient Safety Incident Response Framework Place Partnerships Provider Collaboratives

KEY SOURCES OF ASSURANCE		
First Line	Second Line	Third Line
Regional Operations Centre EOC Management IUC Management PTS Management CBU Management Groups Directorate Management Groups Operational Leadership Group TEG	Performance Management Framework Business Plan Delivery Reports Risk and Assurance Group Clinical Governance Group Patient Safety Learning Group Resilience Governance Group BI Performance Assurance Reports	Internal Audit External Audit CQC Assurance NHSE Oversight Framework National datasets Coroner’s Inquests

HIGH-LEVEL ASSURANCE MAP			
Bold Ambition	**Our Patients**		
Strategic Risk	**3**	**Patient Flow**	

KEY ASSURANCE FLOWS		Finance and Performance Committee				Audit and Risk Committee				Trust Board			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
1st Line	Operational Assurance Highlight Report												
	Operations Performance Report												
	Integrated Performance Report												
	Service / Issue Deep Dives												
2nd Line	FPC Chair's AAA Report												
	FPC Risk Assurance Report												
	FPC Annual Report												
	FPC BAF and Risk Report												
	Trust BAF and Risk Report												
	Business Plan Progress Report												
	System Partnership Reports												
	PSIRF Reporting												
3rd Line	National Datasets												
	NHSE / CQC Oversight												

Aspects of this risk about which the Trust is **not** assured		Recent Third Line Assurance Outcomes			
			24/25	NHSE Oversight Framework	2
			23/24	NHSE Oversight Framework	2

BOARD ASSURANCE FRAMEWORK						
Bold Ambition	**Our Patients**					
Strategic Risk	**4**	**Safety, Quality and Clinical Governance**				
Lead Committee	Quality Committee					
Lead Director	Dave Green, Executive Director of Quality and Chief Paramedic					
Risk Score	2024/25 Q1	16	2024/25 Q2		Trend	
WHAT	If the Trust is unable to strengthen quality governance and medicines management to develop a culture of improvement, safety, and learning.					
SO WHAT	It could fail to deliver high standards and continuous improvements in patient safety, effectiveness of care, and patient experience.					
WHAT NEXT	Key mitigation actions to strengthen key controls and / or assurance for this risk:					
A	Assurance: Embed the Patient Safety Incident Response Framework					
B	Control: Increase the number of staff trained in Quality Improvement methodology					
C	Control: Implement Clinical Supervision for frontline staff					
D	Control and Assurance: Improve governance of (1) out-of-date medicines; (2) controlled drugs					

Priority Actions		Executive Lead	Due Date	Delivery Status
A1	Reduce patient incidents relating to on-scene decision-making, or EOC/IUC telephony by 5%	Dave Green	31/35/25	
B1	1750 staff to be trained in introduction to QI	Dave Green	31/03/25	
C1	40% of frontline staff offered a Clinical Supervision session by Q4	Dave Green	31/03/25	
D1	Reduce out-of-date medicines incidents by 25%	Julian Mark	31/03/25	
D2	Achieve 100% compliance in controlled drugs adherence	Julian Mark	31/03/25	

IMPACT	Timescale	Q1	Q2	Q3	Q4
	Forecast Risk	16	16	16	12
	Actual Risk	16			

Comments	

FULL RISK DESCRIPTION		
Bold Ambition	**Our Patients**	
Strategic Risk	**4**	**Safety, Quality and Clinical Governance**
WHAT	IF the Trust is unable to...	Strengthen quality governance and medicines management to develop a culture of improvement, safety, and learning.
	THEN the Trust could…	Fail to embed and utilise quality improvement throughout the organisation. Fail to embed and apply learning from the Patient Safety Incident Review Framework. Fail to sustain and benefit from a research active environment.
SO WHAT	RESULTING IN…	Failure to deliver high standards and continuous improvements in patient safety, effectiveness of care, and patient experience
Risk Appetite	LOW	The Trust has a **low** appetite for risk relating to patient safety. The Trust has a **low** appetite for risk relating to effectiveness of care. The Trust has a **low** appetite for risk relating to patient experience.
	OPEN	The Trust has an **open** appetite for controlled risk-taking relating to service improvement and innovation.

RISK GOVERNANCE AND ASSURANCE	
Board Assurance Committee	Finance and Performance
TEG Reporting Committee	Resilience Governance
Key Governance and Assurance Flows	

Assurance Flows to:

----- Quality Committee

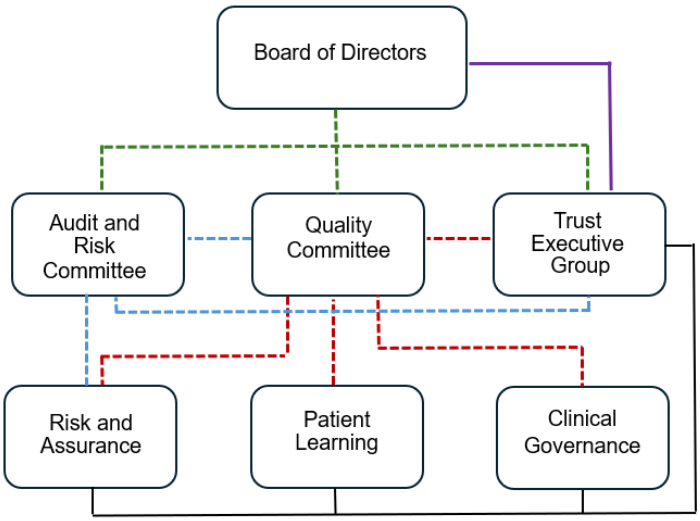
----- Audit and Risk Committee

----- Trust Board

Executive Management Flows to:

— Trust Executive Group

— Trust Board



ASSOCIATED RISKS, CONTROLS AND ASSURANCE

Bold Ambition	**Our Patients**	
Strategic Risk	**4**	**Safety, Quality and Clinical Governance**
Links to other Strategic Risks	1	Timely Response
	2	Access to Appropriate Care
	3	Patient Flow
	9	Leadership, Staff Training and Development
	10	Influential and Collaborative System Partner

RELATED CORPORATE RISKS

Moderate Risks	High Risks
Risk 619: Medicines Checks (West) (12) Risk 527: Serious Incidents Resources (12) Risk 598: Transport of Neonates under 2.5kg (12) Risk 40: Non-Conveyance Decisions (12) Risk 357: Maternity Cre (12)	Risk 625: Industrial Action by GPs (25) Risk 625: Controlled Drugs (South) (15) Risk 614: Controlled Drugs (West) (15) Risk 620: Controlled Drugs (HNY) (15) Risk 624: Medicines Checks (South) (15) Risk 619: Medicines Checks (HNY) (15) Risk 432: 4Cs and PALs Demand (20)

KEY CONTROLS

Internal Controls	External Controls

Trust Strategy 2024-29: ‘Our Patients’ Trust Business Plan 2024-25 Quality Improvement Enabling Plan Quality Account Priorities Quality Impact Assessments Trust Policies and Procedures Clinical Strategy Clinical Governance Framework Clinical Supervision Training and Professional Standards	Regional Ambulance Contract National Strategies, Plans and Policies ICB Strategies and Plans National Performance Targets Patient Safety Incident Response Framework Medicines Management / Controlled drugs Regulations Quality Account Regulations

KEY SOURCES OF ASSURANCE		
First Line	Second Line	Third Line
EOC Management IUC Management PTS Management CBU Management Groups Directorate Management Groups Operational Leadership Group TEG Quality Account Quality and Safety Visits	Performance Review Process Business Plan Delivery Reports Risk and Assurance Group Incident Review Group Clinical Governance Group Patient Safety Learning Group Clinical Audit 4Cs and PALS Inspections for Improvement	Internal Audit External Audit CQC Assurance NHSE Oversight Framework National datasets Coroners’ Inquests

HIGH-LEVEL ASSURANCE MAP

Bold Ambition	**Our Patients**
Strategic Risk	**4** **Safety, Quality and Clinical Governance**

KEY ASSURANCE FLOWS		Quality Committee				Audit and Risk Committee				Trust Board			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
1st Line	Clinical and Quality Highlight Report												
	Integrated Performance Report												
	Quality Committee Dashboard												
	Service / Issues Deep Dives												
	Quality and Safety Visits												
	Quality and Safety Briefing												
2nd Line	Quality Committee Chair's AAA Report												
	Quality Committee Risk Assurance Report												
	Quality Committee Annual Report												
	Quality Committee BAF and Risk Report												
	Trust BAF and Risk Report												
	CQC / Inspections for Improvement												
	PSIRF Reporting												
	Patient Experience												
	Clinical Audit												
3rd Line	Internal Audit: Controlled Drugs (revisit)												
	Internal Audit: Complaints												
	Internal Audit: Infection Prevention and Control												
	Coroners Reports / Learning from Deaths												

		Recent Third Line Assurance Outcomes	23/24	IA: Controlled Drugs	Limited
			23/24	IA: Equipment on Ambulances	Limited

Aspects of this risk about which the Trust			22/23	IA: Patient Safety Incidents	Sig
			22/23	IA: Safeguarding	Limited

BOARD ASSURANCE FRAMEWORK						
Bold Ambition	**Our Patients**					
Strategic Risk	**5**	**Emergency Preparedness, Resilience and Response**				
Lead Committee	Finance and Performance Committee					
Lead Director	Nick Smith, Chief Operating Officer					
Risk Score	2024/25 Q1	16	2024/25 Q2		Trend	
WHAT	If the Trust is unable to develop and maintain effective emergency preparedness, resilience and response arrangements.					
SO WHAT	It could fail to ensure the best possible emergency response to the most critical and complex incidents.					
WHAT NEXT	Key mitigation actions to strengthen key controls and / or assurance for this risk:					
A	Control: Increase compliance with the EPRR Core Standards					
B	Control: Implement the next phase of the Manchester Arena recommendations (subject to resource availability					
C	Control: Implement business continuity audit recommendations					

Priority Actions		Executive Lead	Due Date	Delivery Status
A1	Improve self-assessed compliance with EPPR Core Standards (from 79% in 2023/24)	Nick Smith	30/09/24	
A2	Improve NHSE-assessed compliance with EPRR Core Standards (from 59% in 2023/24)	Nick Smith	31/12/24	
B1	Deliver the Manchester Arena recommendations that are achievable within existing Trust budgets	Nick Smith	31/03/25	
C1	Implement recommendations from the internal audit review of Business Continuity	Nick Smith	In line with audit action timescales	

IMPACT	Timescale	Q1	Q2	Q3	Q4
	Forecast Risk	15	15	15	10
	Actual Risk	15			

Comments	Board Strategic Forum discussion on 25 July regarding EPRR

FULL RISK DESCRIPTION		
Bold Ambition	**Our Patients**	
Strategic Risk	**5**	**Emergency Preparedness, Resilience and Response**
WHAT	IF the Trust is unable to...	Develop and maintain effective emergency preparedness, resilience and response arrangements.
	THEN the Trust could…	Fail to be adequately prepared to provide critical emergency care and specialist co-ordinated responses. Fail to meet the required standards for emergency preparedness, resilience and response.
SO WHAT	RESULTING IN…	Failure to ensure the best possible emergency response to the most critical and complex incidents.
Risk Appetite	LOW	The Trust has a **low** appetite for risk relating to patient safety. The Trust has a **low** appetite for risk relating to effectiveness of care. The Trust has a **low** appetite for risk relating to patient experience.

RISK GOVERNANCE AND ASSURANCE	
Board Assurance Committee	Finance and Performance
TEG Reporting Committee	Resilience Governance
Key Governance and Assurance Flows	

Assurance Flows to:

----- Finance and Performance Committee

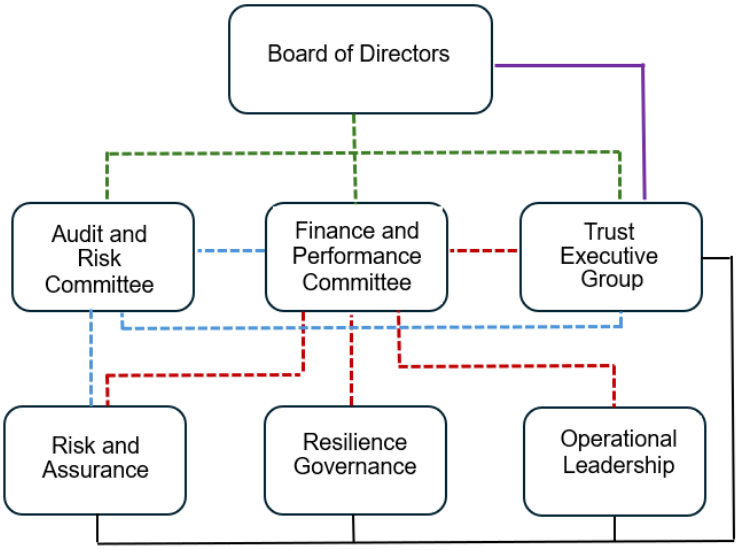
----- Audit and Risk Committee

----- Trust Board

Executive Management Flows to:

— Trust Executive Group

— Trust Board



ASSOCIATED RISKS, CONTROLS AND ASSURANCE

Bold Ambition	**Our Patients**	
Strategic Risk	**5**	**Emergency Preparedness, Resilience and Response**
Links to other Strategic Risks	1	Timely Response
	10	Influential and Collaborative System Partner
	13	Capital Resources
	12	Revenue Resources

RELATED CORPORATE RISKS

Moderate Risks	High Risks
Risk 556: Major Incident Exercising (12) Risk 567: Contininuous Improvement (12) Risk 615: Tactical Command Rota (West) (12) Risk 421: Computer Aided Despatch (SORT) (12)	Risk 555: Major Incident Capability (15) Risk 579: National HART Training Courses (20) Risk 626: Tactical Command Rota (South) (15) Risk 604: Tactical Command Rota (N&E) (15)

KEY CONTROLS

Internal Controls	External Controls

Trust Strategy 2024-29: ‘Our Patients’ Trust Business Plan 2024-25 Operational Plans EPRR Action Plan Manchester Arena Action Plan Manchester Arena Business Case Regional Operations Centre Incident Response Plans and Procedures Strategic and Tactical Command Structure Executive On-Call Arrangements Trust Policies and Procedures Training and Professional Standards Specialist Response Teams: SORT. HART	Civil Contingencies Act (2004) NHS Standard Contract NHS EPRR Framework EPRR Core Standards NHS Business Continuity Management Framework ISO 22301: Business Continuity Management Manchester Arena Inquiry Recommendations National Security Risk Assessment National Risk Register National Ambulance Resilience Unit

KEY SOURCES OF ASSURANCE		
First Line	Second Line	Third Line
Regional Operations Centre EOC Management CBU Management Groups Specialist Teams: HART, SORT Directorate Management Groups Operational Leadership Group TEG	Performance Management Framework Business Plan Delivery Reports Risk and Assurance Group Resilience Governance Group BI Performance Assurance Reports PMO Programme Assurance	Internal Audit External Audit CQC Assurance NHSE Oversight Framework EPRR Core Standards – NHSE Compliance Assessment ISO 22301 Accreditation Audit

HIGH-LEVEL ASSURANCE MAP

Bold Ambition	**Our Patients**	
Strategic Risk	**5**	**Emergency Preparedness, Resilience and Response**

KEY ASSURANCE FLOWS		Finance and Performance Committee				Audit and Risk Committee				Trust Board			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
1st Line	Operational Assurance Highlight Report												
	Operational Performance Report												
	EPRR Core Standards Report												
	EPRR Assurance Report												
	Business Continuity Assurance Report												
2nd Line	FPC Chair's AAA Report												
	FPC Risk Assurance Report												
	FPC Annual Report												
	FPC BAF and Risk Report												
	Trust BAF and Risk Report												
	Business Plan Report												
3rd Line	EPRR Core Standards: NHSE Assessment												
	Internal Audit: Business Continuity ISO 22301												

Aspects of this risk about which the Trust is **not** assured		Recent Third Line Assurance Outcomes	23/24	ISO 22301 Accreditation
			23/24	IA: ISO 22301 Assurance
			23/24	EPPR NHSE Assessment

BOARD ASSURANCE FRAMEWORK						
Bold Ambition	**Our People**					
Strategic Risk	**6**	**Open and Positive Workplace Culture**				
Lead Committee	People Committee					
Lead Director	Mandy Wilcock, Director of People and Organisational Development					
Risk Score	2024/25 Q1	16	2024/25 Q2		Trend	
WHAT	If the Trust is unable to develop and sustain an open and positive workplace culture					
SO WHAT	It could fail to be a diverse and inclusive organisation where everyone feels valued, included, proud to work and can thrive.					
WHAT NEXT	Key mitigation actions to strengthen key controls and / or assurance for this risk:					
A	Control: Deliver the YAS Together programme priorities for 2024/25					
B	Control and Assurance: Equality, Diversity and Inclusion priorities for 2024/25					
C	Control: People Promise Exemplar					

Priority Actions		Executive Lead	Due Date	Delivery Status
A1	YAS Together action (tbc)	Mandy Wilcock	tbc	
A2	YAS Together action (tbc)	Mandy Wilcock	tbc	
B1	Deliver the EDI action plan priorities for 2024/25	Mandy Wilcock	31/03/25	
B2	Improve the Trust's rating in the Equality Delivery System (from 'high developing' in 23/24)	Mandy Wilcock	31/03/25	
C1	Deliver the People Promise Exemplar priorities for 2024/25	Mandy Wilcock	31/03/15	

IMPACT	Timescale	Q1	Q2	Q3	Q4
	Forecast Risk	16	16	12	12
	Actual Risk	16			

Comments	

FULL RISK DESCRIPTION		
Bold Ambition	**Our People**	
Strategic Risk	**6**	**Open and Positive Workplace Culture**

WHAT	IF the Trust is unable to...	Develop and sustain an open and positive workplace culture
	THEN the Trust could…	Fail to ensure that staff are valued, listened to, and encouraged and enabled to speak up. Fail to value difference and improve equality, diversity, and inclusion at all levels of the organisation. Fail to improve employee experience and become a great place to work and volunteer.
SO WHAT	RESULTING IN…	Failure to be a diverse and inclusive organisation where everyone feels valued, included, proud to work and can thrive.
Risk Appetite	LOW	The Trust has a **low** appetite for risk relating to the safety and well-being of staff, volunteers and others engaged in activity on behalf of the organisation.

RISK GOVERNANCE AND ASSURANCE	
Board Assurance Committee	People Committee
TEG Reporting Committee	People and Culture
Key Governance and Assurance Flows	

Assurance Flows to:

----- People Committee

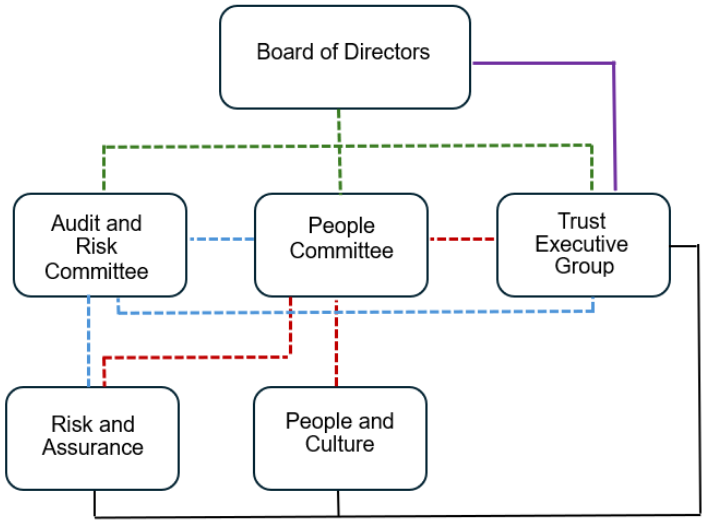
----- Audit and Risk Committee

----- Trust Board

Executive Management Flows to:

— Trust Executive Group

— Trust Board



ASSOCIATED RISKS, CONTROLS AND ASSURANCE

Bold Ambition	**Our People**	
Strategic Risk	**6**	**Open and Positive Workplace Culture**
Links to other Strategic Risks	7	Staff Health and Well-Being
	8	Recruitment and Retention
	9	Leadership, Staff Training and Development

RELATED CORPORATE RISKS

Moderate Risks	High Risks
Risk 362: Sickness Absence (12) Risk 58: Culture and Retention in IUC (12)	

KEY CONTROLS

Internal Controls	External Controls

Trust Strategy 2024-29 Trust Business Plan 2024-25 (‘Our People’) YAS Together Programme Trust Values Trust Behaviours Framework Policies and Procedures Equality, Diversity and Inclusion Plan 2024-27 Sexual Safety Charter Safeguarding Freedom To Speak Up Equality Impact Assessments Joint Steering Group(s) Policy Development Group Staff Training and Awareness	Equality Act 2010 Human Rights Act 1998 / ECHR NHS People Promise NHS National Staff Survey Quarterly Pulse Surveys Equality Delivery System (EDS) Workforce Race Equality Standard Disability Equality Standard Gender Pay Gap Freedom to Speak Up: Office of the National Guardian Fit and Proper Person Framework AACE Culture in Ambulance Services AACE Sexual Safety in Ambulance Services

KEY SOURCES OF ASSURANCE		
First Line	Second Line	Third Line
Directorate Management Groups HR Business Partners Staff Network Executive Sponsors TEG EDS (Source Evidence)	Diversity and Inclusion Group People and Culture Group EDI Plan Reporting Freedom To Speak Up Reporting WRES and WDES Reporting Gender Pay Gap Reporting Risk and Assurance Group EDS (Internal Assurance)	Internal Audit External Audit CQC Assurance NHS National Staff Survey Dataset Quarterly Pulse Survey Dataset WRES and WDES Datasets Gender Pay Gap Datasets EDS (External Peer Assurance)

HIGH-LEVEL ASSURANCE MAP

Bold Ambition	**Our People**	
Strategic Risk	**6**	**Open and Positive Workplace Culture**

KEY ASSURANCE FLOWS		People Committee				Audit and Risk Committee				Trust Board			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
1st Line	Quality and Safety Visits: People	■	■	■	■					■	■	■	■
	Service / Issue Deep Dives	■	■	■	■								
	People and OD Highlight Report									■	■	■	■
	People Committee Chair's AAA Report									■	■	■	■
	People Committee Risk Assurance Report					■	■	■	■				
	People Committee Annual Report	■					■				■		
	People Committee BAF and Risk Report	■	■	■	■								
	Trust BAF and Risk Report					■	■	■	■	■	■	■	■
	People and Culture Group Highlight Report	■	■	■	■								
	Equality, Diversity and Inclusion Plan Reporting		■		■					■			
	Freedom To Speak Up Reporting	■		■		■		■			■		■
	YAS Together – Culture Programme Reporting	■	■	■	■								
	People Promise Exemplar Reporting	■	■	■	■								
	Tribunals and Employee Relations		■	■	■								
3rd Line	Internal Audit: Equality, Diversity and Inclusion Data							■					
	Equality and Diversity System				■					■			
	External data: Staff Survey, WRES, WDES, Pay Gap	■	■	■	■						■		

Aspects of this risk about which the Trust is **not** assured		Recent Third Line Assurance Outcomes	23/24	Equality Delivery System **20**

BOARD ASSURANCE FRAMEWORK						
Bold Ambition	**Our People**					
Strategic Risk	**7**	**Staff Health and Well-Being**				
Lead Committee	People Committee					
Lead Director	Mandy Wilcock, Director of People and Organisational Development					
Risk Score	2024/25 Q1	12	2024/25 Q2		Trend	
WHAT	If the Trust is unable to support staff health and well-being effectively					
SO WHAT	It could fail to achieve the sustained improvements in staff well-being and attendance levels required to support high quality services and patient care.					
WHAT NEXT	Key mitigation actions to strengthen key controls and / or assurance for this risk:					
A	Control: Reduce sickness absence levels					
B	Assurance: National Staff Survey - improved results for staff morale					
C	Control: Violence prevention and reduction - embed the use of bodyworn cameras					

Priority Actions		Executive Lead	Due Date	Delivery Status
A1	Implement and embed the new Occupational Health and specialist services	Mandy Wilcock	31/03/25	
A2	Reduce staff Trust-wide staff sickness by 0.5% to 6.08%	Mandy Wilcock	31/03/25	
B1	Improve the National Staff Survey results for morale by 0.2 or achieve a statistically significant higher score	Mandy Wilcock	31/03/25	
C1	Increase the number of staff trained to use bodyworn cameras by 10%	Dave Green	31/03/25	

IMPACT	Timescale	Q1	Q2	Q3	Q4
	Forecast Risk	12	12	12	9
	Actual Risk	12			

Comments	

FULL RISK DESCRIPTION			
Bold Ambition	**Our People**		
Strategic Risk	**7**	**Staff Health and Well-Being**	
WHAT	IF the Trust is unable to...	Support staff health and well-being effectively	
	THEN the Trust could...	Fail to improve the physical health and well-being of its workforce. Fail to improve the mental health and well-being of its workforce. Fail to reduce staff sickness rates to below the NHS average	
SO WHAT	RESULTING IN...	Failure to achieve the sustained improvements in staff well-being and attendance levels required to support high quality services and patient care.	
Risk Appetite	LOW	The Trust has a **low** appetite for risk relating to the safety and well-being of staff, volunteers and others engaged in activity on behalf of the organisation.	

RISK GOVERNANCE AND ASSURANCE	
Board Assurance Committee	People Committee
TEG Reporting Committee	People and Culture
Key Governance and Assurance Flows	

Assurance Flows to:

----- People Committee

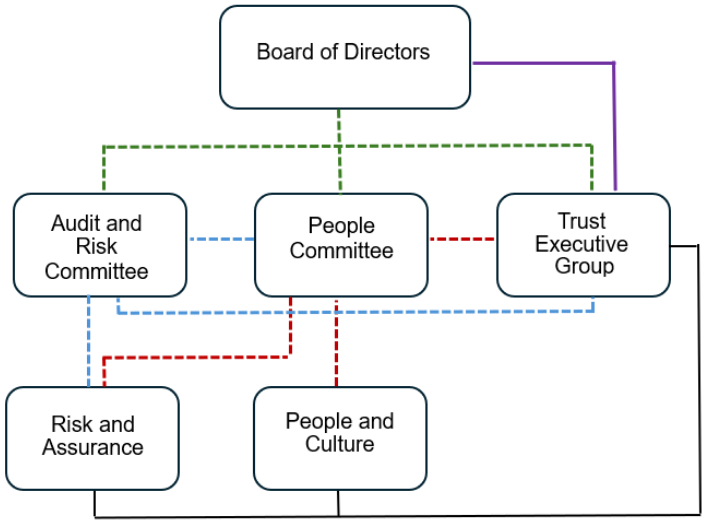
----- Audit and Risk Committee

----- Trust Board

Executive Management Flows to:

— Trust Executive Group

— Trust Board



ASSOCIATED RISKS, CONTROLS AND ASSURANCE

Bold Ambition	**Our People**	
Strategic Risk	**7**	**Staff Health and Well-Being**
Links to other Strategic Risks	6	Open and Positive Workplace Culture
	8	Recruitment and Retention
	9	Leadership, Staff Training and Development

RELATED CORPORATE RISKS

Moderate Risks	High Risks
Risk 817: Moving and Handling (12) Risk 188: Health and Safety Training (12) Risk 195: Health and Safety Training (12) Risk 347: Incidents Near Water (12) Risk 362: Sickness Absence (12) Risk 515: JDM Training (12) Risk 42: Violence and Aggression (12)	

KEY CONTROLS

Internal Controls	External Controls

Trust Strategy 2024-29 Trust Business Plan 2024-25 (‘Our People’) YAS Together Programme Trust Values Trust Behaviours Framework Trust Policies and Procedures Staff Health and Well-Being Plan 2024-27 Occupational Health Provision Violence Prevention and Reduction Plan Sexual Safety Charter Safeguarding Freedom To Speak Up Staff Training and Awareness	Health and Safety At Work Act (1974) NHS People Promise NHS National Staff Survey Quarterly Pulse Surveys Freedom to Speak Up: Office of the National Guardian Fit and Proper Person Framework AACE Culture in Ambulance Services AACE Sexual Safety in Ambulance Services Violence Prevention and Reduction Standard

KEY SOURCES OF ASSURANCE		
First Line	Second Line	Third Line
Directorate Management Groups HR Business Partners Staff Absence Group Local Health and Safety Groups TEG Annual Report	Health and Well-Being Group People and Culture Group Strategic Health and Safety Committee Health and Well-Being Plan Reporting BI: Staff Absence Data Reporting Freedom To Speak Up Reporting Risk and Assurance Group	Internal Audit External Audit CQC Assurance NHSE Oversight Framework NHS National Staff Survey Dataset Quarterly Pulse Survey Dataset Occupational Health Data

HIGH-LEVEL ASSURANCE MAP

Bold Ambition	**Our People**		
Strategic Risk	**7**	**Staff Health and Well-Being**	

KEY ASSURANCE FLOWS		People Committee				Audit and Risk Committee				Trust Board			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
1st Line	Quality and Safety Visits: People	■	■	■	■					■	■	■	■
	Service / Issue Deep Dives	■	■	■	■								
	People and OD Highlight Report									■	■	■	■
	People Committee Chair's AAA Report									■	■	■	■
	People Committee Risk Assurance Report					■	■	■	■				
	People Committee Annual Report	■					■				■		
	People Committee BAF and Risk Report	■	■	■	■								
	Trust BAF and Risk Report					■	■	■	■	■	■	■	■
	People and Culture Group Highlight Report	■	■	■	■								
	Health and Well-Being Plan Reporting			■	■								
	Absence Reduction Plan Reporting		■		■								
	People Dashboard: Compliance	■	■	■	■								
	Strategic Health and Safety Committee Reporting	Currently via Quality Committee											
3rd Line	NHS National Staff Survey Results	■			■						■		

Aspects of this risk about which the Trust is **not** assured		Recent Third Line Assurance Outcomes	23/24	IA: Staff Mental Health Support — Mod
			23/24	NHS Staff Survey Results — N/A
			22/23	IA: Sickness / Absence — Limited
			21/22	IA: Staff Well-Being Support — Sig

			21/22	IA: Attendance Management	Limited

BOARD ASSURANCE FRAMEWORK

Bold Ambition	**Our People**					
Strategic Risk	**8**	**Recruitment and Retention**				
Lead Committee	People Committee					
Lead Director	Nick Smith, Chief Operating Officer					
Risk Score	2024/25 Q1	16	2024/25 Q2		Trend	
WHAT	If the Trust is unable to deliver and sustain improvements in recruitment and retention.					
SO WHAT	It could fail to achieve the capacity and capability required in all staff groups to deliver high quality patient care and services.					
WHAT NEXT	Key mitigation actions to strengthen key controls and / or assurance for this risk:					
A	Control: Deliver the agreed workforce plans for A&E Operations, EOC, IUC, and PTS					
B	Control: Implement the IUC change programme milestones for 2024/25					
C	Control: Implement the EOC change programme milestones for 2024/25					

Priority Actions		Executive Lead	Due Date	Delivery Status
A1	Deliver A&E workforce trajectories: 3606 FTE	Nick Smith	31/03/25	
A2	Deliver EOC workforce trajectories: 247 FTE EMDs, 147 FTE Dispatch, 106 FTE Clinical	Nick Smith	31/03/25	
A3	Deliver IUC workforce trajectories: 276 FTE Health Advisors, 90 FTE Clinical Advisors	Nick Smith	31/03/25	
A4	Deliver PTS workforce trajectories: 471 FTE	Nick Smith	31/03/25	
B1	New IUC rotas, team-based working, career and leadership structures all implemented	Nick Smith	31/03/25	
C1	EOC management restructure completed	Nick Smith	31/12/24	

IMPACT	Timescale	Q1	Q2	Q3	Q4
	Forecast Risk	15	15	10	10
	Actual Risk	15			

Comments	

FULL RISK DESCRIPTION		
Bold Ambition	**Our People**	
Strategic Risk	**8**	**Recruitment and Retention**
WHAT	IF the Trust is unable to...	Deliver and sustain improvements in recruitment and retention.
	THEN the Trust could...	Fail to attract the right numbers of people with the right skills, knowledge, and experience. Fail to retain the right numbers of people with the right skills, knowledge, and experience.
SO WHAT	RESULTING IN...	Failure to achieve the capacity and capability required in all staff groups to deliver high quality patient care and services.
Risk Appetite	LOW	The Trust has a **low** appetite for risk relating to patient safety. The Trust has a **low** appetite for risk relating to effectiveness of care. The Trust has a **low** appetite for risk relating to patient experience.

RISK GOVERNANCE AND ASSURANCE	
Board Assurance Committee	People Committee
TEG Reporting Committee	People and Culture
Key Governance and Assurance Flows	

Assurance Flows to:

----- People Committee

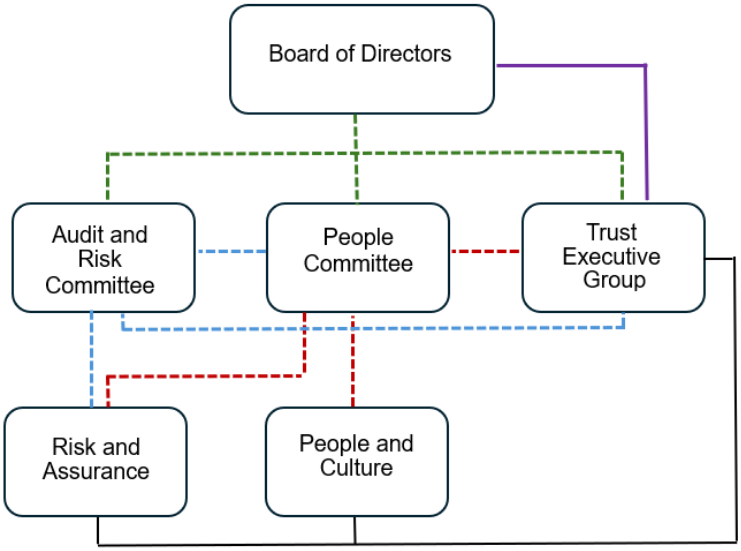
----- Audit and Risk Committee

----- Trust Board

Executive Management Flows to:

— Trust Executive Group

— Trust Board



ASSOCIATED RISKS, CONTROLS AND ASSURANCE

Bold Ambition	**Our People**	
Strategic Risk	**8**	**Recruitment and Retention**
Links to other Strategic Risks	6	Open and Positive Workplace Culture
	7	Staff Health and Well-Being
	9	Leadership, Staff Training and Development

RELATED CORPORATE RISKS

Moderate Risks	High Risks
Risk 578: Job Evaluation (12) Risk 58: Culture and Retention in IUS (12) Risk 367: Unable to Recruit Health Advisers (12)	Risk 588: Visas and Immigration (15) Risk 54: Clinical Capacity in IUC (20) Risk 628: A&E Operations Staffing (South) (15) Risk 618: A&E Operations Staffing (HNY) (15)

KEY CONTROLS

Internal Controls	External Controls

Trust Strategy 2024-29 Trust Business Plan 2024-25 Trust Policies and Procedures Workforce Recruitment and Retention Plans Capacity Planning Statutory, Mandatory and Job-Specific Training Training Plan Apprenticeship Programme Succession Planning Appraisals / Career Conversations	NHS People Promise NHS Workforce Plan NHS Statutory and Mandatory Training Professional Registration NHS Leadership Academy Programmes National Apprenticeship Scheme

KEY SOURCES OF ASSURANCE		
First Line	Second Line	Third Line
Directorate Management Groups Capacity Planning Recruitment Team YAS Academy TEG	Portfolio Governance Boards People and Culture Group Risk and Assurance Group Performance Review Process Staff Capacity Data Reports	Internal Audit External Audit CQC Assurance NHS Oversight Framework NHS National Staff Survey Dataset Ofsted (Apprenticeships)

HIGH-LEVEL ASSURANCE MAP

Bold Ambition	**Our People**		
Strategic Risk	**8**	**Recruitment and Retention**	

KEY ASSURANCE FLOWS		People Committee				Audit and Risk Committee				Trust Board			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
1st Line	Recruitment and Retention Trajectory Reports												
	People and OD Highlight Report												
2nd Line	People Committee Chair's AAA Report												
	People Committee Risk Assurance Report												
	People Committee Annual Report												
	People Committee BAF and Risk Report												
	Trust BAF and Risk Report												
	Apprenticeship Programme Assurance												
3rd Line	Internal Audit: Workforce Planning												
	Internal Audit: International Recruitment												

Aspects of this risk about which the Trust is **not** assured		Recent Third Line Assurance Outcomes	

BOARD ASSURANCE FRAMEWORK						
Bold Ambition	**Our People**					
Strategic Risk	**9**	**Leadership, Staff Training and Development**				
Lead Committee	People Committee					
Lead Director	Mandy Wilcock, Director of People and Organisational Development					
Risk Score	2024/25 Q1	12	2024/25 Q2		Trend	
WHAT	If the Trust is unable to deliver and sustain improvements in leadership and staff training and development					
SO WHAT	It could fail to develop and retain the skilled and well-led workforce required in all staff groups to deliver high quality patient care and services.					
WHAT NEXT	Key mitigation actions to strengthen key controls and / or assurance for this risk:					
A	Control: Delivery of the Trust Training Plan 2024/25					
B	Control: Delivery of Leadership Development Programmes					
C	Control: Development of the Trust Training Plan 2025/26					

Priority Actions		Executive Lead	Due Date	Delivery Status
A1	Deliver the planned training hours for 2024/25: 900,000	Mandy Wilcock	31/03/25	
A2	Deliver training trajectories for ASWs, NQPs, AAPs, ACAs (A&E and PTS	Mandy Wilcock	31/03/25	
B1	Commence the Leadership Development Programme for team leaders in IUC	Nick Smith	31/12/24	
B2	Deliver leadership development programmes (Aspiring Leaders, Leading Together)	Mandy Wilcock	31/03/25	
C1	Develop approved Training Plan for 20252/26	Mandy Wilcock	31/03/25	

IMPACT	Timescale	Q1	Q2	Q3	Q4
	Forecast Risk	12	12	12	9
	Actual Risk	12			

Comments	

FULL RISK DESCRIPTION		
Bold Ambition	**Our People**	
Strategic Risk	**9**	**Leadership, Staff Training and Development**
WHAT	IF the Trust is unable to...	If the Trust is unable to deliver and sustain improvements in leadership and staff training and development.
	THEN the Trust could...	Fail to ensure that staff have the right knowledge, skills, and resources they need to deliver high-quality services and patient care. Fail to ensure that staff are well led and well supported by exceptional leaders.
SO WHAT	RESULTING IN...	Resulting in failure to develop and retain the skilled and well-led workforce required in all staff groups to deliver high quality patient care and services.
Risk Appetite	LOW	The Trust has a **low** appetite for risk relating to patient safety. The Trust has a **low** appetite for risk relating to effectiveness of care. The Trust has a **low** appetite for risk relating to patient experience.

RISK GOVERNANCE AND ASSURANCE	
Board Assurance Committee	People Committee
TEG Reporting Committee	People and Culture
Key Governance and Assurance Flows	

Assurance Flows to:

----- People Committee

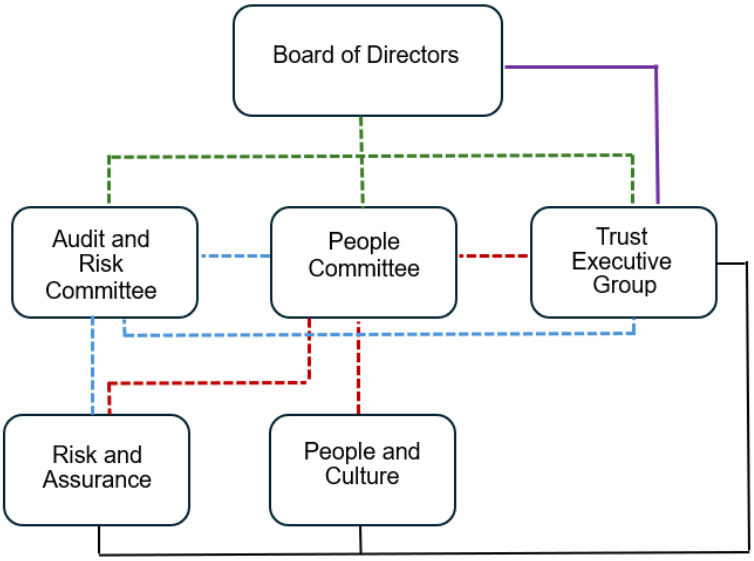
----- Audit and Risk Committee

----- Trust Board

Executive Management Flows to:

— Trust Executive Group

— Trust Board



ASSOCIATED RISKS, CONTROLS AND ASSURANCE

Bold Ambition	**Our People**	
Strategic Risk	**9**	**Leadership, Staff Training and Development**
Links to other Strategic Risks	6	Open and Positive Workplace Culture
	7	Staff Health and Well-Being
	8	Recruitment and Retention

RELATED CORPORATE RISKS

Moderate Risks	High Risks
Risk 58: Culture and Retention in IUS (12) Risk 515: Joint Decision Model Training (12) Risk 188: Health and Safety Training (12) Risk 195: Health and Safety Training (12)	Risk 579: National HART Training Courses (20)

KEY CONTROLS

Internal Controls	External Controls

Trust Strategy 2024-29 Trust Business Plan 2024-25 Trust Policies and Procedures Statutory, Mandatory and Job-Specific Training Training Plan Leadership Development Management Development Apprenticeship Programme Succession Planning Appraisals / Career Conversations Mentoring Schemes Clinical Supervision	NHS People Promise NHS Workforce Plan NHS Statutory and Mandatory Training Professional Registration NHS Leadership Academy Programmes National Apprenticeship Scheme

KEY SOURCES OF ASSURANCE		
First Line	Second Line	Third Line
Directorate Management Groups YAS Academy TEG	Portfolio Governance Boards People and Culture Group Risk and Assurance Group Performance Review Process Staff Capacity Data Reports	Internal Audit External Audit CQC Assurance NHS Oversight Framework NHS National Staff Survey Dataset Ofsted (Apprenticeships)

HIGH-LEVEL ASSURANCE MAP														
Bold Ambition	**Our People**													
Strategic Risk	**9**	**Leadership, Staff Training and Development**												
KEY ASSURANCE FLOWS		People Committee				Audit and Risk Committee				Trust Board				
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
1st Line	Quality and Safety Visits: People													
	Service / Issue Deep Dives													
	People and OD Highlight Report													
2nd Line	People Committee Chair's AAA Report													
	People Committee Risk Assurance Report													
	People Committee Annual Report													
	People Committee BAF and Risk Report													
	Trust BAF and Risk Report													
	YAS Together: Leadership Development													
	YAS Together: Succession Planning													
	YAS Together: Talent Management													
	People Dashboard: Compliance													
	Apprenticeship Governance													
3rd Line	Internal Audit: Training Compliance													

Aspects of this risk about which the Trust is **not** assured		Recent Third Line Assurance Outcomes	23/24	Ofsted: Apprenticeships	Good
			22/23	Electronic Staff Record	Sig/Lim
			22/23	Appraisal	Sig

BOARD ASSURANCE FRAMEWORK						
Bold Ambition	**Our Partners**					
Strategic Risk	**10**	**Influential and Collaborative System Partner**				
Lead Committee	Trust Executive Group / Trust Board					
Lead Director	Chief Executive					
Risk Score	2024/25 Q1	15	2024/25 Q2		Trend	
WHAT	If the Trust is unable to act as a collaborative, integral, and influential system partner					
SO WHAT	It could fail to work efficiently and effectively with partners to deliver service improvements, increase productivity, mitigate risk, and develop joined-up, patient-centred urgent and emergency care.					
WHAT NEXT	Key mitigation actions to strengthen key controls and / or assurance for this risk:					
A	Control: Hospital handover: work with system partners to reduce hospital arrival to handover times					
B	Control: Increase the availability of alternative care pathways and improve utilisation of these					
C	Control: Embed the Mental Health and Learning Disabilities Programme					

Priority Actions		Executive Lead	Due Date	Delivery Status
A1	Reduce arrive to handover times in all five CBU areas	Nick Smith	31/03/25	
A2	Reduce overall average arrive to handover time to below 24 mins	Nick Smith	31/03/25	
B1	Develop new pathways with system partners following a review of pathways and utilisation	Nick Smith Julian Mark	31/12/24	
B2	Data dashboard implemented to show patient flow and pathways effectiveness	Nick Smith Julian Mark	31/03/24	
C1	Increase specialist mental health response as sole response to mental health incidents to 20%	Dave Green	31/03/25	
C2	Implement PUSH model in all local Mental Health Services to respond to lower acuity 999 calls	Dave Green	31/03/25	

IMPACT	Timescale	Q1	Q2	Q3	Q4
	Forecast Risk	15	15	15	10
	Actual Risk	15			

Comments	

FULL RISK DESCRIPTION		
Bold Ambition	**Our Partners**	
Strategic Risk	**10**	**Influential and Collaborative System Partner**
WHAT	IF the Trust is unable to...	Act as a collaborative, integral, and influential system partner
	THEN the Trust could...	Fail to support seamless integration of services to provide joined-up care cross the wider system. Fail to become an effective co-ordinator and navigator for access to urgent and emergency care and supporting services. Fail to optimise the collective skills and resources of partner organisations to the benefit of patients.
SO WHAT	RESULTING In…	Failure to work efficiently and effectively with partners to deliver service improvements, increase productivity, mitigate risk, and develop joined-up, patient-centred urgent and emergency care.
Risk Appetite	OPEN	The Trust has an **open** appetite to risk relating to viable service improvements and opportunities to pursue new and innovative ways of working, internally and collaboratively with external partners. The Trust recognises that an **open** appetite for controlled risk-taking relating to service improvement and innovation creates opportunities which may bring positive gains to, its patients, the wider organisation, and the health and care system generally

RISK GOVERNANCE AND ASSURANCE	
Board Assurance Committee	Trust Executive Group / Trust Board
TEG Reporting Committee	All
Key Governance and Assurance Flows	

Assurance Flows to:

----- Quality Committee

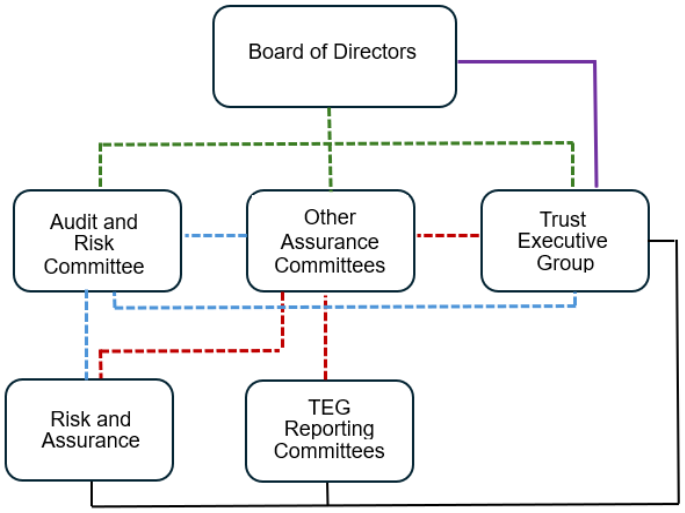
----- Audit and Risk Committee

----- Trust Board

Executive Management Flows to:

— Trust Executive Group

— Trust Board



ASSOCIATED RISKS, CONTROLS AND ASSURANCE

Bold Ambition	**Our Partners**	
Strategic Risk	**10**	**Influential and Collaborative System Partner**
Links to other Strategic Risks	3	Support patient flow across the healthcare system
	11	Collaborate on population health and health inequalities
	1	Timely response
	2	Access to appropriate care

RELATED CORPORATE RISKS

Moderate Risks	High Risks
Risk 367: Unable to Recruit Health Advisers (12) Risk 58: Culture and Retention in IUC (12) Risk 40: Non-Conveyance Decisions (12) Risk 357: Maternity Care (12) Risk 559: PTS Contracts (12)	Risk 647: Industrial Action by GPs (25) Risk 623: Hospital Handover (South) (20) Risk 602: Hospital Handover (N&E) (25) Risk 627: Operational Performance (South) (20) Risk 616: Operational Performance (West) (15) Risk 603: Operational Performance (N&E) (16) Risk 54: Clinical Capacity in IUC (20) Risk 564: Right Care, Right Person (16)

KEY CONTROLS

Internal Controls	External Controls

Trust Strategy 2024-29: ‘Our Patients’ Trust Business Plan 2024-25 Trust Governance Arrangements Operational Plans Trust Policies and Procedures Demand and Capacity Planning Seasonal Plan Recruitment and Retention Plans Capital Plan (Fleet Capacity)	NHS Provider License Health and Care Act 2022 NHS Code of Governance Regional Ambulance Contract Patient Transport Service Contracts National Strategies, Plans and Policies ICB Strategies and Plans Provider Collaboratives Place Partnerships National Performance Targets

KEY SOURCES OF ASSURANCE		
First Line	Second Line	Third Line
Regional Operations Centre EOC Management IUC Management PTS Management CBU Management Groups Directorate Management Groups Operational Leadership Group TEG Annual Report	Performance Management Framework Business Plan Delivery Reports Risk and Assurance Group Clinical Governance Group Patient Safety Learning Group Resilience Governance Group BI Performance Assurance Reports	Internal Audit External Audit CQC Assurance NHSE Oversight Framework Coroner’s Inquests

HIGH-LEVEL ASSURANCE MAP														
Bold Ambition	**Our Partners**													
Strategic Risk	**10**	**Influential and Collaborative System Partner**												
KEY ASSURANCE FLOWS		Trust Executive Group				Audit and Risk Committee				Trust Board				
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
1st Line	Operational Assurance Report													
	TEG Dashboard													
	Integrated Performance Report													
	Chief Executive's Report													
	TEG Update Report													
	Service / Issue Deep Dives													
	Clinical Governance Group Report													
	Patient Safety Learning Group Report													
2nd Line	Trust BAF and Risk Reports													
	System Partnership Reports													
	System Partnership Board Minutes													
	Business Plan Reports													
3rd Line	Internal Audit: Strategic Governance													
	Internal Audit: Board Assurance Framework													
	NHSE / CQC Oversight													

Aspects of this risk about which the Trust is **not** assured		Recent Third Line Assurance Outcomes	24/25	NHSE Oversight Framework	2
			23/24	NHSE Oversight Framework	2

BOARD ASSURANCE FRAMEWORK						
Bold Ambition	**Our Partners**					
Strategic Risk	**11**	**Collaborate on Population Health and Health Inequalities**				
Lead Committee	Quality Committee					
Lead Director	Julian Mark, Executive Medical Director					
Risk Score	2024/25 Q1	tbc	2024/25 Q2	tbc	Trend	
WHAT	If the Trust is unable to collaborate effectively to improve population health and reduce health inequalities					
SO WHAT	It could fail to support improved population health by identifying and responding effectively to unwarranted variations.					
WHAT NEXT	Key mitigation actions to strengthen key controls and / or assurance for this risk:					
A	Control: Strengthen capacity and capability for health inequalities data and intelligence					
B	Control: Enhance the availability and use of health inequalities data intelligence					
C	Assurance: The Reducing Health Inequalities Maturity Matrix					

Priority Actions		Executive Lead	Due Date	Delivery Status
A1	Conduct a review of clinical and public health analytics capacity	Julian Mark	30/09/24	
B1	Develop and embed place-based reporting on ambulance health inequalities indicators	Julian Mark	31/12/24	
B2	Develop and embed aggregate reporting on ambulance health inequalities indicators for Board	Julian Mark	31/12//24	
B3	Conduct deep dive into risk factors for deaths relating to alcohol, drugs and self-harm.	Julian Mark	31/12//24	
C1	Undertake the Reducing Health Inequalities Maturity Matrix	Julian Mark	30/09/24	

IMPACT	Timescale	Q1	Q2	Q3	Q4
	Forecast Risk	tbc	tbc	tbc	tbc
	Actual Risk				

Comments	A Trust Board session on 20 June 2024 confirmed the Board's appetite for and commitment to health inequalities. This section of the BAF will be developed further as the Board's priorities for health inequalities are confirmed.

FULL RISK DESCRIPTION		
Bold Ambition	**Our Partners**	
Strategic Risk	**11**	**Collaborate on Population Health and Health Inequalities**
WHAT	IF the Trust is unable to...	Collaborate effectively to improve population health and reduce health inequalities
	THEN the Trust could...	Fail to support system-wide work to reduce health inequalities. Fail to proactively use the role of anchor organisation to impact positively on the health and well-being of local populations. Fail to support patients to access a wide range of health, care, and preventative services in their communities
SO WHAT	RESULTING In…	Failure to support improved population health by identifying and responding effectively to unwarranted variations in access to care services and in health outcomes.
Risk Appetite	OPEN	The Trust has an **open** appetite to risk relating to viable service improvements and opportunities to pursue new and innovative ways of working, internally and collaboratively with external partners.

RISK GOVERNANCE AND ASSURANCE	
Board Assurance Committee	Quality Committee
TEG Reporting Committee	Clinical Governance
Key Governance and Assurance Flows	

Assurance Flows to:

----- Quality Committee

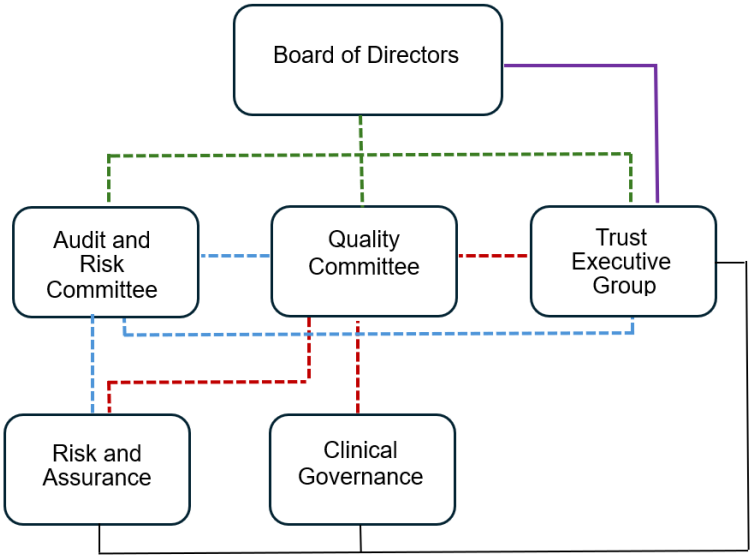
----- Audit and Risk Committee

----- Trust Board

Executive Management Flows to:

— Trust Executive Group

— Trust Board



ASSOCIATED RISKS, CONTROLS AND ASSURANCE

Bold Ambition	**Our Partners**	
Strategic Risk	**11**	**Collaborate on Population Health and Health Inequalities**
Links to other Strategic Risks	10	Influential system partner

RELATED CORPORATE RISKS

Moderate Risks	High Risks

KEY CONTROLS

Internal Controls	External Controls

Trust Strategy 2024-29: ‘Our Patients’ Trust Business Plan 2024-25 Trust Governance Arrangements Health Inequalities Action Plan Trust Policies and Procedures Trust Report: Ambulance Health Inequalities Indicators	NHS Provider License Health and Care Act 2022 NHS Code of Governance Regional Ambulance Service Contract National Strategies, Plans and Policies ICB Strategies and Plans Provider Collaboratives Place Partnerships AACE Health Inequalities Toolkit Reducing Health Inequalities Maturity Matrix

KEY SOURCES OF ASSURANCE		
First Line	Second Line	Third Line
To be confirmed	To be confirmed	To be confirmed

HIGH-LEVEL ASSURANCE MAP		
Bold Ambition	**Our Partners**	
Strategic Risk	**11**	**Collaborate on Population Health and Health Inequalities**

KEY ASSURANCE FLOWS		Quality Committee				Audit and Risk Committee				Trust Board			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
1st Line													
2nd Line													
		Assurance Mapping to Be Confirmed											
3rd Line													

Aspects of this risk about which the Trust is **not** assured		Recent Third Line Assurance Outcomes			

BOARD ASSURANCE FRAMEWORK						
Bold Ambition	**Our Planet and Pounds**					
Strategic Risk	**12**	**Revenue Resources**				
Lead Committee	Finance and Performance Committee					
Lead Director	Kathryn Vause, Executive Director of Finance					
Risk Score	2024/25 Q1	12	2024/25 Q2		Trend	
WHAT	If the Trust is unable to secure sufficient revenue resources and use them wisely					
SO WHAT	It could fail to use resources productively, achieve value for money, and deliver financially sustainable patient care and services.					
WHAT NEXT	Key mitigation actions to strengthen key controls and / or assurance for this risk:					
A	Control: Revenue planning for 2024/25					
B	Control: Financial management during 2024/25					
C	Control and Assurance: Planning and achievement of efficiency savings for 2024/25					

Priority Actions		Executive Lead	Due Date	Delivery Status
A1	Develop an approved balanced financial plan (revenue) for 2024/25	Kathryn Vause	30/06/24	Complete
B1	Ensure the Trust works within its approved financial plan during 2024/25	Kathryn Vause	31/03/24	
C1	Achieve the overall organisational efficiency target of 5.5% for 2024/25	Kathryn Vause	31/03/24	
C2	Achieve the recurrent organisational efficiency target of 1.1% for 2024/25	Kathryn Vause	31/03/24	
C3	Strengthen the oversight of efficiency and productivity schemes via the Organisational Efficiency group.	Marc Thomas	30/09/24	

IMPACT	Timescale	Q1	Q2	Q3	Q4
	Forecast Risk	12	12	12	9
	Actual Risk	12			

Comments	

FULL RISK DESCRIPTION		
Bold Ambition	**Our Planet and Pounds**	
Strategic Risk	**12**	**Revenue Resources**
WHAT	IF the Trust is unable to...	Secure sufficient revenue resource and it use it wisely
	THEN the Trust could...	Fail to achieve a balanced revenue plan. Fail to achieve effective and efficient use of resources. Fail to support system-wide financial sustainability
SO WHAT	RESULTING In…	Failure to use resources wisely and productively, achieve value for money, and deliver financially sustainable patient care and services.
Risk Appetite	LOW	The Trust has a **low** appetite for risk relating to statutory financial compliance and related financial controls.

RISK GOVERNANCE AND ASSURANCE	
Board Assurance Committee	Finance and Performance
TEG Reporting Committee	TEG
Key Governance and Assurance Flows	

Assurance Flows to:

----- Quality Committee

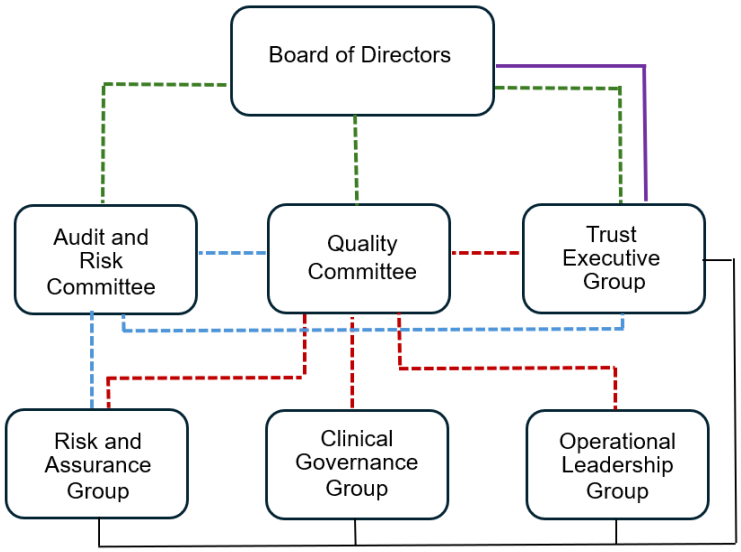
----- Audit and Risk Committee

----- Trust Board

Executive Management Flows to:

— Trust Executive Group

— Trust Board



ASSOCIATED RISKS, CONTROLS AND ASSURANCE

Bold Ambition	**Our Planet and Pounds**	
Strategic Risk	**12**	**Revenue Resources**
Links to other Strategic Risks	13	Capital Resources

RELATED CORPORATE RISKS

Moderate Risks	High Risks
Risk 522: BPPC Performance (12)	Risk 591: Finance Team Resources (16)

KEY CONTROLS

Internal Controls	External Controls

Trust Strategy 2024-29 Trust Business Plan 2024-25 Trust Financial Plan (Revenue) 2024-25 Organisational Efficiency Targets Budget Setting, Monitoring and Reporting Processes Trust Governance Arrangements SFIs and Scheme of Financial Delegation Trust Policies and Procedures Budget and Financial Reporting Finance Business Partners Financial Management Training Counter Fraud Plan 2024/25	NHS National Planning Guidance NHS Standard Contract NHSE Revenue Finance and Contracting Guidance NHS Financial Framework ICB Planning Process ICB Financial Management Processes HM Treasury Guidance (Managing Public Money) DHSE Group Accounting Manual HFMA Codes and Guidance Accounting Policies and Professional Standards Auditing Policies and Professional Standards Government Counter Fraud Standard

KEY SOURCES OF ASSURANCE		
First Line	Second Line	Third Line
Directorate Management Groups TEG Finance Business Partners Budget Holders Reports Annual Report	Monthly Finance Reports Risk and Assurance Group Organisational Efficiency Group Trust Procurement Group Contracting Reports Procurement Reports Reports on SFI Waivers, Special Payments etc Annual Accounts	Internal Audit External Audit CQC Assurance NHSE Oversight Framework Counter Fraud Specialist

HIGH-LEVEL ASSURANCE MAP		
Bold Ambition	**Our Planet and Pounds**	
Strategic Risk	**12**	**Revenue Resources**

KEY ASSURANCE FLOWS		Finance and Performance Committee (FPC)				Audit and Risk Committee				Trust Board			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
1st Line	Operational Performance / Assurance Reports												
2nd Line	Finance Report												
	FPC Chair's AAA Report												
	FPC Risk Assurance Report												
	FPC Annual Report												
	FPC BAF and Risk Report												
	Trust BAF and Risk Report												
	Business Plan Report												
	Contracting and Procurement Reports												
	Compliance reports: SFIs, STWs, Special Payments												
3rd Line	External Audit: ISA 260 and Annual Report 2023/24												
	Internal Audit: Budget Setting, Monitoring, Reporting												
	Internal Audit: Accounts Payable												
	Internal Audit: Cashflow and Treasury Management												

Aspects of this risk about which the Trust is **not** assured		Recent Third Line Assurance Outcomes	23/24	EA: Accounts	Unq
			23/24	IA: Financial Ledger / Reporting	Sig
			23/24	IA: Financial Systems: Assets	Sig
			22/23	EA: Accounts	Unq

			22/23	IA: Accounts Receivable	Sig

BOARD ASSURANCE FRAMEWORK						
Bold Ambition	**Our Planet and Pounds**					
Strategic Risk	**13**	**Capital Resources**				
Lead Committee	Finance and Performance Committee					
Lead Director	Kathryn Vause, Executive Director of Finance					
Risk Score	2024/25 Q1	20	2024/25 Q2		Trend	
WHAT	If the Trust is unable to secure sufficient capital resource and it use it wisely					
SO WHAT	It could fail to invest adequately in safe, effective, and well-equipped environments for staff and patients.					
WHAT NEXT	Key mitigation actions to strengthen key controls and / or assurance for this risk:					
A	Control: Capital planning for 2024/25					
B	Control: Key capital developments in 2024/25 - Estates					
C	Control: Key capital developments in 2024/25 - Fleet					
D	Control: Key capital developments in 2024/25 - ICT					

Priority Actions		Executive Lead	Due Date	Delivery Status
A1	Develop an approved capital plan for 2024/25	Kathryn Vause	30/06/24	Complete
B1	Estates: Hull transformation project (to be defined)	Kathryn Vause	tbc	
C1	Fleet: receive and mobilise new DCAs (balance of the 2023/24 order and the 2024/25 order.	Kathryn Vause	31/03/25	
C2	Fleet: receive and mobilise the new PTS electric vehicles (balance of 2023/24 order)	Kathryn Vause	31/03/25	
D1	ICT: deliver the 2024/25 milestones in the ePR replacement project	Sam Robinson	31/03/25	

IMPACT	Timescale	Q1	Q2	Q3	Q4
	Forecast Risk	20	20	16	16
	Actual Risk	20			

Comments	

FULL RISK DESCRIPTION		
Bold Ambition	**Our Planet and Pounds**	
Strategic Risk	**13**	**Capital Resources**
WHAT	IF the Trust is unable to...	Secure sufficient capital resource and it use it wisely to invest in infrastructure (estate, fleet, equipment, technology)
	THEN the Trust could...	Fail to provide fit for purpose workplaces. Fail to provide the required quantity, quality, and availability of fleet. Fail to support staff and patients with up-to-date technology, equipment, and facilities.
SO WHAT	RESULTING In…	Failure to invest adequately in safe, effective, and well-equipped environments for staff and patients.
Risk Appetite	LOW	The Trust has a **low** appetite for risk relating to statutory financial compliance and related financial controls.

RISK GOVERNANCE AND ASSURANCE	
Board Assurance Committee	Finance and Performance Committee
TEG Reporting Committee	Capital Planning
Key Governance and Assurance Flows	

Assurance Flows to:

----- Finance and Performance Committee

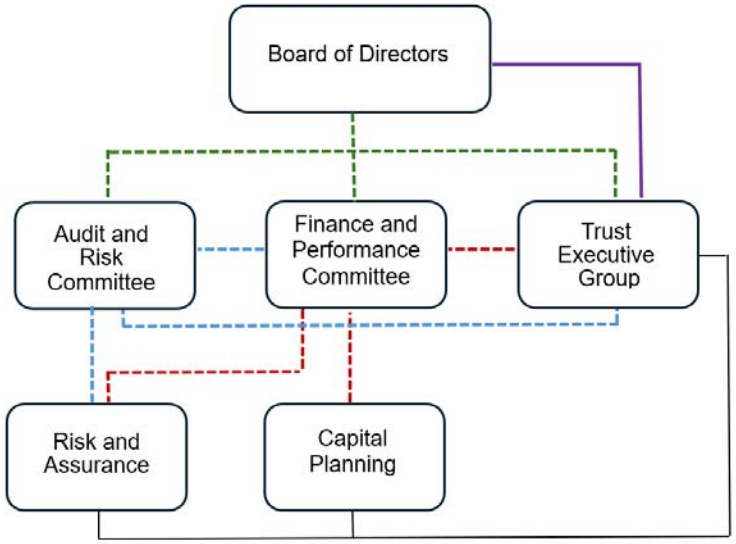
----- Audit and Risk Committee

----- Trust Board

Executive Management Flows to:

— Trust Executive Group

— Trust Board



ASSOCIATED RISKS, CONTROLS AND ASSURANCE

Bold Ambition	**Our Planet and Pounds**	
Strategic Risk	**13**	**Capital Resources**
Links to other Strategic Risks	12	Revenue Resources
	15	Action on Climate Change
	14	Digital Technology and Cyber Security
	1	Timely Response

RELATED CORPORATE RISKS

Moderate Risks	High Risks
Risk 561: CDEL Notification (12)	Risk 560: CDEL Limits(16) Risk 511: Estates Funding (EFF) (15)

KEY CONTROLS

Internal Controls	External Controls

Trust Strategy 2024-29 Trust Business Plan 2024-25 Trust Financial Plan (Revenue) 2024-25 Organisational Efficiency Targets Trust Governance Arrangements Estates Enabling Plan Fleet Investment Plans Digital Route-Map SFIs and Scheme of Financial Delegation Trust Policies and Procedures Financial Reporting Procurement Category Managers Procurement Training Counter Fraud Plan 2024/25	NHS National Planning Guidance NHS Capital Guidance 2022-25 Capital Departmental Expenditure Limits NHS Standard Contract NHS Financial Framework ICB Planning Process ICB Infrastructure Strategies HM Treasury Guidance (Managing Public Money) DHSE Group Accounting Manual HFMA Codes and Guidance Accounting Policies and Professional Standards Auditing Policies and Professional Standards Government Counter Fraud Standard Estates Returns Information Collection (ERIC)

KEY SOURCES OF ASSURANCE		
First Line	Second Line	Third Line
Directorate Management Groups TEG Finance Business Partners Budget Holders Reports Annual Report	Monthly Finance Reports Risk and Assurance Group Organisational Efficiency Group Capital Planning Group Trust Procurement Group Contracting Reports Procurement Reports Reports on SFI Waivers, Special Payments etc Annual Accounts	Internal Audit External Audit CQC Assurance NHSE Oversight Framework Counter Fraud Specialist

HIGH-LEVEL ASSURANCE MAP		
Bold Ambition	**Our Planet and Pounds**	
Strategic Risk	**13**	**Capital Resources**

KEY ASSURANCE FLOWS		Finance and Performance Committee (FPC)				Audit and Risk Committee				Trust Board			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
1st Line	Operational Performance / Assurance Reports												
2nd Line	Finance Report												
	FPC Chair's AAA Report												
	FPC Risk Assurance Report												
	FPC Annual Report												
	FPC BAF and Risk Report												
	Trust BAF and Risk Report												
	Capital Planning Group												
	Business Plan Report												
	Contracting and Procurement Reports												
	Compliance reports: SFIs, STWs, Special Payments												
3rd Line	External Audit: ISA 260 and Annual Report 2023/24												

Aspects of this risk about which the Trust is **not** assured		Recent Third Line Assurance Outcomes	23/24	IA: Financial Systems – Assets	Sig
			23/24	IA: Procurement	Sig/Lim
			23/24	EA: Accounts	Unq
			22/23	IA: IT Asset Management	Limited
			22/23	IA: Accounts	Unq

			21/22	IA: Fleet Management	Sig

BOARD ASSURANCE FRAMEWORK						
Bold Ambition	**Our Planet and Pounds**					
Strategic Risk	**14**	**Digital Technology and Cyber Security**				
Lead Committee	Finance and Performance Committee					
Lead Director	Sam Robinson, Chief Digital Information Officer					
Risk Score	2024/25 Q1	12	2024/25 Q2		Trend	
WHAT	If the Trust is unable to deliver safe and effective technology and cyber security					
SO WHAT	It could fail to realise the benefits that technology, data and intelligence can bring to decision-making, support services, and patient care.					
WHAT NEXT	Key mitigation actions to strengthen key controls and / or assurance for this risk:					
A	Control: Strengthen the planning and governance of digital work to support the Trust strategy					
B	Control: Deliver priority digital developments for 2024/25					
C	Assurance: Strengthen the Board's oversight of cyber security / cyber risk					

Priority Actions		Executive Lead	Due Date	Delivery Status
A1	Develop an enabling plan for digital / technology	Sam Robinson	31/03/25	
A2	Establish a digital / technology governance body	Sam Robinson	31/12/24	
B1	ICT: deliver the 2024/25 milestones in the ePR replacement project	Sam Robinson	31/03/25	
C1	Strengthen cyber security assurance reporting via the Finance and Performance Committee	Sam Robinson	31/03/25	
C2	Organise Board-level awareness training in cyber security / cyber risk	David O'Brien	31/03/25	

IMPACT	Timescale	Q1	Q2	Q3	Q4
	Forecast Risk	12	12	12	12
	Actual Risk	12			

Comments	

FULL RISK DESCRIPTION		
Bold Ambition	**Our Planet and Pounds**	
Strategic Risk	**14**	**Digital Technology and Cyber Security**
WHAT	IF the Trust is unable to...	Deliver safe and effective digital technology developments and cyber security arrangements
	THEN the Trust could...	Fail to utilise technology and analytics to develop new and digitally enabled ways of working to optimise patient care and services. Fail to meet legal and regulatory standards regarding information governance and cyber security Fail to protect its systems and data from the occurrence or impact of cyber-attacks and system outages
SO WHAT	RESULTING In…	Failure to realise the benefits that technology, data and intelligence can bring to decision-making, support services, and patient care.
Risk Appetite	LOW	The Trust has a **low** appetite for risk relating to security and integrity of technology infrastructure, information systems and other digital solutions.
	OPEN	The Trust has an **open** appetite for risk relating to new developments consistent with the organisation's strategic priorities, financial affordability, and capacity to deliver and embed change.

RISK GOVERNANCE AND ASSURANCE	
Board Assurance Committee	Finance and Performance Committee
TEG Reporting Committee	New Digital Management governance body to be established during 2024/25
Key Governance and Assurance Flows	

Assurance Flows to:

----- Finance and Performance Committee

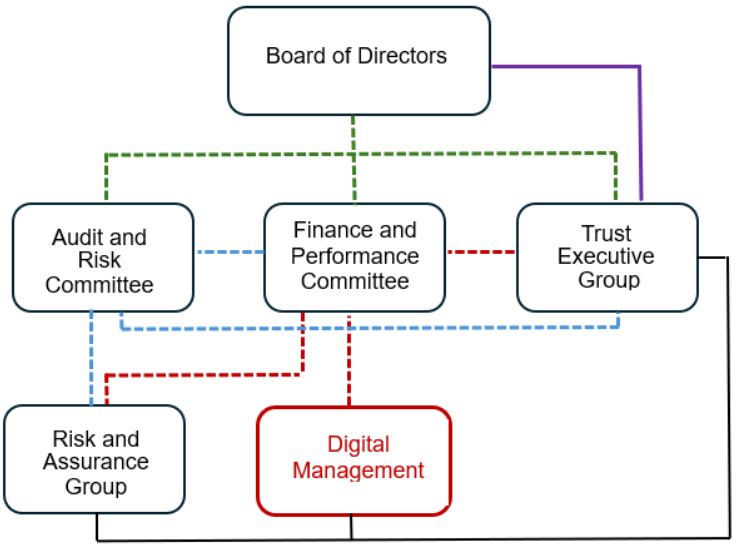
----- Audit and Risk Committee

----- Trust Board

Executive Management Flows to:

— Trust Executive Group

— Trust Board



ASSOCIATED RISKS, CONTROLS AND ASSURANCE

Bold Ambition	**Our Planet and Pounds**	
Strategic Risk	**14**	**Digital Technology and Cyber Security**
Links to other Strategic Risks	12	Revenue Resources
	13	Capital Resources

RELATED CORPORATE RISKS

Moderate Risks	High Risks
Risk 456: Phishing Emails (12) Risk 457: Denial of Service Cyber Attack (12) Risk 545: Out of Area Calls - Isle of Wight (12) Risk 546: Radio Recordings (12) Risk 421: Computer Aided Despatch (SORT) (12) Risk 28: Management of Paper Records (12) Risk 538: Clinical Records Data Loss (12)	Risk 560: CDEL Limits (20) Risk 509: EOC Duplicate Calls (15) Risk 500: No Triage System - EOC Cyber Attack (15)

KEY CONTROLS

Internal Controls	External Controls

Trust Strategy 2024-29 Trust Business Plan 2024-25 Trust Digital Roadmap Trust Policies and Procedures Statutory and Mandatory Training Designated Roles: SIRO, DPO, IAO, Caldicott Guardian Project Management Standards Business Planning / Business Case Processes Capital Plan Data Protection Impact Assessments	Data Security and Protection Toolkit General Data Protection Regulation (UK) Data Protection Act (2018) National Data Guardian Data Security Standards ISO 27001: Information Security ISO 20000: IT Service Management ITIL Standards Office of the Information Commissioner Northern Ambulance Alliance National / Sector Digital and Technology Priorities

KEY SOURCES OF ASSURANCE		
First Line	Second Line	Third Line
Directorate Management Groups TEG	Digital Management Group (to be established during 2024/25) Risk and Assurance Group IG Working Group Security Review Group Performance Review Process Capital Planning Group	Internal Audit External Audit CQC Assurance NHS England Information Commissioner Reports National Cyber Security Centre

HIGH-LEVEL ASSURANCE MAP															
Bold Ambition	**Our Planet and Pounds**														
Strategic Risk	**14**	**Digital Technology and Cyber Security**													
KEY ASSURANCE FLOWS		Finance and Performance Committee (FPC)				Audit and Risk Committee				Trust Board					
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4		
1st Line	Digital / IT Assurance Report														
	Cyber Security Assurance Report														
2nd Line	FPC Chair's AAA Report														
	FPC Risk Assurance Report														
	FPC Annual Report														
	FPC BAF and Risk Report														
	Trust BAF and Risk Report														
	Business Plan Report														
	Digital Management Group Reporting	Tbc when established													
3rd Line	Internal Audit: DSPT Assurance														
	Internal Audit: Cyber Governance (Phishing) Part 1														
	Internal Audit: Cyber Governance (Phishing) Part 2														

Aspects of this risk about which the Trust is **not** assured		Recent Third Line Assurance Outcomes	24/25	IA: DSPT Assurance	Mod
			23/24	IA: Cyber Phishing	Sig
			23/24	IA: IT System Resilience	Sig
			23/24	IA: DSPT Assurance	Mod
			23/24	IA: Cyber Phishing	Sig

			23/24	IA: IT Asset Management	Limited

BOARD ASSURANCE FRAMEWORK						
Bold Ambition	**Our Planet and Pounds**					
Strategic Risk	**15**	**Action on Climate Change**				
Lead Committee	Finance and Performance Committee					
Lead Director	Kathryn Vause, Executive Director of Finance					
Risk Score	2024/25 Q1	12	2024/25 Q2		Trend	
WHAT	If the Trust is unable to act responsibly and effectively on climate change.					
SO WHAT	It could fail to make sufficient progress in reducing the Trust's environmental impact and in and mitigating the effects of climate change on Trust operations.					
WHAT NEXT	Key mitigation actions to strengthen key controls and / or assurance for this risk:					
A	Control: Fleet improvements to support environmental sustainability					
B	Assurance: Governance arrangements for environmental sustainability					

Priority Actions		Executive Lead	Due Date	Delivery Status
A1	Reduce environmental impact by implementing telematics systems: complete phase one	Kathryn Vause	31/03/25	
A2	Complete the delivery and rollout of PTS electric vehicles	Kathryn Vause	31/03/25	
B1	Establish a new Trust-wide governance body for environmental sustainability / net zero work	Kathryn Vause	31/12/24	
B2	Strengthen Board-level assurance of sustainability work via the Finance and Performance Committee	Kathryn Vause	31/12/24	

IMPACT	Timescale	Q1	Q2	Q3	Q4
	Forecast Risk	15	15	10	10
	Actual Risk	15			

Comments	

FULL RISK DESCRIPTION		
Bold Ambition	**Our Planet and Pounds**	
Strategic Risk	**15**	**Action on Climate Change**
WHAT	IF the Trust is unable to...	Act responsibly and effectively on climate change
	THEN the Trust could...	Fail to adequately support efforts to reduce the Trust's environmental impact by moving towards net-zero emissions. Fail to identify and manage the potential impact of climate change on the Trust's estate and operations. Fail to identify and manage the potential impact of climate change on patient care and services.
SO WHAT	RESULTING In…	Failure to make sufficient progress in reducing the Trust's environmental impact and in mitigating the effect of climate change on Trust operations.
Risk Appetite	OPEN	The Trust has an **open** appetite for risk relating to some aspects of statutory compliance, regulatory requirements and the delivery of national standards and targets (treated on a case-by-case basis). The Trust has an **open** appetite to risk relating to viable service improvements and opportunities to pursue new and innovative ways of working, either internally or collaboratively with external partners.

RISK GOVERNANCE AND ASSURANCE	
Board Assurance Committee	Finance and Performance Committee
TEG Reporting Committee	New Net Zero / Sustainability governance body to be established during 2024/25
Key Governance and Assurance Flows	

Assurance Flows to:

----- Finance and Performance Committee

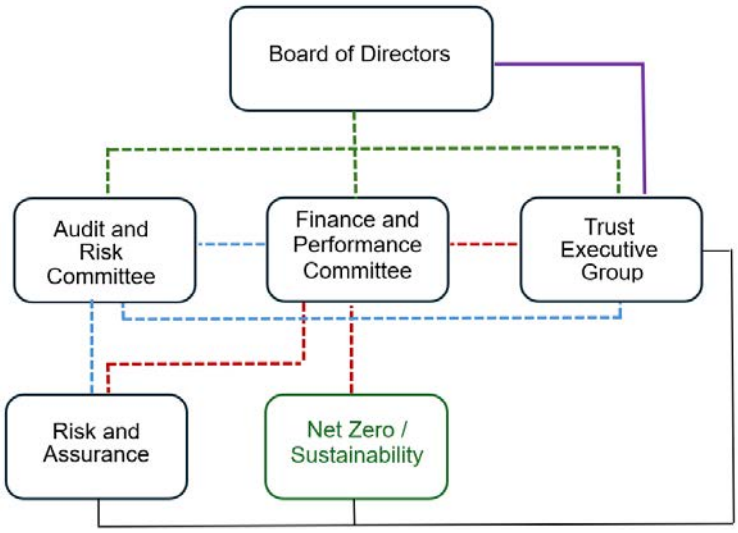
----- Audit and Risk Committee

----- Trust Board

Executive Management Flows to:

— Trust Executive Group

— Trust Board



ASSOCIATED RISKS, CONTROLS AND ASSURANCE

Bold Ambition	**Our Planet and Pounds**	
Strategic Risk	**15**	**Action on Climate Change**
Links to other Strategic Risks	12	Revenue Resources
	13	Capital Resources
	10	Influential System Partner

RELATED CORPORATE RISKS	
Moderate Risks	High Risks
	Risk 62: Climate Change (15)

KEY CONTROLS	
Internal Controls	External Controls

Trust Strategy 2024-29 Trust Business Plan 2024-25 Trust Green Plan Operational Plans Trust Policies and Procedures Capital Plan Estates Enabling Plan Climate Change Risk Assessments Climate Change Adaptation Plans	Health and Care Act (2022) Climate Change Act (1998) NHS Provider License ICB Green Plans NHS England: How to Produce a Green Plan NHS England: Greener NHS NHS England: Delivering a Net Zero NHS NHS England: Net Zero Supplier Roadmap NHS England: Net Zero Building Standard Estates Returns Information Collection (ERIC)

KEY SOURCES OF ASSURANCE		
First Line	Second Line	Third Line
Service and Directorate Management Reports TEG Annual Report	Net Zero / Sustainability Group (to be established during 2024/25) Capital Planning Group Risk and Assurance Group	Internal Audit External Audit CQC Assurance NHSE Oversight Framework

HIGH-LEVEL ASSURANCE MAP		
Bold Ambition	**Our Planet and Pounds**	
Strategic Risk	**15**	**Action on Climate Change**

KEY ASSURANCE FLOWS		Finance and Performance Committee				Audit and Risk Committee				Trust Board			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
1st Line	Fleet Assurance Report												
	Green Plan / Net Zero Performance Reports												
	Estates Enabling Plan Progress Reports												
2nd Line	FPC Chair's AAA Report												
	FPC Risk Assurance Report												
	FPC Annual Report												
	FPC BAF and Risk Report												
	Trust BAF and Risk Report												
	Business Plan Report												
	Net Zero / Sustainability Group Assurance Reports	Tbc when established											
	Procurement and Contracting Reports												
3rd Line	External Audit (Annual Report Disclosures)												

Aspects of this risk about which the Trust is **not** assured		Recent Third Line Assurance Outcomes	22/23	Green NHS and Sustainability	Sig

NHS
Yorkshire
Ambulance Service
NHS Trust

Board of Directors (held in Public)
25 July 2024
Finance and Performance Committee Chair's Report
Report of the Finance and Performance Committee Chair

Report from: Finance and Performance Committee
Date of meeting: 25 June 2024

Key discussion points at the meetings and matters to be escalated to board:
Alert:
The Annual Assurance report of the FPC Committee will go to Audit and Risk Committee prior to Trust Board. The committee wished to highlight to Board the need to maintain pressure at system level to support actions at acute providers that enable the release of vehicles at handover. The committee recommends the ePR business case after requiring assurance with respect to the impact of deployment to current smartphone users (to be phased out in favour of basic phones), to iPads. The committee recommends the A&E contract for approval subject to reflecting the appropriate nominee as Health and Wellbeing Guardian.
Advise:
The latest operational performance (M2) was reviewed. Slippage in recruitment targets is being managed to budget by overtime with no current adjustment needed to maintain the year end target trajectories. The 12 additional paramedic recruitment target is also expected to be achieved but behind the current profile of costs. Key communication that is taking place between operational capacity planning group and finance is expected to support collaboration for delivery overall of year end targets. Drivers of resource availability (and consequently costs) include the Category 1 demand. YAS is an outlier with varying degrees of impact on each area. The committee reviewed a paper outlining the revised vehicle delivery profile and consequential impact on performance. It further considered a proposal for more vehicles. However, it is recommended that the replacement of vehicles is accelerated if capital is available – in line with the proposal previously approved by Board. This would give the option of decommissioning less vehicles to increase capacity if necessary. With regards to 23/24 EPRR standards, they are subject to change following the Manchester Arena Inquiry recommendations. At this point the Trust would no longer have sufficient resource to meet those standards. This risk has been cited previously.

The committee approved the revised Medical Devices Policy and agreed an extension for updates to 2 overdue policies.

The committee approved the procurement strategy for PTS stretcher vehicles although the Board will need to approve the tender given anticipated value.

Assure:

The Committee:

- Were advised that monthly performance reviews with executives were in place at service level with each area identifying issues that require support to maintain or explain operational performance against plan.
- Noted the M2 financial performance highlight report though financial plans are not signed off.
- The committee noted that the first executive performance review meeting had taken place on the business plan priorities. The committee is assured on the *development* of the framework and looks forward to reviewing its effectiveness for delivery.
- The committee received an update with respect to developing the governance for the Operational Efficiency Group and reporting into this committee. An update is expected this calendar year to review assurance effectiveness.
- The committee was assured that the Trust meets its EPRR based on the 23/24 self-assessment.
- The committee were assured of the governance for policy & procedural documents approval.
- With regards to Vocare performance reviews, the committee were assured that review elements are additionally included for future tendering for this type of contract to ensure more effective and timely performance management, and note they are being used to manage Vocare's contractual obligations.

The committee received the quarterly procurement report, and received appropriate assurance on activity.

Risks discussed:

Handover delays impacting availability of vehicles and staff and impacts to performance targets.

24/25 Capital allocation risk – the leased capital allocation is not yet confirmed. It is possible we will be able to manage the allocations for leased and purchased capital as one. However this is not confirmed, and puts at risk the best use of capital for the Trust.

There are vacancies and capacity constraints in the finance team.

New risks identified:

No new risks were identified.

Report completed by: Amanda Moat, Non-Executive Director/Finance and Performance Committee Chair.
Date: 15/07/2024

Board of Directors held in Public
25 July 2024
Agenda Item: 3.4

Report Title	Assurance Report of the Chief Operating Officer
Author (name and title)	Nick Smith. Chief Operating Officer
Accountable Director	Nick Smith. Chief Operating Officer
Previous committees/groups	n/a
Recommended action(s) Approval, Assurance, Information	Assurance
Purpose of the paper	Assurance
Recommendation(s)	Note the content of the paper

Executive summary (overview of main points)

This paper identifies the key highlights, lowlights, issues, actions taken and planned actions regarding the YAS Operational Directorate overseen by the Chief Operating Officer.

This paper is for Board assurance purposes and covers Remote Patient Care, A&E Operations, Integrated Urgent Care and Emergency Planning, Resilience and Response (EPRR).

Strategic ambition(s) this supports Provide brief bullet point details of link to Trust strategy	Our Patients	Deliver the national, regional and local performance targets for 999, NHS 111 and Patient Transport Service (PTS).
	Our People	Invest in developing our people (staff and volunteers), ensuring they have the skills, support and resources they need to deliver high-quality care and services, now and in the future.
	Our Partners	Work collaboratively with all our partners to achieve better experiences and outcomes for patients, optimising all of our collective skills and valued resources. We will ensure we deliver the most appropriate response to patients requiring of out-of-hospital emergency or urgent care and be an effective co-ordinator and navigator for access to urgent and emergency care, and supporting services.
	Our Planet and Pounds	Use our resources wisely and ensure value for money
Link with the BAF Include reference number (board and level 2 committees only)		

Highlights	Lowlights
We had confirmation in late June that the Trust had secured non-recurrent funding for June and July to improve Category 2 performance. Due to the short notice and non-recurrent nature the additional funding has been targeted to increase Private Ambulance Crews for our Integrated Transport, GPs and incentivised clinical shifts in EOC. Due to the late confirmation the actions will be continued into August, Additional 'recurrent funding' has been identified for Category 2 performance improvement but we are still waiting for confirmation of more detail. **Remote Patient Care** The full leadership is now in place and the implementation of the Remote Care Transformation Plan is happening at pace, specifically IUC. **Emergency Operations Centre (EOC)** We continue to answer around 15 thousand 999 calls per week. We also have an average call answer time of 5 seconds since 1st April 2024. For the same period in 2023/24 it was 16 seconds. On the 17th July YAS implemented CRS/LifeX. This is a nationally mandated digital radio interface system and this successfully went live at 11am with no operational issues seen. This was a significant piece of work between ICT/BI/EOC and they should be congratulated. Recruitment to 999 Call Handler remains good at 232 FTE, aim is 240. **Integrated Urgent Care (IUC)** We have continued to provide the best 111 call handling performance in the country, despite the withdrawal of national support. Performance is extremely good with 92% of calls answered in 60s during July. The 'Case for Change' is progressing well. New, more attractive, rotas went live in early June without any impact on performance. Green uniform has now been issued to majority of staff with many now wearing. It will be mandatory from September. Feedback has been very good. After investigating an anomaly with 111 reporting the team have identified an error with the 'clock start' time that shows we are currently performing better than we are reporting, We will be asking NHSE to allow us to re-submit.	**Remote Patient Care** Turnover continues to be higher than plan for both EOC and IUC. Actions taking in the first quarter are expected to impact in quarter 2. However we would have expected to have seem some improvement in June. **Emergency Operations Centre (EOC)** We still continue to see variation in call taking performance at times of high demand, this is despite additional call handler recruitment. An example was the 24th June which was exceptionally busy and had an average call answer of 28 seconds. Recruitment into Clinical Assessor roles continue to be challenging and slow despite significant focus by the team. Despite increases in Hear & Treat month on month its slightly below trajectory at 15.3% (target is 15.9%). **Integrated Urgent Care (IUC)** Recruitment pipeline is good, but we still have high reliance on agency for recruiting new staff. This is causing a significant financial overspend at Month 3. Mitigating actions are being taken. We are working closely with one of our sub-contractors to review intermittent significant delays with clinical advice within IUC. After investigating an anomaly with 111 reporting the team have identified an error with the 'clock start' time that shows we are currently performing better than we are reporting, We will be asking NHSE to allow us to re-submit. **Accident & Emergency Operations (A&E)** Although Category 2 performance is narrowing due to improved response times in HNY there remains significant variation in response times to patients across Yorkshire. Handover delays continue to significantly impact on our ability to respond in a timely way. The average handover time YTD is 29 minutes, versus a standard of 15 minutes. Crew clear times are a concern in West Yorkshire as they are 26 minutes, versus a target of 15 minutes.

Accident & Emergency Operations (A&E)
The year-to-date position for Category 2 mean performance is just over 29 minutes, with *West Yorkshire* (28 minutes), *South Yorkshire* (24 minutes) and Humber and North Yorkshire (35 minutes). In July *Humber and North Yorkshire* are achieving 28 minutes.

Although still challenging, handover delays in Humber and North Yorkshire have improved falling from an average of 44 minutes in June to 36 minutes in July so far.

Patient Transport Service (PTS)
Timeliness of response remains good, especially for our vulnerable renal patients. Of specific note is our call answer improvement which is now often exceeding the 90% target. This is over double the performance in the same period last year.

Emergency Planning Resilience and Response (EPRR)
LAS have taken the hosting of National Ambulance resilience Unit (NARU) from WMAS from the 1st April 2024. Everything appears to be good with discussions still taking place around the role of the National Ambulance Coordination Centre (NACC) between LAS/WMAS and NHSE.

Good progress is being made with the EPRR Core and Interoperability Standards and we continue to meet the HART (Hazardous Area Response Team) and SORT (Specialist Operational Response Team) availability standard. This ensures our capability to respond to significant incidents.

The proportion of 999 calls getting a disposition of Category 1 is higher in YAS than any other ambulance service in the UK. In June it was 16.5% with the next highest LAS on 15.1%. The lowest was SCAS with only 8.5%. Although the use of AMPDS rather than NHS Pathways is one influence, it is not the only one.

Vehicle availability is often impacting on the availability of crews at the start of a shift. It is hoped that the current delivery trajectory of new DCAs will help ease this issue.

Patient Transport Service (PTS)
Our commissioners have taken a decision that the implementation of Patient Eligibility will not be implemented until April 2025

Key Issues to Address	Action Implemented	Further Actions to be Made
Remote Patient Care **Emergency Operations Centre (EOC)** We need to maximise our remote clinical assessment capacity to improve Hear and Treat. Turnover is high for 999 Call Handlers. **Integrated Urgent Care (IUC)** Expenditure on Agency is too high, leading to significant overspend in Month 3. Turnover is exceptionally high for Health Advisors We have too much reliance on agency staff for IUC. **Accident & Emergency Operations (A&E)** Category 2 response times across Yorkshire are too long. There is also significant variation across ICB footprints. Hospital Handover and Crew Clear times are too high at specific hospitals. The ratio of Category 1 calls to other calls is too high in YAS. Fleet numbers are now a limiting factor in the number of crews we can put out. **Patient Transport Service (PTS)** Delayed implementation of Eligibility **Emergency Planning Resilience and Response (EPRR)** The business case based upon the recommendations of the Manchester Arena Inquiry (MAI) still requires funding.	**Remote Patient Care** **Emergency Operations Centre (EOC)** Operations/EOC Task and Finish Group set up to drive forward the Clinical Assessor numbers. Majority of band 7 Clinical Navigator posts advertised and now filled. Remote Clinical Hubs in place in Hull, Leeds, Keighley, Sheffield for rotation. Overtime incentives paid during late June and July. **Integrated Urgent Care (IUC)** New rotas in place. Consultation ongoing and some new roles advertised. Uniforms issued. **Accident & Emergency Operations (A&E)** Increased use of Private Ambulance Crews to support Integrated Transport. Implemented 'Duty to Rescue' process during significant handover problems together with the testing for W45 (45m maximum wait). Maximised operation hours through annual profiling. **Emergency Planning Resilience and Response (EPRR)** MAI Business Case supported by ICBs subject to funding availability.	**Remote Patient Care** Continue discussions with stakeholders around Board Supported Band 3 to Band 4 career pathway, **Emergency Operations Centre (EOC)** Maximise the opportunities for preceptorship for recently trained remote clinical assessors. This is a limiting factor. Continue the implementation of the new EOC structure. **Integrated Urgent Care (IUC)** Continue next stages of the implementation of IUC Transformation Programme (Case for Change) Continue to reduce agency and increase direct recruitment. **Accident & Emergency Operations (A&E)** Incorporate 'in extremis' actions into REAP 4. Complete the operationalising of the 'Duty to Rescue' and the 45-minute maximum wait model. **Patient Transport Service (PTS)** Continue to progress Eligibility on behalf of commissioners for delivery from 1st April 2025. Implement the PTS efficiency schemes of PTS. Increased fleet from July 2024, from 437 to 498 **Emergency Planning Resilience and Response (EPRR)** Secure ICB funding for the approved MAI Business Case.

Board of Directors (held in Public)
25 July 2024
Agenda Item: 3.5

Of

NHS Yorkshire Ambulance Service NHS Trust

Report Title	Financial Performance as at 30 June 2024 (Month 3)
Author (name and title)	Matt Turner, Head of Financial Management; Louise Engledow, Deputy Director of Finance
Accountable Director	Kathryn Vause, Executive Director of Finance
Previous committees/groups	Finance & Performance Committee 23 July 2024 Trust Executive Group 24 July 2024
Recommended action(s) Approval, Assurance, Information	Information
Purpose of the paper	To inform Trust Board of the current financial position as at month 3, period ending 30 June 2024.
Recommendation(s)	It is recommended that the Trust Board note: - • the Trust's financial performance to 30 June 2024; • the capital expenditure against plan; and • all associated risks.

Executive summary (overview of main points)

- YTD deficit £0.9m, FCOT breakeven
- Overall Forecast variance currently to plan and to be developed over the coming months with efficiency programmes put in place.
- Trust vacancy factor efficiency and the unidentified efficiency target applied in month 3 to services at cost centre level.

Strategic ambition(s) this supports Provide brief bullet point details of link to Trust strategy	Our Patients	
	Our People	
	Our Partners	
	Our Planet and Pounds	Use resources wisely and ensure value for money
Link with the BAF Include reference number (board and level 2 committees only)		4a

Board of Directors (held in Public)
25 July 2024
Financial Performance as at 30 June 2024 (Month 3)

1. SUMMARY

1.1 At month 3, the Trust are reporting a year-to-date deficit of £870k and a forecast break-even position against plan.

1.2 **Key Financial Metrics:**

Income & Expenditure Position:	£870k deficit year to date and breakeven forecast outturn		
Agency Cap:	YTD overspend £608k against cap. FCOT overspend £619k against cap.		
Cash:	Month end balance £50.6m		
		Volume	Value
BPPC YTD:	**Non NHS**	96%	95%
	NHS	97%	100%
Capital:	**Purchased assets:** YTD underspend of £163k. FCOT breakeven.		
	Leased Assets: YTD zero spend and plan. FCOT breakeven.		
Cost savings / efficiencies Delivery:	The Trust is currently reporting underperfomance against the cost savings plan. YTD £579k under plan. FCOT £1,107k under plan		

2. MONTH 3 POSITION

2.1 The Trust-wide summary financial position at month 3 is shown below at table 1, with more detail at directorate level shown at table 2.

2.2 Trust pay budgets reflect the agreed vacancy factor and unidentified efficiency targets. Overall, there is a small YTD underspend.

2.3 Non-pay expenditure is slightly higher than plan and reflects the use of additional private providers for improving Cat 2 performance. Additional funding is available to offset this.

2.4 **Agency** spend is £2m YTD and exceeding our agency cap by £608k. The majority of this expenditure is within IUC. Agency usage should reduce later in the year as part of the IUC case for change implementation.

	Year to date (June 24)			Full Year 2024/25		
	PLAN	ACTUAL	VARIANCE	PLAN	ACTUAL	VARIANCE
	£000			£000		
Income	(103,617)	(102,811)	806	(414,468)	(413,772)	696
Pay	77,618	77,356	(262)	315,635	314,982	(652)
Non Pay	26,191	26,325	134	98,833	98,789	(44)
(Surplus)/Deficit	**192**	**870**	**678**	**-**	**(0)**	**(0)**

Table 1: Financial Performance M3 - Summary Trust Position

Summary Directorate Position

	Year to Date (Apr - Jun)			Forecast		
	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000
Income (excluding MHIS)	(98,169)	(98,131)	38	(392,676)	(392,604)	72
Block Income	**(98,169)**	**(98,131)**	**38**	**(392,676)**	**(392,604)**	**72**
Income	-	(12)	(12)	-	(12)	(12)
Pay	215	241	25	862	958	96
Non Pay	-	5	5	-	18	18
Chief Operating Officer	**215**	**234**	**18**	**862**	**964**	**102**
Income	(610)	(544)	66	(2,441)	(2,057)	384
Pay	43,271	43,751	480	176,199	177,617	1,418
Non Pay	2,105	2,185	81	6,697	7,209	511
A&E	**44,765**	**45,392**	**627**	**180,455**	**182,769**	**2,314**
Income	-	(36)	(36)	-	(69)	(69)
Pay	6,599	6,293	(306)	26,396	25,563	(833)
Non Pay	295	307	12	838	843	5
EOC	**6,894**	**6,564**	**(330)**	**27,234**	**26,337**	**(897)**
Income	-	-	-	-	1	2
Pay	6,802	7,853	1,051	28,909	30,329	1,420
Non Pay	221	292	71	884	1,058	174
NHS 111	**7,023**	**8,145**	**1,123**	**29,793**	**31,388**	**1,594**
Income	-	(104)	(104)	-	(346)	(346)
Pay	5,386	5,663	277	21,545	22,786	1,241
Non Pay	3,826	4,306	480	15,302	16,190	888
Patient Transport Services	**9,212**	**9,865**	**653**	**36,847**	**38,630**	**1,783**
Income	(577)	(583)	(6)	(2,306)	(2,406)	(100)
Pay	2,809	2,717	(92)	11,235	11,276	40
Non Pay	364	331	(33)	1,455	1,554	99
Central Services	**2,596**	**2,465**	**(131)**	**10,384**	**10,424**	**40**
Income	(1,275)	(580)	695	(5,100)	(4,522)	578
Pay	568	420	(148)	2,272	2,125	(148)
Non Pay	718	62	(655)	2,871	1,644	(1,227)
Mental Health	**11**	**(97)**	**(107)**	**43**	**(754)**	**(797)**
Income	(2,986)	(2,721)	266	(11,944)	(11,299)	646
Pay	11,758	10,271	(1,488)	47,293	45,715	(1,578)
Non Pay	16,847	18,545	1,698	67,390	68,286	897
Support Services	**25,620**	**26,095**	**475**	**102,738**	**102,703**	**(35)**
Income	-	(100)	(100)	-	(456)	(456)
Pay	210	148	(62)	924	(1,385)	(2,309)
Non Pay	1,815	291	(1,525)	3,395	1,985	(1,409)
Reserves	**2,025**	**338**	**(1,687)**	**4,319**	**144**	**(4,175)**
(Surplus)/Deficit	**192**	**870**	**678**	**(0)**	**(0)**	**(0)**

Table 2: Financial Performance M3 – Summary Directorate Position

3. CASH

3.1 At 30th June 2024, the Trust had cash balances of £50.6m compared with £60.1m at 31st March 2024.

The reduction is due to the final HMRC payment for last year being made in April (£6.1m) and ICB Contract Income for M1-3 remaining at 23/24 levels whilst 24/25 contracts were being finalised. The shortfall of £4.35m has been rectified in month 4 invoices.

4. PAYABLES PERFORMANCE

4.1 The Better Payment Practice Code (BPPC) requires NHS bodies to pay 95% of all valid invoices (by volume and by value) by the due date or within 30 days of receipt, whichever is later.

4.2 The table below summarises the monthly and year-to-date BPPC performance.

Table 3: Monthly BPPC performance - Overall percentage paid within 30 days

Category	Mar-24	Apr-24	May-24	Jun-24	YTD
Invoice Volume	94%	96%	97%	95%	96%
Invoice Value	95%	98%	96%	81%	95%

5. STATEMENT OF FINANCIAL POSITION

5.1 The SoFP at any year end reflects the timing of transactions and matters which may be specific to that year end.

	30-Jun-24	31-Mar-24
	£m	£m
Non-current assets	**144.0**	**147.9**
Current assets		
Inventories	2.4	2.4
Trade and other receivables	18.1	13.5
Cash and cash equivalents	50.6	60.1
Total current assets	**71.1**	**76.1**
Current liabilities		
Trade and other payables	(35.4)	(40.6)
Borrowings	(6.3)	(6.3)
Provisions	(2.8)	(2.0)
Total current liabilities	**(44.5)**	**(48.9)**
Total assets less current liabilities	**170.6**	**175.1**
Non-current liabilities		
Borrowings	(12.5)	(15.2)
Provisions	(7.3)	(8.2)
Total non-current liabilities	**(19.8)**	**(23.4)**
Total net assets employed	**150.8**	**151.7**
Financed by		
Public dividend capital	94.4	94.4
Revaluation reserve	22.5	22.5
Income and expenditure reserve	34.0	34.8
Total taxpayers' and others' equity	**150.8**	**151.7**

Table 4: Statement of Financial Position

6. SYSTEM POSITION

6.1 YAS provide a regional service across 3 ICB footprints although planning activities and financial performance monitoring are undertaken through a single host system; West Yorkshire Integrated Care System (WY ICS).

6.2 On 12 June 2024 the WY system submitted a £50m deficit financial plan. This plan is owned by all system partners, and we will utilise peer review and mutual accountability to review/improve as necessary.

6.3 The expenditure controls imposed in the previous financial year remain in place.

7. RECOMMENDATIONS

7.1 It is recommended that the Board note:

- the Trust's financial performance to 30 June 2024
- all associated risks.

Yorkshire Ambulance Service NHS Trust

Board of Directors (held in Public)
25 July 2024
Quality Committee Chair's Report
Report of the Quality Committee Chair

Report from: Quality Committee
Date of meeting: 21 June 2024

Key discussion points at the meetings and matters to be escalated to board:
Alert:
Nothing to report.
Advise:
The Committee reminds the Board that there were still long response times to some of our patients and that we should not accept this was becoming normalised. During the month before the QC meeting, 300 patients awaiting a CAT 1 response waited more than 30 minutes, and 732 patients awaiting a CAT 2 response waited more than 80 minutes. These times are 2 x 90th centile response standard. Although this month shows a marginal improvement, we need to focus on improving this position. The Committee continues to closely monitor the risk and resulting actions relating to 'Right Care Right Person'. Whilst YAS continues to make sure we have in place operational plans to deal with the issues relating to RCRP there continues to be a number of cases that have been referred to the Coroner from the Humberside area. The committee continues to monitor the risk relating to Controlled Drugs which remains an active risk. The Quality Improvement enabling plan was approved with minor amendments to be recommended to the Board.
Assure:
The committee received assurance on the following: • General update on safety and performance • Updated committee Terms of Reference
New risks identified: No new risks were identified.

Report completed by: Anne Cooper, Non-Executive Director/Quality Committee Chair.
Date: 15/07/2024

Board of Directors (held in Public)
25 July 2024
Agenda Item: 3.7

Report Title	Quality & Clinical Highlight Report
Author (name and title)	Dave Green, Executive Director of Quality & Chief Paramedic; Dr Julian Mark, Executive Medical Director
Accountable Director	Dave Green, Executive Director of Quality & Chief Paramedic; Dr Julian Mark, Executive Medical Director
Previous committees/groups	Individual subjects discussed at: TEG, Quality Committee, Clinical Governance Group
Recommended action(s) Approval, Assurance, Information	Information
Purpose of the paper	To update on highlights, lowlights, issues, actions and next steps in relation to Quality and Clinical areas.
Recommendation(s)	Provide oversight on the clinical effectiveness and quality of care delivered, including the areas of improvement identified.

Executive summary (overview of main points)

The report is a highlight/lowlight summary report.

Strategic ambition(s) this supports Provide brief bullet point details of link to Trust strategy	Our Patients	Deliver high-quality patient care and achieve the Ambulance Clinical Outcome measures. Continually develop, providing both conditions and opportunities for all our teams to thrive in a research-active environment, and embed quality improvement throughout the Trust.
	Our People	
	Our Partners	Listen and respond to patients, partners and communities to develop and deliver high-quality care, which is continuously improving. Work collaboratively with all partners to achieve better experiences and outcomes for patients optimising all our collective skills and valued resources. Work in partnership to maximise benefit of our collective knowledge with academic and education partners and be a leading service provider in partnership with voluntary, community and social enterprise partners.
	Our Planet and Pounds	Ensure decisions are informed by evidence, research, data and intelligence. Develop and deliver improvement, through learning and adoption of best practice
Link with the BAF Include reference number (board and level 2 committees only)		3a) Capacity and capability to plan and deliver the Trust strategy, transformation and change 3b) Ability to influence and respond to change in the wider health and care system

QUALITY AND CLINICAL 25 July 2024

Highlights	Lowlights
Patient Safety • A revision of the terms of reference to the Trust Learning Group (now re-named the Patient Safety Learning Group) has been undertaken. PSLG focusses on learning and improvement from incidents (from all sources) and clinical audit. • 2 x local PSIRF themes and suggested learning were presented at PSLG in April and June meetings. The first being 999/IUC telephony concerns and Care of patients who have fallen in our care. These were presented in a paper to Quality Committee in July. • YAS now have three Patient Safety Partners (PSP) and they are encouraged to engage with After Action Reviews, Low, No Harm, Quality Committee and recruitment activities. **Patient Experience** • As part of the ongoing review of the complaints process, complaints are being discussed at Local Incident Review Groups (LIRG) for South and EOC during the early stages of a complaint being received. It is planned for this to be rolled out across the Trust over the next few months. • Critical Friends Network (CFN) continue to meet every six weeks and have been supporting or contributing on a number of issues and projects including the patient belongings project, specialist moving and handling equipment project and review of the Clinical Safety Plan scripts for EOC. **Clinical Effectiveness and research** • The YAS-sponsored and hosted NIHR Health Services and Delivery Research-funded study “impact and care trajectory for ambulance patients who have a long lie after a fall” has begun (income of £750,000 over 27 months). • CRASH-4 trial (TXA in mild TBI) ongoing, with new sites opening in South Yorkshire shortly. A total of 81 participants have been recruited. • YAS are preparing to open the SPEEDY study which aims to improve access to thrombectomy for stroke patients across East and South Yorkshire. • The clinical audit team have launched their newly developed clinical audit app and have been utilising this to conduct the national ambulance clinical outcome indicators (AmbCO) audits, this has pushed the team one step further towards the goal of more effectively reporting this clinical data at clinician level. • The integrated performance report (IPR), now contains unverified as well as verified clinical data, moving us one step further to our goal of automation. This means more effective clinical decision making based on timely data. • Work continues on the new clinical data mart as part of a move to improve our data warehousing across the trust with the ambition to better join our data, to tell our patient story. **Compliance, quality assurance and quality improvement** • A routine engagement meeting has been held with CQC colleagues with positive feedback following this.	**Patient Safety** • Delayed handover and delayed response have been highlighted from the data collection and thematic review from Q1 and are now being reviewed as a Patient Safety Incident Investigations (PSII) • On scene decision making, this has already been highlighted as local PSIRF theme and is due to be presented at PSLG in July. **Patient Experience** • Staffing challenges in the patient relations team during Q4 of last year and Q1 this year. This has meant that each coordinator has been carrying a higher number of cases during this time, this has meant a decline in performance for closing cases in the agreed timeline with complainants. The team are now back to full establishment and a recovery plan is in place. • Formal complaint themes remain static with attitude, call handling and clinical care remaining the top three reasons. Delayed response complaints have decreased over the quarter. **Clinical Effectiveness and research** • A costed extension to the RADOSS (Risk of Adverse Outcomes after a Suspected Seizure) research study has been agreed by the NIHR (study funder) due to delays with the availability of the linked data set required for the primary outcome. • ePR usage has recently remained below 90%, meaning continued increase in demand on the health records team, however we now have two substantive posts within the team to mitigate this. **Compliance, quality assurance and quality improvement** • Adherence to the Controlled Drugs (CD) signing out process by some frontline clinicians is still a concern and further work is underway to address the issue. • Adherence of bare below the elbow for some frontline staff.

• The QI Enabling Plan has been updated and gone through a number of groups and committees following feedback from Board and will be presented again for sign off at Board on the 25 July. • Clinical Supervision Framework, a working group has been established and is meeting on a regular basis. 199 staff have attended clinical peer review sessions, these were a mixture of Newly Qualified Paramedics (NQP) and Critical Care Paramedics.	

Key Issues to Address	Action Implemented	Further Actions to be Made
• The adherence to the CD policy by some clinical staff in regard to joint signatures and following process.	• Clinical peer support sessions implemented • Engagement with wider Trust and colleagues of QI Enabling Plan.	• Further communication to frontline staff regarding the adherence to bare below. • Facilitate for staff clinical peer support sessions c.700 by end of Q3. • Engagement and communication briefings for staff for Clinical Supervision Framework.

Trust Board (in Public)
25 July 2024
People Committee – Chair's report
Item 3.8

Report Title	People Committee – Chair's report
Author (name and title)	Tim Gilpin, Non-Executive Director/Chair of People Committee Suzanne Hartshorne, Deputy Director of People
Accountable Director	Mandy Wilcock, Director of People
Previous committees/groups	N/A
Recommended action(s)	Assurance/Information
Purpose of the paper	The report provides highlights of the People Committee to provide assurance to the Trust Board.
Recommendation(s)	The Board are asked to note the contents of the report.

Executive summary (overview of main points)

The report provides highlights of the People Committee to provide assurance to the Trust Board. The paper aims to update the board on discussions taking place to reduce the risks as set out in the Board Assurance Framework.

Strategic ambition(s) this supports. Provide brief bullet point details of link to Trust strategy.	Our Patients	
	Our People	- Invest in developing our people (staff and volunteers), ensuring they have the skills, support and resources they need to deliver high-quality care and services, now and in the future. - Invest in leadership development to ensure that our people are well supported by their exceptional leaders. - Ensure our culture is one where our people are listened to, encouraged and enabled to speak up when they have concerns about patient or colleague safety and wellbeing, or when they have suggestions for how the Trust might be better run. - Become a great place to work and volunteer, with staff survey engagement and feedback scores above average for the NHS. - Improve staff health, wellbeing and attendance, reducing sickness rates to better than the NHS average.
	Our Partners	
	Our Planet and Pounds	Use our resources wisely and ensure value for money.
Link with the BAF Include reference number. (board and level 2 committees only)		2a, 2b, 2c

Highlight Report

Report from: People Committee

Date of the meetings: 9 July 2024

Key discussion points at the meetings and matters to be escalated to board:
Alert:
None
Advise:
None
Assure:
Meeting of 9 July 2024 The Committee was quorate and:- • Received and noted the risks aligned to the People Committee. Noting the new risks relating to national minimum wage and staff being underpaid due to salary sacrifice agreements and employment checks for student paramedics. The Committee also noted the closure of risks relating to job evaluation and C1 driver training. • Received and noted the highlight report from the People & Culture Group. • Received and noted the metrics relating to the BAF on the Committee dashboard. The Committee were pleased with the progress of the dashboard but wished to see developments relating to trajectories to be able to determine if the Trust are off-track and where focussed attention is required. • Received and noted the progress on recruitment and retention. The Committee were assured on progress but wished to continue oversight to ensure current trajectories remain on-track. • Received and noted the Staff Survey Improvement Road map and were assured that the right priorities have been identified. This will proceed to the Trust Board. • Received and noted the progress on YAS Together as well as the work towards the achievement of the NHS People Promise. • Received and praised the work of Emergency Operations Centre on health and wellbeing through a Staff Story presentation on Active Workstations. • Received and noted the work to reduce sickness absence. Although the Committee were assured that progress was going in the right direction, they wished to see more forecasting on the likelihood of meeting the targets, with focussed action on any potential shortfalls. • Received and noted the Workforce Race and Disability Standards data. The Committee discussed the recruitment metric at length, with concern that this metric is deteriorating, but that gaining data on reasons, is difficult. The Committee asserted that efforts need to be invested to support articulation of what resources and changes need to happen. Also, where support needs to be enlisted outside of the organisation. • Received and noted the employee relations report, which detailed efforts of the Trust in dealing with sexual safety issues.

• Received and approved the Committee's terms of reference, with an amendment to the number of times the Committee will meet annually – current document references 10 meetings, but there are 6 meetings as the Committee meets bi-monthly.
Risks discussed: New risks relating to the national minimum wage, employment checks for student paramedics as well as those closed or downgraded on the Corporate Risk Register.
New risks identified: • None

Report completed by: Tim Gilpin, Non-Executive Director, Chair of People Committee, Suzanne Hartshorne, Deputy Director of People
Date: 12 July 2024

Board of Directors in Public
25 July 2024
Item 3.9 People & Organisational Development Highlight Report

Report Title	People Directorate: Executive Report
Author (name and title)	Suzanne Hartshorne, Deputy Director of People Dawn Adams, Associate Director of Education & OD
Accountable Director	Mandy Wilcock, Director of People
Previous committees/groups	N/A
Recommended action(s) Approval, Assurance, Information	Assurance/Information
Purpose of the paper	The report provides a brief overview of the highlights, lowlights, and risks within the services in the People Directorate. The paper aims to update the board on key successes and outcomes and current/future projects.
Recommendation(s)	The Board are asked to note the contents of the report.

Executive summary (overview of main points)

The report provides a brief overview of the highlights, lowlights, and risks within the services in the People Directorate. The paper aims to update the board on key successes and outcomes and current/future projects.

Strategic ambition(s) this supports. Provide brief bullet point details of link to Trust strategy.	Our Patients	
	Our People	- Invest in developing our people (staff and volunteers), ensuring they have the skills, support and resources they need to deliver high-quality care and services, now and in the future. - Invest in leadership development to ensure that our people are well supported by their exceptional leaders. - Ensure our culture is one where our people are listened to, encouraged and enabled to speak up when they have concerns about patient or colleague safety and wellbeing, or when they have suggestions for how the Trust might be better run. - Become a great place to work and volunteer, with staff survey engagement and feedback scores above average for the NHS. - Improve staff health, wellbeing and attendance, reducing sickness rates to better than the NHS average.
	Our Partners	
	Our Planet and Pounds	
Link with the BAF Include reference number. (board and level 2 committees only)		2a, 2b, 2c, 2d

People Directorate, Executive Report

Highlights	Lowlights
• **Recruitment trajectory** – Q1 recruitment has been strong for Ambulance Support Workers (ASW) and Associate Ambulance Practitioners (AAP) (102% planned training places) with strong future pipelines in place for ASW, AAP and Paramedics. On track to achieve delivery of 100% training requirement. 'New Starters to YAS Academy' quality improvement initiative Rapid Process Improvement workshop is complete with 'Readiness to Learn' pilot taking place for the autumn ASW intakes. • The **Succession Planning** toolkit was launched in June 2024 with Directorates asked to complete their plans by end of Q3. To our knowledge, the toolkit is the first NHS succession planning tool, hence there has been considerable external interest in our roll out. Progress will be monitored by the YAS Together Programme Board. • **People Promise Exemplar** – People Promise Manager (PPM) is in place until March 2025 with collaborative development of 2024/25 priorities based on a self-assessment and review of relevant data sets including turnover, sickness absence and National Staff Survey (NSS23) results. The work includes work from the Culture Review of Ambulance Trusts. There is strong engagement in communities of practice at national, regional and sector levels. Priorities include flexible working, talent management, culture dashboard, inclusive recruitment and induction and onboarding. • **YAS Together** – priorities identified through People Promise are aligned to the YAS Together pillars and shared with key stakeholder groups including Trade Unions, as 'YAS Together, Our Culture Programme'. A Talent Management Workshop is scheduled for 9 August with engagement from NHSE Talent Management Team. • The **National Staff Survey (NSS) 2023** outcomes have been used to create the YAS Improvement Roadmap and inform the People Promise Exemplar priorities. By implementing the People Engagement Process, enabling local directorate and team ownership of the survey outcomes, data and intelligence. A variety of information has been shared with stakeholders to inform thinking for high level and localised commitments to making improvements and identifying priorities to create 'Our Voice, Our Commitment' for YAS.	• **Appraisal compliance** – there has been a notable upturn in Q1 to 80.4% compared to a relatively static position across 2023/24 (73.7% end of March 24). Training compliance is 83.9% (target 90% both measures). The Senior Leader appraisal window ran Apr-June contributing to this increase however, compliance is at 65.1% (18 Jul). Targeted support being provided including the recording of completed appraisals on ESR. • Total **sickness absence** for June 2024 was 6.3%; slightly higher than in June 2023. Total absence for June 2024 comprised of 2.8% short term and 3.5% long term. The work of the Sickness Absence Group continues with a focus on compliance with day one callbacks, return to work meetings and adherence to trigger points. • **Sexual Safety Charter -** Since the 6-month post charter review a working group has been set up (Chaired by Clare Ashby, Deputy Director of Quality with Alison Cockerill, Head of People Services as Vice Chair). This group meet fortnightly and their current priorities are with regards to a training plan, and finalising the ongoing communications strategy to improve engagement across the organisation on this agenda. Connections have been made with colleagues from West Yorkshire Police to share learning from their experience in this area. As at end of May 24 there were a total of 17 open disciplinary cases, of which 9 were linked to sexual safety. Also at this point there were 8 members of staff who were suspended from the Trust, 5 of which were linked to sexual safety. June 2024 saw the launch of the Professional Standards Panel. The group oversee decisions regarding Suspensions, Professional Body referrals, HPAN (Healthcare Professional Alert Notification) referrals, Requests for ESAs (Early Sanction Agreements) in sexual safety & discrimination cases and some high-risk recruitment decisions. It provides increased seniority to decision making on behalf of the Trust in this area and ensure further consistency across service lines. Training for very senior managers in the Trust who will be hearing these cases is scheduled for September 24. • **WRES Metric 2 -** Relative likelihood of white staff being appointed from shortlisting compared to that of BME staff being appointed from

Highlights	Lowlights
• **Employee Relations –** We launched our new Disciplinary Policy in October 2023 and analysis has shown that the average time for proceedings has reduced from 10.6 months to 4.4 months; despite some highly complex cases. There are also early indications from the data available that the amount of work being done by the HR team to address and resolve issues restoratively is having a positive impact on the amount of grievances being managed formally. • **WRES/WDES –** Data submission completed to meet mandatory deadline of 31 May 2024 following TEG approval. The 2024 data is a mixed picture with improvement in a number of areas and issues in others. Overall, the workforce profile has increased for BME (6.2%, 2023 to 7.1%, 2024) and staff living with disabilities (7.79%, 2024 from 5.78%, 2023). Consultation with stakeholders is underway to develop an action plan to address the disparities for BME and Disabled Staff, with approval in Sept '24 aligned to the 3-year EDI Plan. • **AACE Equality and Diversity Improvement Plan for the Ambulance Sector:** The Culture Review of the English Ambulance Services highlighted 6 areas of concern and for imminent action. These included leadership styles that do not adequately support staff to speak up and instances where those who voiced concerns faced intimidation or inaction. A paper with recommendations has been submitted to AACE which aims to support discussion about specific and bold actions to shift the dial on EDI indicators, reduce disparities in recruitment, disciplinary actions and improve the experience of staff from under-represented groups. This plan is intended to support improvement across the UK ambulance sector and governance for delivery of action will sit with the culture review implementation board. Recommendations have been proposed by members of the National Ambulance Diversity & Inclusion Forum **(NADIF)** and build on existing work across Trusts with areas of best practice that can be replicated collaboratively. • The Trust is the winner of the University of Huddersfield **Large Employer of the Year Award** recognising the work across the Trust for all those involved in the Degree Apprentice Paramedic programme. • **Health and Wellbeing Summer campaign Eat, Move Sleep** has had positive engagement with plans to follow the success into a similar approach for the winter campaign.	shortlisting across all posts (The target is 1.0 where BAME and White staff have equal likelihood of being appointed.) The ratio for 2024 has increased again to 2 i.e., White candidates are twice as likely to be appointed over candidates from diverse ethnic backgrounds. The dataset includes candidates that do not accept an offer for interview, or those that fail to attend. The action plan will include proposals to tackle this area. • **WRES Metric 5:** Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months. This has increased for BME staff (41.2%, 2023 to 44.6%, 2024). The action plan will include proposals to tackle this area. • **WDES Metric 4:** Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public, colleagues and managers in last 12 months. Almost half of our staff living with disabilities experience bullying from patients; this has slightly decreased by 2.7% from 2023 (50.2%) to 47.5% in 2024. Disabled staff reporting bullying, harassment and abuse has marginally increased by 0.7% from 2023 (50.6%) to 51.3% in 2024. The action plan will include proposals to tackle this area.

Key Issues/Risks to Address	Action implemented	Further actions to be undertaken
Employment checks for student paramedics – the contract with NHS England mandates the Trust carry out their own employment checks, however the Trust has relied on those undertaken by the Universities	Assessment of the number of checks required. Understanding on whether completed checks can be verified by the Trust or repeated. Understanding of other ambulance service processes and clarification from NHS England. Risk assessment of the issues; consequences are considered to be low.	Establish protocol required for checks to be undertaken. Collation of information from universities for existing students. Engaging with universities to establish a sharing agreement.
Non-compliance with National Minimum Wage (NMW) for staff with salary sacrifice agreements.	Assessment of all staff currently being paid under NMW due to salary sacrifice agreements for vehicles. Where those agreements can be extended with payments made over a longer time period, these have been actioned. Advice received from solicitors in terms of the risk to the Trust. This was established as low. Due to advice that the assessment of eligibility for salary sacrifice arrangements should not include unsocial hours, Standard Operating Procedures have been updated to ensure that the issues do not continue i.e. affordability assessments no longer include unsocial payments in the calculation and are on basic salary only.	Awaiting the annual national pay award as this will bring the majority of staff above NMW. Further assessment in terms of whether salary sacrifice agreements can be terminated with early termination fees paid.

Board of Directors in Public
25 July 2024
Agenda Item: 3.10

NHS Yorkshire Ambulance Service NHS Trust

Report Title	National NHS Staff Survey 2023
Author (name and title)	Paul Whitehouse - Head of Leadership and Organisational Development
Accountable Director	Amanda Wilcock - Director of People and Organisational Development
Previous committees/groups	People Committee 09.07.2024 People and Culture Group 28.06.2024
Recommended action(s) Approval, Assurance, Information	Assurance, Information
Purpose of the paper	Provide assurance for the group that the outcomes of the National Staff Survey 2023 have been considered, rolled out and used to inform an ongoing plan for engagement and improvement.
Recommendation(s)	The Board is asked to note the contents.

Executive summary (overview of main points)

The aim is to provide the assurance that the outcomes of the National Staff Survey 2023 have been utilised to create the YAS Improvement Roadmap by explaining:

- how we have used the data and what it is telling us.
- the process adopted to play back the data and intelligence and seek the high-level commitments across the organisation.
- the identified Trust priorities, how they have been identified and the high level and localised commitments to making improvements and the next steps.

Strategic ambition(s) this supports Provide brief bullet point details of link to Trust strategy	Our Patients	
	Our People	• Ensure our culture is one where our people are listened to, encouraged and enabled to speak up when they have concerns about patient or colleague safety and wellbeing, or when they have suggestions for how the Trust might be better run. • Become a great place to work and volunteer, with staff survey engagement and feedback scores above average for the NHS.
	Our Partners	
	Our Planet and Pounds	
Link with the BAF Include reference number (board and level 2 committees only)		2c

Board of Directors Meeting in Public
25 July 2024

National NHS Staff Survey 2023

1.0 Summary

1.1 This paper aims to provide the Trust Board with assurance as to how the National Staff Survey (NSS) 2023 outcomes have been used to create the YAS Improvement Roadmap and inform the People Promise Exemplar and YAS Together Culture Programme priorities.

1.2 The NSS23 response rate was significantly improved at 51% with all People Promise element and theme scores improved, the majority showing a statistically significant increase, giving a two-year improvement trend.

2.0 Background/Context

2.1 The NHS Staff Survey collates the views and experiences of staff working in the NHS and is administered annually during the autumn by NHS England. Participation is not compulsory, although NHS Trusts are strongly encouraged to use it as an opportunity to canvass staff for their opinions and views, and encourage as many employees as possible to complete the questionnaire.

2.2 All the results are derived from weighted data, which allows for fair comparisons between organisations of different sizes. The results are presented in the context of the best, average, and worst results for similar organisations in sector, i.e., Ambulance Trusts.

2.3 The NSS23 was held from 02 October - 24 November 2023. All staff receive their surveys online except for those on maternity/paternity/adoption leave and long-term sick <90 days, who receive paper copies.

2.4 The People Engagement Process has been introduced for the NSS23 results, see below, enabling local directorate and team ownership of the survey outcomes, data and intelligence. This is in addition to how the results are used to inform Trust priorities, baseline measures and impact metrics.

Fig 1- People Engagement Process

2.5 For the first quarter of 24/25, **'Playback and listen'** has involved sharing the information with all stakeholders, taking time to listen to reactions and responses and enable deeper dives into the data, when and where required, to inform further discussion. **'Identify and plan'** has included encouraging stakeholders to identify key areas of improvement or where they would like to focus their thinking to inform their commitments to improvement.

3.0 2023 Staff Survey Results Highlights

3.1 A summary of the survey results has been made available to all employees on the Pulse Intranet site (NSS23 Results), this includes a video recording of a narrated PowerPoint (Video NSS23). The results have also been promoted on TeamBrief Live and frequently in the Staff Update. The National Staff Survey results are available publicly at National results across the NHS in England | NHS Staff Survey (nhsstaffsurveys.com) with specific YAS reports accessed via the 'Local Results' option.

3.2 The NSS23 saw a 50% increase in the response rate, up from 34% in both 2021 and 2022 to 51%. This was the highest response rate ever achieved for YAS and a result of visible executive leadership support, varied and sustained engagement with colleagues and the first-time use of incentives. It was also in line with the sector average response rate of 51.81% (highest 68.40%).

3.3 Improvements across all People Promise and the additional themes of 'Staff engagement' and 'Morale' were seen, with all but two of these improvements deemed statistically significant. This continues the improvement trend seen from 2021 to 2022, with generally an increase of >1,000 respondents for each theme.

People Promise Element	2021 score	2021 response	2022 score	2022 response	2023 score	2023 response	Statistical change
We are compassionate and inclusive	6.5	1916	6.8	1991	7.0	3125	Significantly higher
We are recognised and rewarded	4.9	1910	5.1	1980	5.4	3125	Significantly higher
We each have a voice that counts	5.8	1909	6.0	1984	6.1	3110	Not significant
We are safe and healthy	5.3	1914	5.4	1986	5.7	3120	Significantly higher
We are always learning	4.1	1776	4.7	1898	5.1	2948	Significantly higher
We work flexibly	5.2	1905	5.4	1974	5.5	3109	Not significant
We are a team	5.6	1914	6.1	1987	6.3	3120	Significantly higher
Themes							
Staff engagement	5.9	1917	6.0	1992	6.2	3128	Significantly higher
Morale	5.3	1917	5.4	1992	5.7	3128	Significantly higher

Scores are out of 10
Response numbers are how many people completed the relevant questions.

3.4 The sector-based benchmarking data (page 12) shows YAS above average in all themes and for the ten Ambulance Trusts in England only (Isle of Wight data removed), YAS is in a favourable position but with definite room for improvement.

We each have a voice that counts	1st
We are always learning	1st
Engagement	1st
Morale	1st
We are compassionate and inclusive	2nd
We are safe and healthy	3rd
We work flexibly	3rd
We are a team	3rd
We are recognised and rewarded	5th

3.5 As an NHS England People Promise Exemplar site, the NSS23 results were used to complete the organisational self-assessment using the People Promise themes and inform the improvement priorities. The NSS23 data has been reviewed in conjunction with other relevant data, e.g., turnover, sickness absence, appraisal completion, and diversity reporting data.

3.6 The People Promise improvement themes and associated plan, have been shared regionally and with the Ambulance sector to enable collaborative working and the sharing of good practice. For example, flexible working has been identified as a key and common improvement priority area, where a sector-wide approach is being adopted with support from the NHS England Flexible Working Team.

3.7 The People Promise themes and improvement priorities have been aligned to the five YAS Together pillars of Lead, Everyone, Excel, Grow and Care Together. The YAS Together Programme underpins the YAS Strategy and is the way we work to achieve to our vision.

3.8 The Women and Allies' Network requested the NHS NSS 2023 data to complete a deep dive using demographic data regarding sexual safety, the data insights were used to inform the network's key priorities for 24/25.

3.9 A thematic analysis of free text responses was conducted and shared with key stakeholders.

4.0 'Our Voice, Our Commitment'

4.1 On receipt of the NSS23 data and results, a variety of directorate and team-specific information, data and intelligence reports have been shared with stakeholders, facilitated and supported by Leadership and Organisational Development Business Partners, to stimulate discussion and ideas generation leading to the development of high-level commitments and improvement priorities.

4.2 These sessions have taken place throughout Quarter 1 of 2024/25 facilitating the play back of the data and intelligence, listening to stakeholders and empowering the development of local improvement actions and plans.

4.3 See the 'Supporting Information' section for examples of local improvements against the People Promise priority themes, highlighting projects and improvement actions included on the YAS Together Culture Programme 24/25.

4.4 The Simply Do innovation platform is also being used to launch challenges specific to the 'We are recognised and rewarded' and 'We each have a voice that counts' themes to engage all YAS staff on ideas to improve.

4.5 'Our Voice, Our Commitments' will be created with local teams and senior leaders to enable a cohesive and robust rollout of the YAS Improvement Roadmap including communicating to all staff members. Communications are designed to be local as well as Trust-wide, and frequent to show how the National Staff Survey and Quarterly People Pulse results are used to inform changes and improve workplace experiences.

4.6 The storyboarding and recording of a video is currently in progress using a variety of different members of staff to explain the improvements that have been made following NHS NSS23. The video will be available to all staff in August 2024.

5.0 Equality Analysis

5.1 The National Staff Survey data informs specific metrics on staff experience and parity between particular staffing groups on the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) data. The 2023/24 data submission was completed to meet mandatory deadline 31 May 2024 and stakeholder engagement is ongoing to develop an action plan to address identified disparities to help improve staff experience.

6.0 Next Steps

6.1 The NSS23 'Our Voice, Our Commitments' video will be finalised and promoted to all staff to communicate how their feedback has been used making improvements to their workplace experience.

6.2 Data insights from both the National Staff Survey and Quarterly People Pulse Survey, in conjunction with other relevant data sources and directorate/team engagement, will be used to inform decision making and improvements. Teams are encouraged to use their own communication channels to share how the data has been used, sharing examples of the difference improvements have made.

6.3 Implement the People Engagement Process to sustain the positive engagement in both NSS and QPPS, aspiring to achieve further improved response rates. The success factors that contributed to the positive increase

to the response rate for NSS23 will be continued and enhanced. The engagement and communication plan will be refreshed, and evaluation outcomes of the improvement initiatives used to showcase the 'Our voice, Our Commitments'.

7.0 Recommendations

It is recommended that the Trust board:

a) Note the contents of this National Staff Survey 2023 results paper.

8.0 Supporting Information

Examples of local improvement action and YAS Together priorities informed by the NSS23 results and data insights.

We are safe and healthy
• Say Yes To Respect (SYTR) rolled out to A&E Operations West senior leadership team to address bullying and harassment NSS results • Sexual Safety included in Investment Days for Clinical Directorate and Emergency Preparedness Resilience and Response (EPPR) and Specialist Operations Teams • Introduction of a health and wellbeing room for Patent Transport Service (PTS) employees • Rollout of SYTR in A&E Operations Rotherham • Sexual Safety included in Investment Days for A&E Operations North Team Leaders and teams • Interlinking health and wellbeing NSS data with People Pulse to support and inform decision making • Focus on the importance of compassionate conversations and employee health and wellbeing • Data to better understand the daily stressors and burnout
YAS Together: Our Culture Programme 24/25 priorities
• Compassionate and Inclusive Conversations and embed mental health programme • Launch of anti-racist framework • Violence prevention and reduction – body cameras, communications plan and violence prevention champions • Sexual safety awareness and professional standards panel • Active bystander to upstander programme for all protected characteristics (to include sexual safety)

We are always learning: Leadership and Management
• Proposal for a career progression framework within Ambulance Vehicle Preparation (AVP) • Art of Brilliance and introduction to positive psychology for leaders within Integrated Urgent Care (IUC). • Practical exercises for wellbeing and resilience for leaders to apply daily • Employee and team leader huddles to give team leaders and employees a voice to be heard (linking with our People Promise 'we each have a voice that counts) • Leadership development programmes – Manage2Lead, Aspiring Leaders, Lead Together, Compassionate Conversations, Say Yes To Respect (SYTR) & Performance Management • A&E Operations South - talent management for aspiring team leaders and senior leadership academic qualifications. Wellbeing dashboard training for team leaders to support employees with mental health. Podcast for clinical learning. • Launch of mentoring, Women and Allies' Network mentoring and reciprocal mentoring programmes.
YAS Together: Our Culture Programme 24/25 priorities
• Promote and embed YAS leadership behaviours framework • Promote and embed the leadership development framework • Embed Restorative Just and Learning culture • Implement outcomes and recommendations of Team Based Working Review • Implement a Talent Management model

We each have a voice that counts
• Newsletter developed to encompass the voice of YAS, covering engagement stories, case studies and promoting benefits for staff, health and wellbeing resources. • Station surgeries in A&E West and A&E South to provide opportunities for employees to feedback and increase visibility of senior leaders. Station surgeries in A&E South are being moved to the wellbeing and visiting hospital sites. • Online application (App) created for daily availability of command/team leaders. Staff able to instantly access details of who is Operational/Tactical Command and other Team Leaders on duty from their mobile phone. • Implemented a South Yorkshire briefing email and leaflets on station. • A&E West improvement plan set up to provide employee input into change and will be monitored Bi-monthly at the People & Culture group meetings. • QR Codes are being set up at the new Huddersfield Emergency Department to gain feedback from staff around issues that arise. • Engagement sessions held with finance and payroll employees to understand their experiences of burnout and collaboratively come up with actions to help improve these areas for improvement. Suggested actions included - a focus on appraisals to ensure all team members have an appraisal annually, sharing of patient experience videos at team meetings to feel connected to patient care, further discussions around ways of working to reduce burnout. • Ensuring Freedom To Speak Up (FTSU) remains confidential to obtain trust and allow people to speak up freely without judgement or repercussion.
YAS Together: Our Culture Programme 24/25 priorities
• Restorative Just and Learning Culture (RJLC) – Develop key staff members in RJLC, adapt and roll out training, embed in relevant services, policies and procedures. • Improve employee engagement with NSS and Quarterly People Pulse Survey – maintain and improve response rates for 2024. • Stay Interviews - Further embed and roll out stay interviews in IUC/EOC. • Exit Process - Review exit process, develop questionnaire, and promote better use/take up.

We are recognised and rewarded
• AVP/Ancillary reward & recognition framework introduced. • Piloting a recognition and appreciation scheme within Emergency Operations Centre (EOC) to understand how people like to be appreciated. • Recognition badges in IUC for colleagues, managers and service users, e.g., 90+ staff celebrated who have been with IUC from day one, ‘10 years’ recognition badges. • A&E West reward and recognition improvement plan with regular monitoring.
YAS Together: Our Culture Programme 24/25 priorities
• Talent management model supported by NHS England Talent Team. • Promote and embed appreciation and recognition guide. • Pensions information availability and case studies.

NHS Yorkshire Ambulance Service NHS Trust

Board of Directors (held in Public)
25 July 2024
Audit & Risk Committee Chair's Report
Report of the Audit & Risk Committee Chair

Report from: Audit & Risk Committee
Date of the meeting: 26 June 2024 and 27 June 2024

Key discussion points and matters to be escalated from the discussion at the meeting:
Alert:
There are no issues arising to alert the board to.
Advise:
The Committee: • Noted potential issues regarding the administration of Right of Use Assets and capacity within the Finance team; it recommended that this be monitored by the Finance and Performance Committee.
Assure:
The Committee: • Approved the annual Counter Fraud plan for 2024/25 via email correspondence. • Received and noted 360 Assurance's Head of Internal Audit Opinion for 2023/24 as Moderate Assurance. This is the second highest level on the assurance scale used by 360 Assurance. • Recommended the Annual Governance Statement 2023/24 to the Board for approval and publication as part of the Annual Report and Accounts. • Approved the 2023/24 Annual Report and recommended it to the Board for approval. • In reviewing the 2023/24 Accounts and Financial Statements, approved a minor change to the Trust's Accounting Polices and approved the non-adjustment of an immaterial error. The Committee approved the 2023/24 Accounts and Financial Statements and recommended them to the Board for approval. • Noted that there were no post balance sheet events requiring disclosure or adjusting nor any non-adjusting post balance sheet events. • Noted the content of the Board's Letter of Representation to Bishop Fleming and recommended it for Board approval (a revision was approved by the Committee on 27 June). • Noted the Draft External Audit Report for Those Charged with Governance – ISA260 Report. A revision to the report was noted at the Committee's meeting on 27 June. • Received and noted the draft Auditor's Annual Report (VFM Commentary). • Received and noted the Trust's self-assessed position regarding compliance with annual report disclosures required by the NHS Code of Governance and endorsed the proposal to seek external validation of the Trust's compliance with the Code during 2024/25. • Reviewed the 2023/24 Provider Licence declarations, G5 and NHS2, and recommended that the Trust Board approves them. • Noted the Corporate Governance Report on Board Members' Interests. • Reviewed and approved the 2023/24 Quality Account and recommended it to the Board for approval. • Noted the 2023/24 Annual Report for Counter Fraud, Bribery and Corruption, including the Trust's Counter Fraud Functional Standard return.
Risks discussed: N/A
New risks identified: N/A

Report completed by: Andrew Chang, Committee Chair, 14 July 2024

NHS
Yorkshire
Ambulance Service
NHS Trust

Escalation and Assurance Report

Report from: Audit & Risk Committee
Date of the meeting: 16th July 2024

Key discussion points and matters to be escalated from the discussion at the meeting:
Alert:
There are no issues arising to alert the board to.
Advise:
The Committee: • Noted that the small uptick in overdue actions, which was reported through Q4 2023/24 and Q1 this year, persists. ARC will continue to monitor the situation, and the board is asked to note that there is a change in 360 Assurance's focus on action clearance for its Head of Internal Audit Opinion for 2024/25. Going forward, more consideration is to be given to the context and culture of action tracking, focusing on implementation of high and medium risk actions. • Noted the inclusion of six new corporate risks since the previous ARC meeting: • Risk 599: Safeguarding Referrals to Local Authorities (15, high risk) • Risk 598: Transportation of Neonates Weighing Less Than 2.5kg (12, moderate risk) • Risk 610: National Minimum Wage (12, moderate risk) • Risk 637: Industrial action by General Practitioners (25, high risk) • Risk 639: Employment checks for Student Paramedics (12, moderate risk) • Risk 640: Procurement Act 2023 (12, moderate risk) Two areas of emerging risk were reported: • International Nurses' Registration • Idling Vehicles • Received and noted the Limited Assurance internal audit report Management of Equipment on Ambulances. The Trust's policy for the Management of Medical Devices was out of date and deficient. Management reported that the policy had subsequently been reviewed and approved. Additionally, staff were not able to clearly say if there was a policy for the management of consumables. On this, it was found that 10% of the consumables reviewed that were on ambulances had expired. ARC considered the quality implications and determined that the Quality Committee should monitor the risk this presents and that it was for directors involved to collectively agree the way forward to overcome the issues raised.
Assure:
The Committee: • Approved the annual Counter Fraud plan for 2024/25 via email correspondence. • Noted the internal audit progress update including the Significant Assurance report IT Business Continuity – IT System Resilience and Disaster Recovery; and the Moderate Assurance report Data Security and Protection Toolkit. • Approved a change to the 2024/25 internal audit plan to defer the Freedom to Speak Up review to the 2025/26 and undertake a review of International Recruitment with a specific focus on recruitment and onboarding. • Noted the update report on the 2024/25 Counter Fraud plan. • Approved the additional external auditor fees of £32,500 (plus VAT). • Noted the report on the Trust's risk management processes and the proposed new Board Assurance Framework that will align with the new Trust strategy for 2024-2029. • Received assurance reports from the Quality Committee, Finance and Performance Committee and the People Committee. ARC considered the apparent differences in approach taken by these committees in their assurance reporting and resolved that the ARC chair convene a meeting of committee chairs to consider further.

• Received assurance reports on Losses and Special Payments, and Standing Financial Instructions Waivers and Contracts over £100k. • Noted the Annual Review of Compliance with Trust Standing Orders and Standing Financial Instructions. • Noted the Procedural Documents update report. • Noted the Clinical Governance and Audit Assurance report. The ARC chair is to consider with the chair of Quality Committee, the continued appropriateness of direct reporting on clinical audits to ARC. • Approved the Annual Report of the Audit and Risk Committee for 2023/24. • Approved the Annual Reports of the Finance and Performance Committee, the Quality Committee and the People Committee for Board approval.
Risks discussed: As listed above.
New risks identified: N/A

Report completed by: Andrew Chang, Committee Chair
Date: 20th July 2024

Trust Board
25 July 2024
Agenda Item: 4.1

Report Title	QI Enabling Plan 2024 - 2029
Author (name and title)	Spencer Le Grove, Head of Quality Improvement
Accountable Director	Dave Green, Executive Director of Quality and Chief Paramedic
Previous committees/groups	Trust Executive Group Strategy Planning – March 24 Quality Committee – April 24 Trust Board – April 24 Trust Executive Group – May 24 Quality Committee - June 24 People Committee – July 24
Recommended action(s) Approval, Assurance, Information	Approval
Purpose of the paper	The purpose of this paper is to seek Trust Board approval of the Quality Improvement (QI) enabling plan 2024 – 2029.
Recommendation(s)	Approve the QI Enabling Plan 2024 – 2029

Executive summary (overview of main points)

Based on the welcomed and recent feedback from Trust Board in April 2024, this item aims to articulate changes to the Quality Improvement (QI) Enabling Plan 2024 – 2029 for Trust Board approval.

In summary, changes made are to ensure that the QI enabling plan clearly articulates how we will embed continuous QI with QI being our way of working, that is everyone's job and how we do business. The main significant changes are:

- Stronger and more explicit alignment to NHS IMPACT and the single, shared NHS Improvement approach (Item – 2.3)
- Identification of roles and responsibilities of our people for QI (QI Enabling Plan, page 6)
- Requirement for Trust Board level commitment (Item – 8.2)

A full summary of changes can be found in **Appendix A – Summary of Changes**

Strategic ambition(s) this supports Provide brief bullet point details of link to Trust strategy	Our Patients	Embedding quality improvement (QI) across the Trust
	Our People	Embed a culture of collective learning and QI
	Our Partners	Improving and developing how we listen to staff, patients, partners and communities to deliver high quality care, which is continuously improving
	Our Planet and Pounds	Embedded cultures of improvement and innovation to transform care delivery
Link with the BAF Include reference number (board and level 2 committees only)		3a

1. SUMMARY

1.1 The purpose of this paper is to seek Trust Board approval of the Quality Improvement (QI) enabling plan 2024 – 2029.

1.2 The aim of the QI enabling plan is to set out how we, as an organisation, will embed QI in everything we do. This supports the Trust Strategy 2024 - 2029, our Trust values, YAS Together, and aligns to the NHS IMPACT single approach for improvement. This will be accomplished by delivering four key components within the QI enabling plan:

- **Learn:** We will grow together by developing improvement capability and capacity so all our people have access to improvement training and support.
- **Engage:** We will lead together by developing leadership behaviours for improvement with a focus on instilling behaviours that enable QI throughout the Trust and are role modelled by our senior leadership community and Board.
- **Analyse:** We will care together by embedding improvement into management systems and processes that builds on our approach to planning, controls, assurance and improvement to support clinically led improvement
- **Network:** We will bring everyone together by investing in culture and our people by having clear ways of sharing learning, experiences, ideas and celebrating success.

2. BACKGROUND

2.1 The previous QI strategy 2018 – 2023 has undergone rigorous evaluation. This learning along with stakeholder engagement, YAS Together cultural review, new Trust strategy and national drivers has informed this QI enabling plan 2024 – 2029.

2.2 The introduction of NHS IMPACT (Improving Patient Care Together) is the new, single, shared NHS improvement approach. NHS IMPACT has set out five domains that forms the 'DNA' of all evidence-based improvement methods, these principles underpin a systematic approach to continuous improvement. When the NHS IMPACT five components are consistently used, systems and organisations create the right conditions for continuous improvement and high performance.

2.3 The diagram below demonstrates the relationship between the NHS IMPACT five domains, QI enabling plan and YAS together:

NHS IMPACT domains	QI enabling plan	YAS Together alignment
Building a share purpose and vision	Trust strategy & QI enabling plan	Excel together
Building improvement capability and capacity	Learn to Improve	Grow together
Developing leadership behaviours	Engage to Improve	Lead together
Embedding improvement into management systems and processes	Analyse to Improve	Care together
Investing in people & culture	Network to Improve	Everyone together

3. QI METHODOLOGY

3.1 The QI enabling plan supports the delivery of the Trusts strategic objectives. At YAS we strive to excel together so we can find ways to improve and innovate, relentlessly pursuing excellence in what we do. Therefore, it is crucial that we have a methodology for QI that everyone is aware of and can use in their daily work from board to all of our people. This will be achieved by continuing to embed the Model for Improvement as our primary QI methodology.

3.2 It is important that we have the right capability to lead improvement and have the ability to utilise varied improvement approaches by our internal experts. Therefore it is important that we continually develop our QI faculity (core improvement team and team QI leaders) in other improvement techniques such as LEAN methodology.

4. QI EDUCATION

4.1 The QI enabling plan set outs a clear educational offer from introduction to QI at YAS which all of our people must complete to QI leaders for those who are team QI leaders to enable people to lead improvement in their area.

4.2 It is of equal importance that Trust board have the right improvement capability and skills to problem frame, coach and sponsor improvement through board development paying attention to the 'dosing model' for improvement science (QI enabling plan – page 11).

5. FINANCIAL IMPLICATIONS

5.1 There are no financial implications specifically to the QI enabling plan, however, Trust Board should be aware of key dependencey for the successful delivery of the QI throughout the Trust which is:

- Funding for formal QI education and development for improvement experts (core team and QI leaders within teams) within the organisation that will support the Trust's capability for improvement

6. RISK

6.1 **IF WE DO NOT** adopt quality improvement as the primary method for addressing challenges at all levels **WE WILL NOT** create optimum conditions for continuous improvement and high performance. **RESULTING IN** not been able to continuously improve high quality care and services that meet the evolving needs of our patients and communities

7. COMMUNICATION AND INVOLVEMENT

7.1 The QI enabling plan 2024 – 2029 has had input from our people, volunteers, and system through:

- Evaluation and learning of QI strategy 2018 – 2023
- Feedback from local teams, Trust Management and Executive Groups, Quality Committee
- Trust strategy engagement
    - Leadership event
    - Integrated Care System engagement workshops
    - Roadshows

    - Crowdsourcing ideas
- Networking across the health economy

7.2 QI will have a developed visual identity to ensure that QI is not seen as a department but as something that is for everyone and demonstrates the importance and committement from the organisation that is placed on improvement.

7.3 The QI enabling plan will have a developed communication strategy in line with other enabling when this is ready to be launched.

8. EMEDDING QI

8.1 To support the embedding of QI in YAS roles and responsibilities for improvement have been defined for Trust Board, Senior Leadership Community, Leaders and our people (QI enabling plan, page 6).

8.2 Key actions are required from Trust Board to support the embedding of QI in YAS which are:

- Working with senior leaders in their teams to identify leaders to undertake QI leaders training to support building capability and capacity for improvement
- Communicate permission to improve from the Board through to middle managers, and problem frame rather than problem solve, giving specific permission to continuously test different ways of working using improvement methodology
- Undertake regular Board development sessions around improvement and share learning and celebrate improvement success at Board

8.2 Throughout 2024 – 2029 the QI team will work to develop a group of ‘QI Leaders’ which will build capacity and capability for improvement. Additionally, ‘QI Leaders’ will join the QI Faculty where they will receive continuous peer support, build social connectiveness and improvement development.

9. RECOMMENDATIONS

9.1 Approve the QI Enabling Plan 2024 – 2029

Appendix A – Summary of Changes

Summary of changes

Page Number	Section	Changes
3	Overview	• Alignment to Trust Strategy highlighting four bold ambitions • Reference added to the NHS Delivery & Continuous Improvement review • Change to wording to be more explicit around expectations to **This Quality Improvement (QI) enabling plan 2024 -2029 aims to set out how we will embed continuous QI with QI being our way of working, that is everyone's job and how we do business.**
4	Our Methodology	• Brought forward within the plan for better coherence and readability • Graphical changes to Model for Improvement inline with visual identity
5	Embedding QI in YAS	• Alignment to Trust Strategy • QI enabling plan components explicitly cite single, shared NHS improvement approach whilst supporting crucial elements of YAS Together • NHS IMPACT Theory of Change added and referenced which reads: **If we…** adopt quality improvement as the primary method for addressing challenges. **We will**…create optimum conditions for continuous improvement and high performance. **So that**…we can provide high quality health and care services that meet the evolving needs of our patients and communities
6 (NEW)	Roles & Responsibilities	• Roles and responsibilities of our people for QI section has been added to support the embedding of QI.
7	Milestones	• Brought forward within the plan for better coherence and readability
8	Learn to improve	• Headline change to reflect changes made in page 5 to explicitly cite single, shared NHS improvement approach • Language change “How this will be embedded” rather than “What we will do…” NOTE: This is replicated throughout all 4 elements (Learn, Engage, Analyse & Network)
9	Learn to Improve - YAS QI Faculty	• Language changes to be more explicit around what this consists of: o QI Fellows who complete their Fellowship o Team QI Leaders (QI Leaders are staff who have completed the three-day QI Leader course and post course assessment)

		o Core QI Team • This is based on the East London NHS Foundation Trust approach of having local support for QI Help & Support - Quality Improvement - East London NHS Foundation Trust : Quality Improvement – East London NHS Foundation Trust (elft.nhs.uk)
11	Learn to Improve - Education	• Language change in 'who?' section to reflect our people in the organisation and their roles & responsibilities
12 (NEW)	Learn to Improve – Dosing Model	• Dosing model added to reflect the application of improvement science knowledge required by groups within the organisation
13	Engage to Improve	• Headline change to reflect changes made in page 5 to explicitly cite single, shared NHS improvement approach • Language change "How this will be embedded" rather than "What we will do…"
14	Analyse to improve	• Headline change to reflect changes made in page 5 to explicitly cite single, shared NHS improvement approach • Language change "How this will be embedded" rather than "What we will do…"
16	Network to Improve	• Headline change to reflect changes made in page 5 to explicitly cite single, shared NHS improvement approach • Language change "How this will be embedded" rather than "What we will do…"
17 (NEW)	Network to Improve – Social Connectiveness	• Social connectiveness page added to articulate importance of connecting those with improvement skills & knowledge, both within our organisation but with system partners • Social connectivity diagram to illustrate correlation between QI leaders and those capable of applying QI

NHS
Yorkshire
Ambulance Service
NHS Trust

Quality Improvement

Enabling Plan

2024-29

Content

Overview

As a Trust, we believe improvement is a commitment to learning, developing and implementing best practice to deliver better care and services. This is supported by our value of improvement.

This Quality Improvement (QI) enabling plan 2024 -2029 aims to set out how we will embed continuous QI as a part of everything we do. Underpinned by the Model for Improvement as the Trusts QI methodology and aligned with NHS IMPACT, we will embed continuous QI which will support the delivery of the Trusts four bold ambitions:

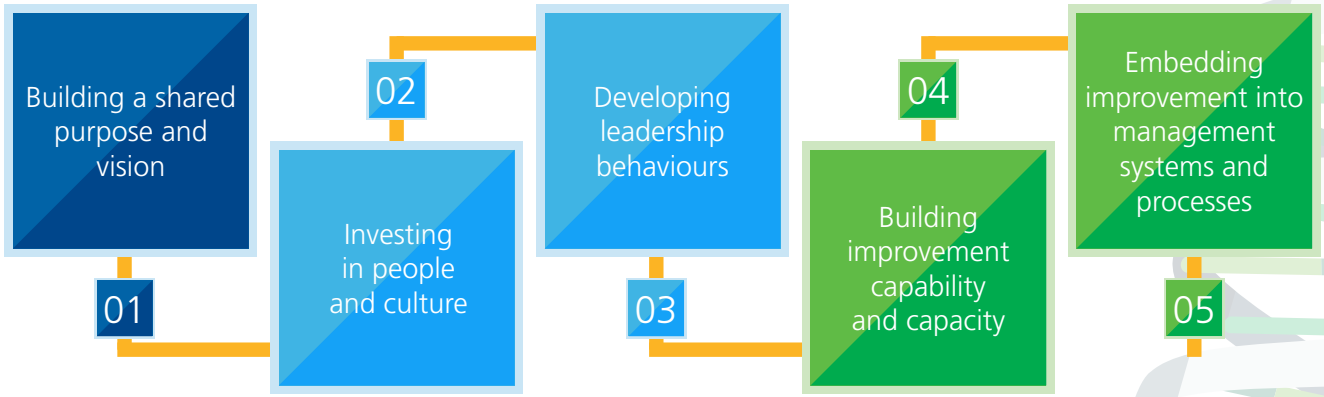
Our Patients | Our People | Our Partners | Our Planets and Pounds

National approach to improvement

Born out of the NHS England 'Delivery and continuous improvement review', NHS IMPACT (Improving Patient Care Together) is the new, single, shared NHS improvement approach. NHS IMPACT's five components form the 'DNA' of all evidence-based improvement methods, these principles underpin a systematic approach to continuous improvement.

When these five components are consistently used, systems and organisations create the right conditions for continuous improvement and high performance, responding to today's challenges, and delivering better care for patients and better outcomes for communities.

Our enabling plan has been designed to align to these five components as set out by NHS IMPACT.



NHS England, 'Delivery and continuous improvement review', 2023

01 Overview

This enabling plan supports the delivery of the Trusts four bold ambitions.
At YAS we strive to **excel together** so we can find ways to improve and innovate, relentlessly pursuing excellence in what we do. It is crucial that we have a method for QI that everyone is aware of and everyone can use in their daily work.

These elements are needed in equal measure for successful and sustainable improvements to be made.

Great Care, Great People, Great Partner

Vision

Clear focus and direction

- Trust strategy
- Yearly business planning
- National improvement approach

Culture

YAS Together

- Care
- Lead
- Grow
- **Excel**
- Everyone

Method

Quality Improvement methodology

- Model for improvement
- Quality management system
- QI Faculty for learning and education

Embedding QI in YAS - Our methodology

The Model for Improvement (MFI)

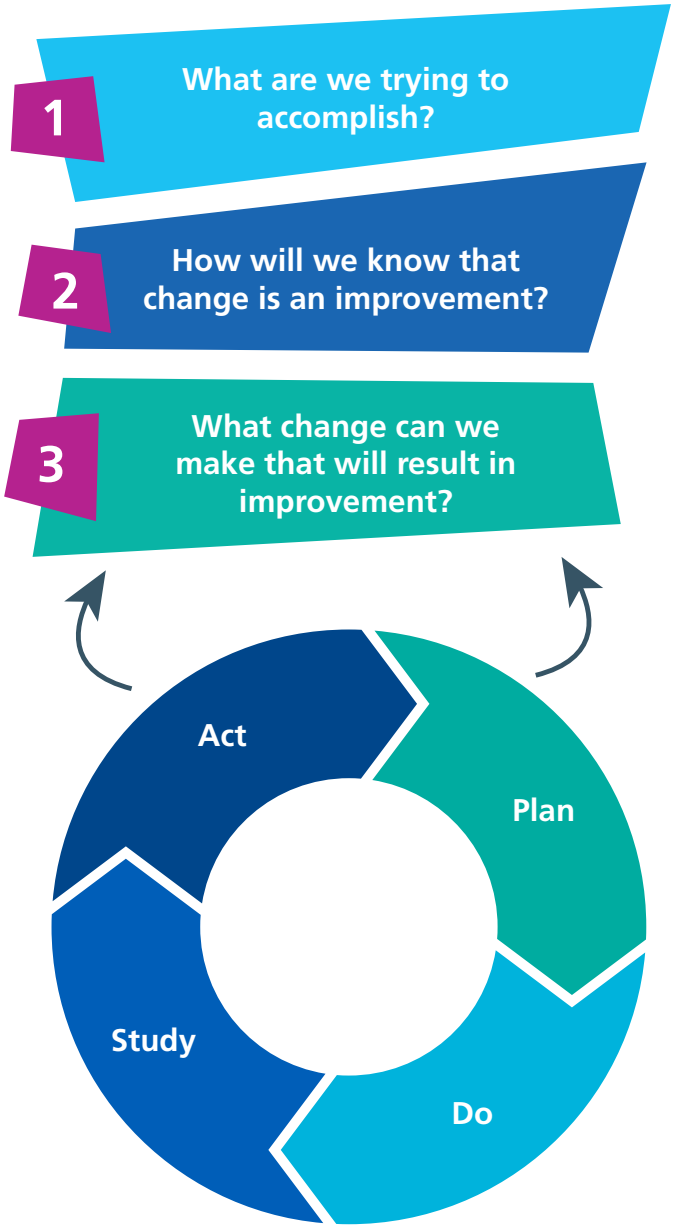
We will continue to use MFI from the Institute for Healthcare Improvement as our main QI methodology.

The model for improvement provides a framework for developing, testing and implementing changes leading to improvement. It is based in scientific method and moderates the impulse to take immediate action with the wisdom of careful study.

Using PDSA cycles enables the testing of changes on a small scale, building on the learning from these test cycles in a structured way before wholesale implementation. This gives stakeholders the opportunity to see if the proposed change will succeed and is a powerful tool for learning from ideas that do and don't work. This way, the process of change is safer and less disruptive for patients and staff.

The MFI is based around three key questions:

1 What are we trying to accomplish?	This is the aim or objective for the improvement effort.
2 How will we know that change is an improvement?	Without data you will not be able to know if the changes you have made actually produced better results.
3 What change can we make that will result in improvement?	There are many things you could do to make changes. Which ones do you believe have the highest chance of achieving the aim?



Embedding QI in YAS - Plan on a page

Great Care, Great People, Great Partner: Our Strategy, 2024-29

4 Bold Ambitions

Our Patients | Our People | Our Partners | Our Planets and Pounds

QI Enabling Plan

Learn to Improve

We will **grow together** by building improvement capability

All our people have access to improvement training and support

Engage to Improve

We will **lead together** by developing leadership behaviours for improvement

A focus on instilling behaviours that enable QI throughout the Trust and are role-modelled by our senior leadership community and Board

Analyse to Improve

We will **care together** by embedding improvement into management systems and processes

Building on our approaches to planning, controls, assurance and improvement that supports clinically led improvement

Network to Improve

We will bring **everyone together** by investing in culture and our people

We have clear and supportive ways of sharing learning, experiences, ideas for improvement and celebrating successes

Vision **Culture** **Method**

If we… adopt quality improvement as the primary method for addressing challenges.
We will…create optimum conditions for continuous improvement and high performance.
So that…we can provide high quality health and care services that meet the evolving needs of our patients and communities

NHS Impact

Embedding QI in YAS - Roles and responsibilities

	Learn to Improve	Engage to Improve	Analyse to Improve	Network to Improve
Board	» Receive QI Foundations training » Create time and space for Senior Leadership Community to undertake QI training » Regular board development sessions focused on improvement science	» Problem frame rather than problem solve » Create time and space to lead and sponsor quality improvement » Regularly walk the 'Gemba' » Listen, acknowledge and empower leadership teams to act on challenges and frustrations	» Own and use a Quality Management System approach » Use data to set the direction for areas for improvement	» De-construct barriers for improvement » Be an active part of QI networks and innovation platform to listen to the organisation » Give permission for the organisation to connect, celebrate success, share learning and improve
Senior Leadership Community	» Support the abstraction of their teams to undertake QI training » Identify people within their departments to undertake and be active 'team QI Leaders' » Undertake QI foundation and QI leaders training	» Sponsor improvement activity within their areas » Encourage, support and empower their teams to make improvements » Active participant in all improvement and innovation activities	» Set controls/ measures and provide assurance » Identify themes and trends in data that will highlight areas for improvement	» Create time for the their areas to connect, celebrate success and share learning » Bring and share information and learning to and from system partners » Develop networks to support others and celebrate success » Own ideas for improvement generated by teams and their staff
Our Leaders	» Undertake QI foundation and QI leader training » Support team members to complete QI Foundation training	» Engage their teams to identify problems and challenges » Engage with teams to problem solve	» Provide assurance to leadership teams around improvements they make » Support communication of areas for improvement to their teams	» Network and connect to share learning and experiences » Utilise networks to support improvement
Our people	» Undertake Introduction to QI at YAS training and QI Foundation training and apply QI in their roles	» Identify the problems and challenges » Generate ideas for improvement to solve problems that have been framed » Actively participate in tests for change	» Generate ideas that will improve quality of patient care, patient and staff safety and wellbeing » Be deeply involved and rooted in improvement activity and apply QI methodology	» Network and connect to share learning, experiences and celebrate success
QI Team and Faculty	» Development, delivery and facilitation of education » Delivery of the QI Fellowship	» Coach and mentor teams » Act as a Subject Matter Experts (SME) utilising a business partner model	» SME support for measurement for improvement » Coach and mentor for controls/ measurement setting where required	» To facilitate QI conferencing and QI Network » To ensure social connectiveness across YAS

Embedding QI in YAS - Milestones

Our QI mission	We will...	What we will focus on		
		In 2024, we will...	In 2025-26, we will...	By 2029, we will...
We continuously improve, innovate and **excel together**	**Grow together** by developing improvement capability and capacity Invest in our people, culture and develop leadership for improvement behaviours that support us to **lead together** **Care together** by continuously analysing how safe and effective we are Work with our people, patients and partners to continuously improve and bring **everyone together**	» All Board members to have completed QI Foundation » Establish a QI faculty » Deliver one YAS QI conference » Start to develop quality management system within local improvement projects » Launch QI Tool-kit » Develop and launch 'Introduction to QI at YAS' » 25% of staff to complete 'Introduction to QI at YAS' » Identify and begin to educate team QI Leaders within every team » Deliver three cohorts of QI Leaders » Deliver nine cohorts of QI Foundation » Establish how we will share improvement work, learning and how we will celebrate successes » Embed QI leadership into practice, working with leadership and organisational development experts through. aspiring leaders, lead together programmes	Build on and further develop the 2024 activities and... » Identify and design space for a YAS improvement and teamwork hub » Develop, from local learning, a strategic quality management system » Launch a QI coaching and mentoring framework » Have a QI business partner model ensuring there are strong connections with our people and system partners	Build on, further develop and embed the 2025-26 activities and... » Ensure 100% of our people have completed introduction to QI at YAS » We will have offered 60 cohorts of QI foundation and 20 cohorts of QI leader training » Have an embedded QI faculty consisting of one team QI leader from each team » Have delivered four 18 month QI fellowships » An established improvement hub » Evaluate our QI enabling plan

We will **grow together** by building improvement capability

All our people have access to improvement training and support

Through

A QI faculty made up of people, in all of our teams, who are able to support the delivery of QI

A Trust requirement that all our people undertake YAS QI education

Developing future QI leaders through our QI Fellowship

How this will be embedded...

- Each team identifying and supporting a minimum of one active 'Team QI Leader' that will form a part of the QI Faculty
- Develop an 'introduction to QI at YAS' online learning resource to ensure 100% of our people, by 2029, know about QI at YAS and how to get involved
- By 2029, QI Foundation training will be delivered with an aim of delivering 9 cohorts per year
- By 2029, QI Leader training will be delivered to those who will lead improvement with an aim of delivering 4 cohorts per year
- Continued delivery of our Quality Improvement Fellowship

Learn to Improve - YAS QI Faculty

Yorkshire Ambulance Service NHS Trust recognises the importance of building capacity and capability for QI within the organisation.

The introduction of the YAS QI faculty, **consisting of**:

» QI Fellows who complete their fellowship
» Team QI Leaders (QI Leaders are staff who have complete the three-day QI Leader course and post course assessment)
» Core QI team

The **function** of the QI Faculty is to:

» Assess QI training needs of staff at all levels
» Ensure everyone has the knowledge and skills to contribute to improvement through building capacity and capability
» Provide expert improvement support
» Actively deliver continuous improvement either Trust wide or within relevant teams

The befits of embedding a QI faculty are scalable:

Trust

» Trust wide improvement capacity and capability
» Trust wide social connectivity for improvement
» Organisational learning
» A culture that supports scale and spread of improvement work
» Easier to sustain improvement work

Team

» Cross service line sustained improvements
» Ability to lead improvement and be self sufficient within teams
» Support development of improvement plans
» Support education for QI
» Sharing of learning from other teams

People

» Personal development
» Involvement in QI opportunities outside of normal area of work
» Increasing organisational knowledge
» Learn from other QI faculty members
» Develop leadership for QI skills
» Increase social connectiveness for improvement

Learn to Improve - YAS QI Fellowship

Building on our success

Here at YAS, we are proud of our QI fellowship, the first of it's kind in the ambulance sector, and its achievements over the past five years, particularly against the backdrop of unprecedented pressures posed by the COVID-19 pandemic.

In the past years we have developed and tested the QI skills and knowledge of **33** members of staff across a broad range of service lines including, A&E operations, PTS, EOC, IUC, Fleet, Estates and many more.

Our fellowship has enabled us to....

- Build a network of quality improvement leaders
- Develop a culture of QI through fellows supporting the delivery of QI training
- Develop our next improvement leaders as 21 of those 33 staff have successfully taken promotional opportunities since completing their fellowship.
- Develop and embed our approach to QI further through learning and feedback from those staff who have completed the fellowship

Finally, we are excited to continue our QI Fellowship, which will provide formal education, mentorship and dedicated time to develop and put into practice their improvement skills.

The fellowship is aimed at people who are keen to develop their skills and knowledge in improvement at an accelerated pace, particularly aspiring improvement leaders.

This program will be a key part of our efforts to grow a QI faculty that:

» Lives our value of improvement
» Supports the delivery our four bold ambitions
» Continuously excels together

Learn to Improve - Education

Who?	What?	How?	
Our people	Introduction to QI at YAS and how to get involved	Online learning	**Introduction to QI at YAS** *"I know what QI is and how to get involved"*
Our people	Can apply fundamental QI technical skills which are aligned to the Model for Improvement	One-day education session	**QI Foundation** *"I can apply QI"*
Our Leaders and Senior Leadership Community	Can frame opportunities for improvement, progress and lead QI projects	Three, one-day education sessions	**QI Leader** *"I am a QI leader"*
Team QI Leaders	Can teach all levels of QI training to our people and coach them through improvements	Assessment upon completion of QI Leaders	**QI Faculty** *"I am an expert that can teach and coach QI"*
Trust Board	Setting the direction of QI and framing opportunities for improvement with knowledge of improvement science specifically the model for improvement and system of profound knowledge as well as reverse mentoring with QI experts	Board development in QI	**Board** *"I set the direction for QI"*

Learn to Improve - Dosing model

The chart below provides our application of the science of improvement dosing approach to groups organised by roles. The column headings identify the relevant groups of individuals in the organisation who require varying doses of science of improvement knowledge and skills. The rows indicate select science of improvement content areas, and the shading within the rows indicates the dose (minimal, moderate or maximum) of content required by each group.

Science for improvement content area	Board	Senior Leadership Community	Our Leaders	Our People	QI Team and Faculty
	Executive and Non Executive Directors including Chair	Deputy and Associate Directors, Heads of Departments and Consultant and Advanced clinicians	Managers, team leaders, specialist paramedics and nurses	All other roles	Core improvement team and team QI leaders
Model for Improvement					
System of Profound Knowledge					
Seven steps to measurement for improvement					
QI Governance					
Leading improvement					
Sponsoring improvement					
Scale and spread					
Stakeholder management					
Deep understanding on improvement methods and statistical process control (SPC)					

Legend	
Minimal dose	
Moderate dose	
Maximum dose	

We will **lead together** by developing leadership behaviours for improvement

A focus on instilling behaviours that enable QI throughout the Trust and are role-modelled by our senior leadership community and Board

Through

Developing leadership for improvement behaviours at all levels

Develop a collaborative and inclusive workforce to maximise improvement efforts

A physical, as well as virtual space, that maximises co-production, improvement and innovation

How this will be embedded...

- Create an innovation and improvement hub which is in place by 2029
- To have at least one Quality Improvement Leader across all teams by 2029
- Quality Improvement is identified to be a core responsibility of all staff within YAS and is embedded in all job descriptions
- Establish mechanisms to connect people, projects and expertise
- Introduce a framework for improvement coaching and mentorship
- Work with leadership and organisational development experts to embed leadership for improvement into practice

Analyse to Improve

We will **care together** by embedding impovement into management systems and processes

Building on our approaches to planning, controls, assurance and improvement that supports the delivery of clinically led improvement

Through

Improvement activity that is informed by data be that from incidents, risks, clinical audit and performance

Continuously improve patient safety through QI programmes identified through patient safety incident response activity

Develop an explicit quality management system that aligns with the strategy, vision and purpose of the Trust

How this will be embedded...

- Develop an explicit Quality Management System which enables ongoing continuous improvement of the services we provide
- In line with Patient Safety Incident Response Framework (PSIRF), QI methodology is consistently utilised and evidenced to support patient safety incidents and associated actions
- QI methodology is used to reduce organisational and local risks, improve processes, and optimise efficiency
- Trust board and leadership teams are committed to own and use a Quality Management System approach to manage the everyday running of the organisation

Analyse to Improve - Quality Management System

Delivery of high quality care requires organisations to have a consistent and coordinated approach to managing quality that is applied from team through to board level. This is known as a Quality Management System (QMS). At YAS we will establish a robust and effective QMS that delivers sustainable improvement.

What – Quality planning is the mechanism to understand and identify areas for improvement to meet the needs of our patients and people.

How – Board meets to identify objectives and communicates this to the organisation at all levels.

When – Annual basis or when it is clear that the needs of our patients and people are unmet.

What – Identifying and setting measures that will transparently monitor quality and performance for all objectives.

How – Leaders and their teams regularly meet to visually review measures, key process data and identify actions for improvement. This has clear escalation back to the board when teams are unable to 'problem solve'.

When – This is done in 'real time' or as near as possible.

What – A systematic process to improving quality and performance.

How – Deeply involving those closest to the work/issues. QI projects formed, and using the Model for Improvement, ideas are tested whilst collecting data to understand the impact of change. Results and status is reported back to the board highlighting improvements, lessons learnt, risks and issues.

When – Daily, reporting back to the board monthly.

What – Occasionally checks to ensure we are providing 'exemplary' care and/or meeting minimum requirements and standards. Additionally, assurance helps to identify gaps and develop improvement plans.

How – Senior leaders meet their teams to review standards

When – Weekly/monthly.

Network to Improve

We will bring **everyone together** by investing in culture and our people

We have clear and supportive ways of sharing learning, experiences, ideas for improvement and celebrating successes

Through

Empowering teams to share their innovative ideas to improve patient care, processes, deliver efficiencies and make YAS a great place to work

Sharing learning and celebrating success and good practice across our organisation and the system

Embedding patient voice through co-production and ensuring great partnership working

How this will be embedded...

- Actively working in partnership with Integrated Care Boards and partners ‘at place’ to enable and support system wide improvement
- Include patients in improvement work where possible
- Hold two QI conferences per year to showcase the Trust’s improvement work and celebrate the efforts of our people
- Empower teams through effective processes and plans to share their innovative ideas to improve patient care, processes, deliver efficiencies and make YAS a great place to work
- Have a QI business partner model ensuring there are strong connections with our people and system partners

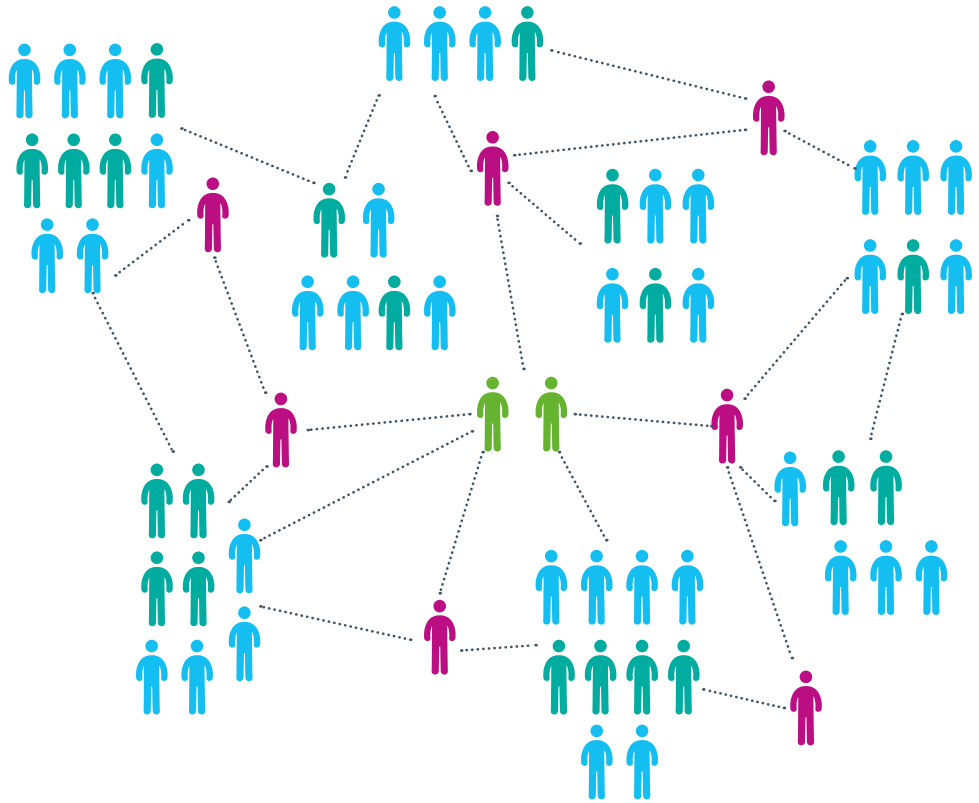
Network to Improve - Social connectiveness

For YAS to effectively embed QI into all aspects of our operations, maintaining strong social connectiveness is paramount. Research indicates that organisations fostering robust social connectivity demonstrate superior abilities to promote knowledge sharing, coordinate initiatives, and foster substantial collaborations for enhancement. Establishing these strong relationships conveys the message of the potential impact of improvements on practices and plays a critical role in the successful embedding of improvement initiatives.

Therefore, our 'Network to Improve' component is essential to achieve highly connected networks with reciprocal, collaborative relationships not only internally but with our system partners as well. This will result in the delivery of improvements that are more substantial and longer lasting.

The social connectivity diagram roughly illustrates the correlation between individuals proficient in QI and those capable of applying and engaging in QI practices. As the network expands, the dissemination of knowledge, shared experiences, and recognition of achievements accelerates on a broader scale.

Capability	Capacity	Who?
'We have completed Introduction to YAS QI and help to support QI'	14	Everyone at YAS
'We have completed QI Foundations and can apply QI'	10	People leading or involved in QI projects
'We are team QI Leaders and support the QI Faculty'	6	Our leaders and those leading QI projects
'We are QI subject matter experts'	3	Core QI team, utilising a business partner model and providing subject matter expert advice



Yorkshire Ambulance Service NHS Trust

Quality Improvement enabling plan 2024-29

yas.quality.improvement@nhs.net

Meeting Title: Board of Directors (in Public)
Meeting Date: 25 July 2024
Agenda Item: 6.1

Report Title	**Board Governance Report**
Author (name and title)	David O'Brien, Director of Corporate Services and Company Secretary
Accountable Director	David O'Brien, Director of Corporate Services and Company Secretary
Previous committees/groups	None
Recommended action(s) Approval, Assurance, Information	Information
Purpose of the paper	This report provides an update on issues and developments relating to Board governance.
Recommendation(s)	The Board notes the developments in Board governance outlined in this report

Executive Summary

This report provides an update on issues and developments relating to Board governance, as follows:

1. An update on the new Trust Establishment Order that will increase the number of positions on the Board of Directors
2. Confirmation of extended terms of office for two existing Non-Executive Directors
3. Confirmation that the Trust met the requirements of the Fit and Proper Person Test Framework for 2023/24
4. An update regarding the Insight Programme for aspirant Non-Executive Directors

Strategic ambition(s) this supports Provide brief bullet point details of link to Trust strategy	Our Patients	All priorities
	Our People	All priorities
	Our Partners	All priorities
	Our Planet and Pounds	All priorities
Link with the BAF Include reference number (board and level 2 committees only)		All strategic risks

Board of Directors (in Public)
25 July 2024
Board Governance Report
Director of Corporate Services and Company Secretary

1. INTRODUCTION

1.1 This report provides an update on issues and developments relating to Board governance.

2. BOARD GOVERNANCE UPDATES

2.1 Trust Establishment Order: Board of Directors

2.1.1 The Trust has received a draft new Establishment Order from the Department of Health and Social Care (DHSC). When approved, this new Establishment Order will increase the number of Non-Executive positions on the Board of Directors from six (Chair plus five) to seven (Chair plus six).

2.1.2 The Trust originally requested a corresponding increase in the number of Executive positions, from five to six (bearing in mind that the Board of Directors must always contain a majority of Non-Executive positions). However, DHSC has advised that as YAS is not a Foundation Trust it is permitted to have no more than five Executive positions as voting members of its Board of Directors.

2.1.3 As a result of the position described in 2.1.2, the Trust will continue to have five voting Executive positions on the Board of Directors. At present these are:

- Chief Executive
- Chief Operating Officer
- Executive Director of Finance
- Executive Director of Quality and Chief Paramedic
- Executive Medical Director

2.1.4 Two other Executive / Director roles are members of the Board of Directors but do not have voting rights. These are:

- Deputy Chief Executive
- Director of People and Organisational Development

2.1.5 Board member voting rights can be transferred to other Executive positions if needed. In particular, in the absence of the Chief Executive the voting right associated with that role would transfer to the Deputy Chief Executive.

2.1.6 Final Ministerial approval for the new Establishment Order to increase the number of NEDs remains outstanding. This has been delayed by the general election and subsequent change in government. The latest advice from DHSC is that the Trust 'should not expect' Ministerial approval until September at the earliest.

2.2 Non-Executive Director Extensions

2.2.1 NHS England has approved one-year extensions to the terms of office of two Non-Executive Directors (NEDs):

- Tim Gilpin, term of office extended to July 2025.
- Anne Cooper, term of office extended to December 2025.

2.2.2 During the remainder of 2024 the Trust will develop a succession plan and associated recruitment programme for NED positions. This is expected to include recruitment to both full NED and Associate NED roles.

2.3 Fit and Proper Person

2.3.1 NHS Trusts are required to submit an annual return to NHS England to confirm that all requirements of the Fit and Proper Person Test Framework have been met during the previous financial year.

2.3.2 For 2023/24 YAS has met these requirements. Confirmation of the Trust's position was submitted to NHS England ahead of the deadline.

2.4 Insight Programme: Aspirant NEDs

2.4.1 Carole Hodgson-Mullings has withdrawn from her aspirant NED placement with the Trust (part of the Insight Programme run by Gatenby Sanderson).

2.4.2 The Trust has expressed an interest in hosting a new placement as part of the next cohort of this programme.

2.5 Corporate Governance Documents

2.5.1 Colleagues will note that the agenda for this meeting includes three further documents relating to Board governance. These are:

- A guidance document on the role of the Board of Directors.
- A compendium of Committee annual reports for 2023/24.
- A compendium of Committee Terms of Reference for 2024/25.

3. FINANCIAL IMPLICATIONS

3.1 This report has no direct financial implications.

4. RISK

4.1 Failure to develop and maintain strong and effective Board governance arrangements for the Trust would present risks relating to strategic leadership capacity and capability, compliance with regulatory frameworks and codes (CQC Well-Led Framework, NHS Code of Governance, NHS Provider License), and reputation.

5. NEXT STEPS

5.1 A NED recruitment programme is being planned and is expected to commence in early Autumn.

5.2 The Trust will seek confirmation regarding the hosting of a new aspirant-NED placement via the Gatenby Sanderson Insight Programme.

6. RECOMMENDATIONS

6.1 The Board notes the developments in Board governance as outlined in this report

David O'Brien
Director of Corporate Services and Company Secretary

July 2024

Meeting Title: Board of Directors (Public)
Meeting Date: 24 July 2024
Agenda Item: 6.2

Report Title	**Committee Annual Reports 2023/24:** • **Finance and Performance Committee** • **Quality Committee** • **People Committee** • **Audit and Risk Committee**
Author (name and title)	David O'Brien, Director of Corporate Services and Company Secretary Lynsey Ryder, Interim Head of Corporate Affairs Committee Chairs
Accountable Director	David O'Brien, Director of Corporate Services and Company Secretary
Previous committees/groups	Finance and Performance Committee: 23 May 2024 Quality Committee: 16 May 2024 People Committee: 14 May 2024 Audit and Risk Committee: 16 July 2024
Recommended action(s) Approval, Assurance, Information	Assurance
Purpose of the paper	Provide assurance regarding the effectiveness of the Board committees in their roles as part of the Trust's governance and assurance framework
Recommendation(s)	The Board receives assurance via the 2023/24 annual reports of the Finance and Performance Committee, the Quality Committee, the People Committee, and the Audit and Risk Committee.

What?

As part of the Trust's corporate governance arrangements each of the main Board assurance committees has prepared and approved an annual report for 2023/24. Amongst other things, these annual reports provide assurance regarding the extent to which each committee fulfilled its purpose and remit in 2023/24 as defined by their Terms of Reference and captured in their annual workplan.

These annual reports are enclosed as appendices to this cover sheet:

Appendix A: Finance and Performance Annual Report
Appendix B: Quality Committee Annual Report
Appendix C: People Committee Annual Report
Appendix D: Audit and Risk Committee Annual Report

Each of these annual reports refers to further material (Committee workplans, ToRs etc). In the interests of brevity that supporting material is not enclosed with these papers, however, it is available upon request should any Board member wish to receive it.

So What?

1. These annual reports provide evidence that, generally speaking, the Trust's governance arrangements are working well and as intended. This constitutes one source of assurance for the Board regarding the effectiveness of the Trust's system of governance, assurance and internal control.

2. As a result of these annual reviews, the Terms of Reference and Workplans for of committees have been strengthened for 2024/25, and the associated reporting and assurance flows clarified and improved.

3. As a result of these annual reviews, and combined with other work such as the assurance mapping relating to the new Board Assurance Framework, specific areas of Trust governance have been identified for further development (for instance, governance and assurance relating to net zero / environmental matters and to technology / cyber security matters.

What Next?

The overall output from this exercise will be a stronger set of arrangements for governance and assurance in the Trust, both at Committee level and in respect of specific areas of Trust activity.

For the 2024/25 annual reports the Trust intends to develop a set of structured effectiveness reviews / maturity matrices bespoke to each committee, with some support from 360 Assurance. This will bring other committees into line with the Audit and Risk Committee which has for several years commissioned a structured effectiveness review via 360 Assurance as part of its self-evaluation processes.

Strategic ambition(s) this supports. Provide brief bullet point details of link to Trust strategy.	Our Patients	All priorities
	Our People	All priorities
	Our Partners	All priorities
	Our Planet and Pounds	All priorities
Link with the BAF Include reference number. (board and level 2 committees only)		All BAF risks

APPENDIX A

Finance and Performance Committee
Annual Report 2023/24

1. Introduction

1.1 The purpose of this report is to provide assurance to the Finance and Performance Committee, the Audit and Risk Committee, and the Trust Board that the Finance and Performance Committee has carried out its obligations in accordance with its Terms of Reference (ToR) during 2023-24.

2.0 Background

2.1 The Finance and Performance Committee (the Committee) is a standing committee that has been formally constituted by the Board of Directors of Yorkshire Ambulance Service NHS Trust (the Trust) in accordance with its Standing Orders.

2.2 The purpose of the Committee is to gain assurance, on behalf of the Board of Directors that the Trust is making sufficient progress towards the timely delivery of the Trust's Strategic ambitions and Operational Plan with consideration to the Trust's financial and performance issues whilst being assured as to compliance with appropriate regulatory and statutory requirements.

2.2 This report describes the Committee's activities from April 2023 to March 2024, compliance with the ToR and a summary of the effectiveness of the meetings.

3.0 Members and Meetings

3.1 Amanda Moat has been the Committee Chair throughout the reporting period.

3.2 During 2023/24, the Committee met formally on ten occasions:

25 April 2023
11 May 2023
8 June 2023
6 July 2023
7 September 2023
5 October 2023
9 November 2023
21 December 2023
8 February 2024
7 March 2024

3.3 The quorum for the Committee is three members, comprising at least two non-executive directors and one executive director present. The meetings were quorate at all times.

Table1. Attendance of the Committee during 2023/24 was as follows:

Members	Role	25 Apr	11 May	08 Jun	06 Jul	07 Sep	05 Oct	09 Nov	21 Dec	08 Feb	07 Mar
Jeremy Pease	Non-executive Director	✓		✓	✓	✓	✓	✓	✓	✓	
Amanda Moat	Non-executive Director	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Tim Gilpin	Non-executive Director		✓	✓		✓	✓	✓	✓		✓
Kathyrn Vause	Executive Director	✓	✓	✓	✓	✓	✓		✓	✓	✓
Nick Smith	Executive Director			✓	✓	✓	✓	✓	✓	✓	✓

3.3 The following individuals were in regular attendance during the course of the year at the Committee's meetings:

- Simon Marsh, Chief Information Officer
- Jeevan Gill, Director of Partnership and Operations
- Louise Engledow, Deputy Director of Finance
- Lynn Hughes, Company Secretary (April to September)
- David O'Brien, Director of Corporate Services and Company Secretary
- Clare Ashby, Director of Quality (interim)
- Carol Weir, Director of Business Planning
- Matt Barker, Head of Procurement and Logistics
- Brian Ladd, Head of Contracts
- Glen Adams, Associate Director of Fleet, Estates and Facilities
- Ian Holdsworth, Senior Planning and Development Manager

3.4 Other managers have also been requested to attend the Committee throughout the year to discuss specific items including emergency preparedness, the hub and spoke transformation project, scheduling, PTS and IUC.

4.0 Review of Compliance with Terms of Reference

4.1 A self-assessment of compliance against all aspects of the ToR was undertaken by the Committee Chair and lead Executive Director. There were 46 areas to be considered regarding the compliance or non-compliance of the Committee, against its terms of reference. The Committee was compliant with 40 areas. There were three areas of partial/non-compliance and three areas that were not applicable, as follows:

- Non-compliant – 11. "*Review progress and key risks in relation to delivery of the Green Plan"*

  The Net Zero Board Lead had been vacant for 12 months, but a new appointment was made in April 2024 (Executive Director of Finance). The

approach to F&PC oversight for assurance of net zero work was agreed at the April 2024 meeting, and the Trust is strengthening its governance of this area of work during 2024/25.

- Partial compliance – 38. "*The Committee Secretary shall minute the proceedings of all Committee meetings and provide draft minutes within five working days, reviewed by the Lead Director and then approved by the Committee Chair within 10 working days of the meeting."*

  Minuting is provided by the Corporate Affairs team. Adherence to the expected timescales has been inconsistent.

- Partial compliance – 44. *"The Chair from each of the operational groups will provide a report to the next meeting of the Committee; and the minutes from the group's meeting to the Committee following approval of the minutes at the next group meeting."*

  The Capital Planning Group has reported to the Committee on decisions and other outputs, but Minutes are not routinely provided.

- Not applicable – 13. "*Review and make recommendations to the Board about any commercial or investment activity e.g., proposed joint ventures or partnerships, in line with the governance requirements"*

  This has not occurred during this Committee cycle.

- Not Applicable – 31. *"In the case that an equality of votes arises, the Chair of the Committee will hold the casting vote."*

  This has not occurred during this Committee cycle.

- Not Applicable – 43. "*The Committee shall have the power to establish sub-Committees/Groups and/or task and finish groups for the purpose of addressing specific tasks or areas of responsibility (once agreed by Trust Executive Group any sub-committees/groups will be added)."*

  No sub-groups have been established during this Committee cycle.

5.0 Committee Workings

5.1 The Committee had a workplan for 2023-24 which included a calendar of key events that sets out the annual cycle of work and reporting. The workplan was kept under regular review and updated as required.

5.2 The Committee worked with other Board assurance Committees and regularly received matters for its consideration with referrals on matters made to other Committees for assurance purposes as and when required. For example, the system approved financial envelope from Quarter 2 was challenged, primarily due to significant revenue underspends being driven in the main by vacancies to plan. The financial and reputational impacts were referred to the People Committee and it

was agreed key actions and response actions to that risk would take place in that Committee. A similar discussion also took place regarding support for the case for change business case.

5.3 Prior to each meeting the Chair formally reviewed the agenda separately with both the Director of Finance and the Company Secretary. Individual agenda items were consulted on with relevant responsible people as required.

5.4 Following each meeting, the Chair reported to the Board, drawing attention to matters of significance. The minutes of the meetings were received by the Board at its meetings in private.

6.0 Review of Meeting Effectiveness

6.1 There was a standing agenda item towards the close of the meeting for all to reflect on the effectiveness of each meeting. Some of the key points raised were as follows:

Administration

Papers were often issued in more than one pack due to late papers, some issued only two or three days prior to the meeting.

Chairing of the meeting

The Chair focused appropriate time on the most important issues and was able to re-order agenda items where required but ensured all business was transacted. There was a good pace and additional assurance sought as required.

Content and appropriateness of agenda

The agenda provides a balance between quality and resource, strategic and operational issues. It reflects Trust priorities, especially regarding operational performance, business plan priorities, and financial management. There was a good balance of assurance and decision-making covering strategic development matters but also current business.

Engagement

There was appropriate staff involvement and representation for proposals presented to the Committee. Patient involvement was noted on one item regarding inter-facility transfers; however, it is not always apparent/evidenced whether patient voice is represented.

Quality and quantity of papers

Reports were of appropriate length and good quality. Some reports were very detailed in places, but this is required and appropriate for the complex nature of the reports. Links to BAF are made on report cover sheets of individual reports (but worth comparing to other committees where this is more explicit on the agenda sheets for meetings.

Risk

The Risk/BAF item was used to set the headlines with expanded discussions then taking place throughout the agenda. All reports contained appropriate links to the BAF, risk mitigation and included other risk-related information. There was an early identified escalation of finance risks. It was not always clear whether the level/nature of finance risk presented in the reports is fully reflected in the risk register and BAF.

Appropriate challenge

All attendees participated in discussions and there was appropriate exec-to-exec challenge. The challenge was constructive, fair and respectful.

Appropriate debate

The committee had significant business to discuss, and the time available was apportioned suitably.

7.0 Work of the Committee

7.1 During 2023-24 the Committee sought assurance regarding sufficient progress towards the timely delivery of the Trust's strategic ambitions and Operational Plan, the Trust's financial and performance, and compliance with appropriate regulatory and statutory requirements. Examples of the work carried out in relation to the purpose of the Committee as defined in the ToR include reviews of:

- Financial performance
- Operational performance
- Capital planning
- Internal audits
- Seasonal plans
- Updates relating to digital/IT, fleet and estates, procurement activity, and operational performance
- Review of contracts and variations
- Review of business cases, tenders and contracts post implementation evaluation

8.0 Conclusions

8.1 The Committee confirms that it has complied with the ToR and fulfilled its role of providing assurance to the Board on matters relating to financial performance and related matters throughout 2023-24.

8.2 As described above, the Committee has received assurance through the course of the year from management, internal groups/committees including TEG, Capital Planning Group and Operational Efficiency Group, the risk management processes, progress reports from the finance and quality directorates, external and internal audit.

APPENDIX B

Quality Committee
Annual Report 2023/24

1.0 INTRODUCTION

1.1 The purpose of this report is to provide assurance to the Quality Committee, the Audit and Risk Committee, and the Trust Board, that the Quality Committee has carried out its obligations in accordance with its Terms of Reference (ToR) during 2023-24.

2.0 BACKGROUND

2.1 The Quality Committee (the Committee) is a standing committee that has been formally constituted by the Board of Directors of Yorkshire Ambulance Service NHS Trust (the Trust) in accordance with its Standing Orders.

2.2 The purpose of the Committee is to provide assurance to the Board on the overall delivery of the Trust's strategic objectives in the context of quality of care and services and the effective mitigation of identified risk, specifically in relation to:

- Improving patient safety, experience and outcomes, and reducing health inequalities;
- Continuous improvement in the quality of services;
- Embedding an effective quality management system that supports the effective delivery of the Trust's strategic objectives and operational plan including quality priorities and the provision of sustainable, high-quality care;
- Overseeing the delivery of quality performance data, ensuring business intelligence is used to support improvements and sustain best practice;
- Facilitating and evidencing the identification and sharing of best practice and learning across the Trust; and
- Demonstrating compliance with statutory and regulatory requirements.

2.3 This report describes the Committee's activities from April 2023 to March 2024, compliance with the ToR and a summary of the effectiveness of the meetings.

3.0 MEMBERS AND MEETINGS

3.1 Anne Cooper has been the Committee Chair throughout the reporting period.

3.2 During 2023/24, the Committee met formally on eight occasions:

11 May 2023
8 June 2023
6 July 2023
7 September 2023
5 October 2023
9 November 2023

21 December 2023
8 February 2024

3.3 The quorum for the Committee is three members, comprising at least two non-executive directors and one executive director present. Due to a Non-Executive Director vacancy on the Committee, it was agreed at the Quality Committee meeting on 8 June 2023 that Andrew Chang, Non-Executive Director would fulfil this position until a substantive post-holder was appointed (minutes reference QC23/022.2). The meetings were quorate at all times.

Table1. Attendance of the Committee during 2023/24 was as follows:
Shaded boxes denote when the individual was not in post as a member of the Committee.

Member	**Role**	11 May	08 Jun	06 Jul	07 Sep	05 Oct	09 Nov	21 Dec	08 Feb
Anne Cooper	Non-executive Director	✓	✓	✓	✓	✓	✓	✓	✓
Jeremy Pease	Non-executive Director	✓	✓	✓		✓	✓	✓	✓
Andrew Chang	Non-executive Director		✓	✓	✓	✓	✓		✓
Clare Ashby	Executive Director of Quality (interim)	✓	✓	✓	✓	✓			
Dave Green	Executive Director of Quality /Chief Paramedic						✓	✓	✓
Steven Dykes	Executive Medical Director (interim)	✓	✓	✓					
Julian Mark	Executive Medical Director					✓	✓	✓	✓

3.4 The following individuals were in regular attendance during the course of the year at the Committee's meetings:

- Zafir Ali, Associate Non-executive Director
- Adam Layland, Director of Partnership and Operations
- Lynn Hughes/David O'Brien, Company Secretary
- Clare Ashby, Deputy Director of Quality and Nursing
- Dave Green, Associate Director of Quality & Safety (interim)
- Phil Gleeson, Critical Friends Network member
- Nick Smith, Chief Operating Officer
- Jeevan Gill, Director of Partnership and Operations

3.5 Other managers have also been requested to attend the Committee throughout the year to discuss specific items including quality improvement, research, health inequalities and business planning.

4.0 REVIEW OF COMPLIANCE WITH TERMS OF REFERENCE

4.1 A self-assessment of compliance against all aspects of the ToR was undertaken by the Committee Chair and lead Executive Director.

4.2 There were 53 areas to be considered regarding the compliance or non-compliance of the Committee, against its terms of reference. The Committee was compliant with 46 areas. There were five areas of non-compliance and two areas which were not applicable, as follows:

- Non-compliance – 4. *Oversee the Trust's policies and procedures regarding the use of clinical data and patient identifiable information, ensuring it is in accordance with relevant legislation and guidance including the Caldicott Guidelines and Data Protection Act.*

  This area has not been specifically presented or discussed during this Committee cycle.

- Non-compliance – 7*. Oversee information governance and Health related IT clinical safety compliance across the Trust's functions.*

  This area has not been specifically presented or discussed during this Committee cycle. However, risk reports received by the committee have included assurance relating to this.

- Non-compliance – 39*. The Committee will meet at least 10 times a year. The Committee shall meet at any other time that the Chair of the Committee, in consultation with the Director Lead, shall require, in order to allow the Committee to discharge all of its responsibilities.*

  The committee met eight times during 2023-24. No meeting was arranged for April 2023 and the March meeting was cancelled due to lack of quorum members.

- Partial compliance – 35. *Members must demonstrably consider, and take appropriate positive action in respect to, the equality and diversity implications of decisions taken by the Committee*

  Health inequalities is a key area of focus for the committee but there has not been explicit consideration given to other equality and diversity impacts by the Committee.

- Partial Compliance – 45. *The Committee Secretary shall minute the proceedings of all Committee meetings and provide draft minutes within five working days, reviewed by the Lead Director and then approved by the Committee Chair within 10 working days of the meeting.*

  It was considered that some adherence to timescales had been inconsistent.

- Not Applicable – 36. *Decisions will be taken in accordance with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Committee Chair may call a vote.*

  A vote has not been held, nor required to be held, in this Committee cycle.

- Not Applicable – 38. *In the case that an equality of votes arises, the Chair of the Committee will hold the casting vote.*

  A vote has not been held, nor required to be held, in this Committee cycle.

5.0 COMMITTEE WORKINGS

5.1 The Committee had a workplan for 2023-24 which included a calendar of key events that sets out the annual cycle of work and reporting. The workplan was kept under regular review and updated as required.

5.2 The Committee worked with other Board assurance Committees and regularly received matters for its consideration with referrals on matters made to other Committees for assurance purposes as and when required. Requests for internal audit reviews were made to the Audit and Risk Committee on controlled drugs and the complaints process.

5.3 Prior to each meeting the Chair formally reviewed the agenda separately with both the Executive Director of Quality and the Company Secretary. Individual agenda items were consulted on with relevant responsible persons as required.

5.4 Following each meeting, the Chair reported to the Board, drawing attention to matters of significance. The minutes of the meetings were received by the Board at its meetings in private.

6.0 REVIEW OF MEETING EFFECTIVENESS

6.1 There was a standing agenda item towards the close of the meeting for all to reflect on the effectiveness of each meeting. Some of the key points raised were as follows:

6.1.1 <u>Administration</u>

Generally timely, effective and of a good standard. Some delayed papers and issues accessing links.

6.1.2 Chairing of the meeting

Meetings were chaired in an effective manner, with good governance and Trust values demonstrated. The Chair maintained momentum without restricting discussion and ensured relevance to topic. Summaries were given at the end of each item and actions clarified.

6.1.3 Content and appropriateness of agenda

The agendas gave a good balance of strategic, patient-focussed and operational topics and reflected the Trust's priorities in relation to the quality agenda.

6.1.4 Engagement

Papers showed collaboration with staff and wider stakeholders as appropriate. Sometimes limited evidence of patient involvement in actions/decisions due to the nature of the agenda items.

6.1.5 Quality and quantity of papers

Papers were generally of a high standard with appropriate links to business plan priorities. There was a good balance of corporate responsibilities and operational detail showing responsiveness to ongoing issues. Some papers were longer than necessary and didn't clearly demonstrate a link to patient care.

6.1.6 Risk

There was appropriate and informed consideration of risks with good links to the board assurance framework and the corporate risk register relating to the quality agenda: patient safety, effectiveness of care, and patient experience. Risks were reviewed at each agenda item and reconsidered at the end of the meetings.

6.1.7 Appropriate challenge

There was a high degree of constructive challenge, including exec to exec. Challenges were raised in a supportive manner consistent with Trust values and intended to encourage development and improvement.

6.1.8 Appropriate debate

Debate within the meeting was appropriate, conducted suitably and managed well. All Committee members participated in discussions and debate.

7.0 WORK OF THE COMMITTEE

7.1 During 2023-24 the Committee sought assurance of the overall delivery of the Trust's strategic objectives in the context of quality of care and services and the effective mitigation of identified risk. The main areas of reporting to receive this assurance were as follows:

- Clinical Audit
- Complaints/Concerns/Comments/Compliments
- Coroners/Claims
- Duty of Candour – Being Open

- Health and Safety
- Incidents and investigations including serious incident investigations
- Learning from incidents
- Patient experience
- Patient outcomes
- Patient safety
- Safeguarding

8.0 CONCLUSIONS

8.1 The Committee confirms that it has complied with the ToR and fulfilled its role of providing assurance to the Board on matters relating to quality of care and services throughout 2023-24.

8.2 As described above, the Committee has received assurance through the course of the year from management, internal groups/committees, the risk management processes and progress reports from operations, clinical and quality directorates, and internal audit.

8.3 The Chair and Lead Executive Director noted that the 2023/24 terms of reference were no longer fit for purpose as the detail within them did not accurately reflect some of the duties of this assurance committee. The ToR have been reviewed by the Committee which, along with a matrix to map assurance, will assist in ensuring the Committee is effectively carrying out its duties during 2024/25.

APPENDIX C

People Committee
Annual Report 2023/24

1.0 Introduction

1.1 This report aims to provide assurance to the People Committee, the Audit and Risk Committee, and the Trust Board that the Committee has carried out its obligations in accordance with its Terms of Reference (ToR) during 2023-24.

1.2 A self-assessment of compliance against the ToR for People Committee has been undertaken to inform this report.

2.0 Background

2.1 The People Committee (the Committee) is a standing committee that has been formally constituted by the Board of Directors of Yorkshire Ambulance Service NHS Trust (the Trust) in accordance with its Standing Orders.

2.2 The purpose of the Committee is to gain assurance, on behalf of the Board of Directors, that the Trust is making sufficient progress towards its 'Our People' priorities to support the delivery of the Trust's strategic objectives and Operational Plan whilst being assured as to compliance with appropriate regulatory and statutory requirements.

2.3 This report describes the Committee's activities from April 2023 to March 2024, compliance with the ToR and a summary of the effectiveness of the meetings.

3.0 Members and Meetings

3.1 Tim Gilpin, Non-Executive Director/Deputy Chair was the Committee Chair throughout the reporting period.

3.2 During 2023/24, the Committee met formally on seven occasions:

4 May 2023
29 June 2023
25 July 2023
26 September 2023
28 November 2023
16 January 2024
28 March 2024

3.3 The quorum for the Committee is three members, comprising at least two non-executive directors and one executive director present. The meetings were quorate at all times.

Table 1. Attendance of the Committee during 2023/24 was as follows:

Member	**Role**	04 May	29 Jun	25 Jul	26 Sep	28 Nov	16 Jan	28 Mar
Tim Gilpin	Non-Executive Director	✓	✓	✓	✓		✓	✓
Amanda Moat	Non-Executive Director	✓	✓	✓	✓	✓	✓	✓
Andrew Chang	Non-Executive Director		✓	✓		✓	✓	✓
Mandy Wilcock	Director	✓	✓	✓	✓	✓	✓	✓
Nick Smith	Executive Director	✓	✓	✓	✓	✓	✓	✓

3.4 The following individuals were in regular attendance during the year at the Committee's meetings:

- Zafir Ali, Associate Non-executive Director
- Rachel Gillott, Director of Partnership and Operations
- Dawn Adams, Associate Director Education and Organisational Development
- Suzanne Hartshorne, Deputy Director People and Organisational Development
- Lynn Hughes, Company Secretary (May and June)
- David O'Brien, Director of Corporate Services and Company Secretary (July onwards)

3.5 Other managers have also been requested to attend the Committee throughout the year to discuss specific items including workforce planning, education, health, and wellbeing.

4.0 Review of Compliance with Terms of Reference

4.1 A self-assessment of compliance against all aspects of the ToR was undertaken by the Committee Chair and lead Executive Director.

4.2 There were 40 areas to be considered regarding the compliance or non-compliance of the Committee, against its terms of reference. The Committee was compliant with 36 areas. There were two areas of non-compliance and two areas which were not applicable, as follows:

- Non-compliance – 26. *"The Committee will meet at least 10 times a year. The Committee shall meet at any other time that the Chair of the Committee, in*

consultation with the Director Lead, shall require, in order to allow the Committee to discharge all of its responsibilities."

The Committee was initially expected ed to meet 10 times a year. The Committee met on seven occasions. No meetings were cancelled, but the reduced frequency of the meetings was agreed by the Committee Chair, Executive Director Lead and the (previous) Company Secretary.

- Partial Compliance – 32. *"The Committee Secretary shall minute the proceedings of all Committee meetings and provide draft minutes within five working days, reviewed by the Lead Director, and then approved by the Committee Chair within 10 working days of the meeting."*

  It was considered that some adherence to timescales had been inconsistent.

- Not Applicable – 24*. "Only members present at a meeting of the Committee may vote. Each member is allowed one vote, and a majority will be conclusive on any matter."*

  A vote has not been held, nor required to be held, in this Committee cycle.

- Not Applicable – 25. *"In the case that an equality of votes arises, the Chair of the Committee will hold the casting vote."*

  A vote has not been held, nor required to be held, in this Committee cycle.

5 Committee Workings

5.1 The Committee had a work plan for 2023-24 which included a calendar of key events that sets out the annual cycle of work and reporting. The work plan was kept under regular review and updated as required. Other relevant items were referred into People Committee.

5.2 The Committee worked with other Board assurance Committees and regularly received matters for its consideration with referrals on matters made to other Committees for assurance purposes as and when required. For example, people matters raised in the Quality Committee were referred to the People Committee for discussion e.g. those matters which had arisen during the Board quality visits.

5.3 Prior to each meeting the Chair formally reviewed the agenda separately with both the Director of People and OD and the Company Secretary. Individual agenda items were consulted on with relevant responsible persons as required.

5.4 Following each meeting, through the provision of a People Committee Chair's report, the Chair reported to the Board, drawing attention to matters of significance. The minutes of the meetings were received by the Board at its meetings in private.

6 Review of Meeting Effectiveness

6.1 There was a standing agenda item towards the close of the meeting for all to reflect on the effectiveness of each meeting. Some of the key points raised were as follows:

Administration

The papers came out on time as a combined pack in the majority of cases. It was noted that on one occasion the papers were late and there were only three working days to review the papers.

Chairing of the meeting

The Chair managed the time well with a steady constructive pace. Time was allowed for reflection and discussion with appropriate intervention to ensure debate remained focused. There was excellent closure on each agenda item to summarise understanding and clear statements for minute capture. The Chair showed appreciation for colleague's hard work and input.

Content and appropriateness of agenda

The agendas brought the right number of papers organised around strategic direction, key risks and risk issues aligned to organisational priorities and Trust strategy.

Engagement

Many items had direct evidence of staff input, particularly the Freedom to Speak Up agenda items.

Quality and quantity of papers

The mix of standard reports, presentations and video case studies were well thought through and provided an excellent mix of materials to retain participation and interest in the people agenda. The papers were people subject orientated and referred to the importance of good culture and demonstrating YAS values. However, not all papers had a cover sheet and, although reviewed during the meetings on screen, some links were not directly accessible to members.

Risks

The BAF and corporate risk register is a standing agenda item at the start of the meeting and all papers referenced those updates. There was good discussion regarding risk emphasis, which was placed on where monitoring of risks would be focussed.

Appropriate challenge

All members and attendees participated fully in the meeting and were very engaged in the matters of the committee. Discussions were collaborative, not defensive and were informative and sought solutions. There was open sharing and proper discussion between NEDs, executive directors, and regular senior managers on difficult issues.

Appropriate debate

All members and attendees participated fully in the meeting.

7 Work of the Committee

7.1 During 2023-24, the Committee sought assurance of the overall delivery of progress towards its people priorities to support the delivery of the Trust's strategic objectives, Operational Plan and compliance with appropriate regulatory and statutory requirements. Examples of the work carried out in relation to the purpose of the Committee as defined in the ToR are:

- Gender Pay Gap reporting
- Workforce Race Equality Standard
- Workforce Disability Equality Standard
- Fit and Proper Person Compliance
- Freedom to Speak Up

8 Conclusions

8.1 The Committee confirms that it has complied with the ToR and fulfilled its role of providing assurance to the Board on matters relating to its people throughout 2023-24.

8.2 As described above, the Committee has received assurance through the course of the year from management, internal groups/committees and progress reports.

APPENDIX D

Audit and Risk Committee Annual Report 2023/24

1.0 Introduction

1.1 The purpose of this report is to provide assurance that the Audit and Risk Committee has carried out its purpose and duties in accordance with its Terms of Reference (ToR).

1.2 The main focus of this report is the year 2023/24. However the report also includes an initial commentary on the Audit and Risk Committee's year-end work during 2024/25 to conclude the governance, assurance and reporting associated with the 2023/34 annual report and accounts.

2.0 Background

2.1 Under the NHS Code of Governance and other related regulatory frameworks each NHS trust is expected to include within its governance and assurance arrangements a formally constituted audit committee (or equivalent) that reports to its governing body. The Trust's Standing Orders 4.6 and 4.6.1 provide for the establishment of the Audit and Risk Committee to report direct to the Board of Directors.

2.2 The remit of the Audit and Risk Committee is formally agreed in its Terms of Reference and is consistent with the guidelines for NHS audit committees as set out in HFMA NHS Audit Committee Handbook (Fifth Edition, 2024).

2.3 This report primarily covers the work of the Audit and Risk Committee during the 2023/24 financial year. In particular, it addresses various matters for which the Audit and Risk Committee has oversight for the Board:

3.0 Members and Meetings

3.1 Standing Order 4.6.1 stipulates that the Audit and Risk Committee should be chaired by a Non-Executive Director. Throughout the period covered by this report the committee was chaired by Andrew Chang, a Non-Executive Director. Throughout this period the Executive Lead for the committee was Kathryn Vause, Executive Director of Finance.

3.2 During 2023/24 the Audit and Risk Committee met formally on seven occasions as shown below.

- 18 April 2023
- 29 June 2023
- 25 July 2023
- 22 September 2023
- 16 November 2023
- 28 November 2023
- 18 January 2024

3.3 All meetings were quorate, and the proceedings managed in accordance with Trust Standing Orders and the Committee's Terms of Reference.

3.4 As a result of the protracted external audit work relating to the 2022/23 financial year the transaction of year-end governance, assurance and reporting items took place across the meetings held in June, July and September.

3.5 The meeting held on 28 November was an extraordinary meeting convened to consider the recommendations of the Auditor Panel in relation to the appointment of a new external auditor for the Trust.

3.6 Appendix A sets out the attendance record of the principal and regular attendees for the above-mentioned meetings

3.7 In addition, the following Executive Directors attended meetings of the committee in order to account for internal audit reviews for which a 'limited' assurance rating had been awarded. These were:

Meeting	Name	Role	Review
25 July 2023	Nick Smith	Chief Operating Officer	Divisional Risk Management: EOC and A&E Operations
25 July 2023	Simon Marsh	Chief Information Officer	IT Asset Management

3.8 Throughout the year the committee held meetings in private with internal and external auditors.

4.0 Audit Committee Governance Arrangements

4.1 The Audit and Risk Committee operates in accordance with its Terms of Reference. For the 2023/24 financial year the Terms of Reference were reviewed and approved by the committee at its meeting held on 29 June 2023.

4.2 The work of the Audit and Risk Committee is scheduled and delivered in accordance with an approved workplan derived from the committee's Terms of Reference. The workplan sets out an annual cycle of governance, assurance and

reporting. The workplan is kept under regular review, retains sufficient flexibility to accommodate new requirements and ad hoc items, and is updated as required.

4.3 The Audit and Risk Committee works with other Board assurance committees and regularly receives matters for its consideration. It also refers matters to other committees for assurance purposes as and when required.

4.4 Prior to each meeting of the committee the Chair formally reviews the agenda with both the Director of Finance and the Company Secretary. Individual agenda items were consulted on with the relevant responsible person on an 'as needed' basis.

4.5 Following each meeting of the committee the Chair formally reports to the Board of Directors via a 'Triple A' (Alert, Advise, Assure) report.

5.0 Committee Effectiveness

Maturity Self-Assessment

5.1 During 2023/24 the committee undertook a self-assessment review, facilitated by 360 Assurance. This review applied an audit committee maturity model developed by 360 Assurance in conjunction with the Good Governance Institute. The review found that across most domains the committee is either already mature or is improving towards maturity.

5.2 Identified areas of maturity included:

- The committee's clarity of purpose
- The committee's relationship with the Board of Directors
- The assurance received via the Board Assurance Framework
- The committee's role in internal audit planning
- The committee's relationships with internal and external audit
- The committee's agenda, reports, administration and cycle of business

5.3 One area identified for development is the Committee's maturity in respect of assurance mapping. This is being addressed in 2024/25 as part of the work to develop the Trust's new Board Assurance Framework.

Compliance with Terms of Reference

5.4 This annual report includes an assessment of the Committee's compliance with its own Terms of Reference for 2022/23. Appendix B sets out an analysis of this. Overall the committee demonstrated a significant level of compliance with its terms of reference during 2022/23.

5.5 Areas of partial compliance or non-compliance were as follows:

ToR Reference		Compliance
3.1(h)	Ensure that systems for financial reporting to the Board, including those of budgetary control, are subject to review as to the completeness and accuracy of information provided to the Board. A primary source of assurance in this regard shall be the Finance and Performance Committee.	Partial
4.1(d)	The policies for ensuring compliance with the relevant regulatory, legal and code of conduct requirements.	Partial
4.3.1(f)	Development and implementation of a policy on the engagement of the External Auditor to supply non-audit services.	Not compliant
7.5	The Chief Executive shall attend meetings to discuss with the Committee the process for assurance that supports the Annual Governance Statement, to review each year's draft internal audit plan and the draft annual accounts.	Partial

Meeting Evaluation Feedback

5.6 Meeting evaluation forms were completed and submitted for three meetings during 2023/24:

- 25 July 2023
- 16 November 2023
- 16 January 2024

5.7 The main consistent themes emerging from these evaluation forms was:

- The chairing of committee meetings is effective, inclusive and engaging.
- Meeting agendas provide a good balance of strategic and operational issues.
- Papers are of good quality and provide the right level of detail (reflecting the complexity of the organisation and its operating context) but also signpost to the key points.
- Members and attendees participate fully in discussions and reach decisions by consensus.
- The Committee has a culture of openness, honesty, and transparency. Executive colleagues take responsibility to own and resolve difficult issues.
- The Committee achieves appropriate assurance.

6.0 Key Work of the Committee

2022/23 Annual Report and Accounts

6.1 The Committee reviewed the Annual Report and Accounts for 2022/23 and recommended these for approval by the Board of Directors. The Committee also reviewed and received other items associated with year-end governance and reporting. The 2022/23 year-end items considered by the committee were:

- Annual Report
- Annual Accounts and Financial Statements
- Statement of Post-Balance Sheet Events
- Annual Governance Statement
- Internal Audit Annual Report and Opinion
- External Audit ISA 260
- Letter of Representations to the External Auditor
- Provider Licence Declarations
- Quality Account

6.2 Completion of the 2022/23 year-end process was delayed due to additional external audit work. The Committee reviewed the 2022/23 annual report and accounts at its meeting held on 22 September 2023. Upon the Committee's recommendation, the Board of Directors approved the annual report and accounts on 24 September 2023.

External Audit

6.3. From April 2023 to December 2023 the Committee was advised by and received reports and technical updates from Ernst and Young in their capacity as the Trust's external auditor. The Committee received the external auditor's reports regarding the planning, completion and findings of audit of the 2022/23 annual report and accounts

6.4 During 2023/24 the Committee undertook an effectiveness review of Ernst and Young as the Trust's external auditor. As a result of this review the Committee convened the Auditor Panel to oversee the process of tendering for external audit services. Following this process, on 30 November 2023 the Board of Directors approved the recommendation from the Auditor Panel and Audit and Risk Committee that Bishop Fleming be appointed as the Trust's external auditor.

Internal Audit

6.5 Throughout 2023/24 the committee was advised by and received reports and technical updates from 360 Assurance in their capacity as the Trust's internal auditors. The Committee approved the 2023/24 internal audit plan, received regular updates on the progress of the plan, the findings of individual reviews, and the implementation of management actions arising from reviews.

6.6 The Committee received the Internal Audit Annual Report for 2022/23, including the Head of Internal Audit Opinion. For 2022/23 the Trust received an overall opinion of 'moderate' assurance.

6.7 During 2023/24 the Committee undertook an effectiveness review of its internal auditors. As a result of this review the Committee approved a recommendation to trigger a contract extension to retain 360 Assurance as the Trust's internal auditors for a further two years.

Counter Fraud

6.8 Throughout the year the committee received advice and reports from 360 Assurance in their capacity as the Trust's counter fraud service provider. The Committee approved the annual Counter Fraud plan, received regular progress reports and updates, and received the Counter Fraud annual report.

6.9 The Committee approved the submission of the Counter Fraud Functional Standard Return for 2022/23 which confirmed full compliance with the Counter Fraud Functional Standard.

6.10 With reference to 6.7 above, the Committee approved a recommendation to trigger a contract extension to retain 360 Assurance as the Trust's counter fraud service provider for a further two years.

Governance, Risk Management and Internal Control

6.11 During the year, the Committee received reports on various aspects of the Trust's system of governance, risk management and internal control. This included regular reporting of corporate risks and the strategic risks set out in the Trust's Board Assurance Framework

6.12 The Committee reviewed and approved the Trust's Annual Governance Statement which sets out in detail the main features of the organisation's system of governance, risk management and internal control and how effectively these operated during 2022/23.

6.13 Financial controls routinely reviewed by the Committee include contracts, single tender waivers, and special payments. During 2023/24 the Committee commissioned additional assurance reporting relating to salary overpayments.

Assurance from Other Committees

6.14 Under its Terms of Reference the Audit and Risk Committee should expect to receive risk assurance reports and / or other reports from committees, as follows:

- Quality Committee
- Finance and Performance Committee
- People Committee (newly constituted in 2023/24)
- Charitable Funds Committee

6.15 During 2023/24 the Committee received quarterly risk assurance reports from the Quality Committee and the Finance and Performance Committee. The People Committee did not provide risk assurance reports during 2023/24 (but has subsequently commenced such reporting in 2024/25).

6.16 The Committee received an annual report from the Charitable Funds Committee.

7.0 URGENT AND FLEXIBLE DECISION MAKING

7.1 The Trust's Standing Orders allow for urgent and flexible decisions to be taken by the Chairs of Committees outside of the planned cycle of committee meetings. Such decisions should be ratified by the committee at its next ordinary meeting.

7.2 During 2023/24 the Chair of the Audit and Risk Committee enacted two urgent decisions, as follows:

Date	Decision	Ratified
12 October 2023	Recommendation that the Board of Directors approves an updated Letter of Representations to External Audit for 2022/23,	16 November 2023
12 October 2023	Approval of variances to the 2023/24 Internal Audit Plan,	16 November 2023

7.3 Note that although the Trust's Standing Orders make provision for urgent and flexible decision-making, the Terms of Reference for individual committees, including the Audit and Risk Committee, were silent on this matter and so the power to enact such decisions had been implicit rather than explicit. For 2024/25 all committee Terms of Refence now include explicit clauses relating to urgent and flexible decision-making, consistent with the Trust's Standing Orders.

8.0 2023/24 YEAR-END

2023/24 Annual Report and Accounts

8.1 At meetings held on 26 and 27 June 2024 the Committee reviewed the Annual Report and Accounts for 2023/24 and recommended these for approval by the Board of Directors. The Committee also reviewed and received other items associated with year-end governance and reporting. The 2023/24 year-end items considered by the committee were:

- Annual Report
- Annual Accounts and Financial Statements

- Statement of Post-Balance Sheet Events
- Annual Governance Statement
- Internal Audit Annual Report and Opinion
- External Audit ISA 260
- External Audit Annual Report
- Letter of Representations to the External Auditor
- NHS Code of Governance Compliance
- Provider Licence Declarations
- Quality Account

8.2 Upon the Committee's recommendation, the Board of Directors approved the annual report and accounts on 27 June 2024.

Counter Fraud Annual Report and Functional Standard

8.3 At its meeting held on 26 June 2024 the Committee received the Counter Fraud Annual Report for 2023/24. The Committee approved the submission of the Counter Fraud Functional Standard Return for 2023/24 which confirmed full compliance with the Counter Fraud Functional Standard

9.0 Supporting Information

Appendix A - 2023/24 Meeting Attendance Record

Andrew Chang
Chair, Audit and Risk Committee

David O'Brien
Director of Corporate Services and Company Secretary

July 2024

AUDIT AND RISK COMMITTEE

MEETING ATTENDANCE RECORD 2023-24

Committee Members and Attendees	18 Apr	29 Jun	25 Jul	22 Sep	16 Nov	28 Nov	18 Jan
Andrew Chang	✓	✓	✓	✓	✓	✓	✓
Anne Cooper	✓	✓	✓	✓			✓
Amanda Moat	✓	✓	✓	✓	✓	✓	✓
Kathryn Vause	✓	✓	✓	✓	✓	✓	✓
Clare Ashby	✓	✓	✓				
Dave Green					✓		✓
Lynn Hughes	✓	✓	✓	✓			
David O'Brien	✓		✓	✓	✓	✓	✓
Internal Audit	✓	✓	✓	✓	✓		✓
External Audit	✓		✓	✓			✓

Other Regular Attendees in 2023/24:

Terenia MacRory	Head of Finance Services
Louise Engledow	Deputy Director of Finance
Matt Barker	Head of Procurement and Logistics (attended x2)
Jeremy Pease	Non-Executive Director (attended x2)

Attended one meeting in 2023/24:

Steven Page	Director of Transition
Chipo Kazoka	Interim Head of Corporate Affairs
Nick Smith	Chief Operating Officer
Simon Marsh	Chief Information Officer
Glen Adams	Associate Director Fleet and Estates
Peter Reading	Chief Executive
Martin Havenhand	Chair

Meeting Title: Board of Directors (in Public)
Meeting Date: 25 July 2024
Agenda Item. 6.3

Report Title	**Committees' Terms of Reference**
Author (name and title)	David O'Brien, Director of Corporate Services and Company Secretary
Accountable Director	David O'Brien, Director of Corporate Services and Company Secretary
Previous committees/groups	TEG: 19 June, 03 July Quality Committee: 16 May, 21 June Finance and Performance Committee: 23 April, 23 May People Committee: 28 March, 09 July Audit and Risk Committee: 16 April Charitable Funds Committee: 12 January
Recommended action(s) Approval, Assurance, Information	Approval
Purpose of the paper	Approval of the Committees' Terms of Reference
Recommendation(s)	The Board of Directors approves the Committees' Terms of Reference, pending any final amendments that may be required.

Executive Summary

What?

The Trust's Standing Orders recommend that the Terms of Reference of Committees are reviewed on an annual basis and approved by the Board of Directors.

Each of the following Committees have reviewed their Terms of Reference and present them in the enclosed document for approval by the Board:

- Trust Executive Committee (known as the Trust Executive Group)
- Quality Committee
- Finance and Performance Committee
- People Committee
- Audit and Risk Committee
- Charitable Funds Committee

Note that:

1. The Committee workplans for 2024/25 have also been reviewed and are explicitly linked to the content of the Terms of Reference.

2. The reviews of Terms of Reference have been informed by the findings of the annual reports of Committees (see Item 6.2) on this agenda.

3. For 2024/25 the Committees' Terms of Refence now include explicit clauses relating to urgent and flexible decision-making, consistent with the Trust's Standing Orders.

Remuneration and Nominations Committee ToR

The Remuneration and Nominations Committee Terms of Reference have not been formally reviewed by the membership of that Committee ahead of this meeting.
However, these have been reviewed by the Company Secretary and one key update is proposed at.3.3, bulletpoints 7 and 8. This clarifies that the Committee's role in respect of remuneration for Executive Director and other VSM roles is to set the parameters of any proposed remuneration package but not to approve the final offer made to appointees (which is for the Chief Executive to negotiate).

So What?

It is good practice to maintain a readily available set of committee Terms of Reference, to review and update these regularly so that they remain current and fit for purpose, and to bring them to the Board of Directors for approval.

The NHS Code of Governance requires Trusts to make available information about the role of Board committees in their corporate governance structure. This document supports the Trust to meet that requirement and comply with the NHS Code of Governance.

What Next?

This document will be published on Pulse and on the Trust website.
Committee Terms of Reference will be reviewed and updated as required for 2025/26.

Strategic ambition(s) this supports. Provide brief bullet point details of link to Trust strategy.	Our Patients	All priorities
	Our People	All priorities
	Our Partners	All priorities
	Our Planet and Pounds	All priorities
Link with the BAF Include reference number. (board and level 2 committees only)		All strategic risks

NHS
Yorkshire
Ambulance Service
NHS Trust

Corporate Governance Guide: Committees Terms of Reference

Version 1.0: July 2024

DOCUMENT CONTROL INFORMATION

Document name	**Corporate Governance Guide: Committees Terms of Reference**
Version	1.0
Responsible Committee	Board of Directors
Responsible Director	Director of Corporate Services and Company Secretary
Document Owner (title)	Director of Corporate Services and Company Secretary
Document Lead (title)	Director of Corporate Services and Company Secretary
Approved By	Board of Directors
Date Approved	Approval scheduled for 25 July 2024
Review Date	tbc
Equality Impact Assessed (EIA)	Not applicable
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DOCUMENT CONTROL INFORMATION

Version	Date	Author	Status (A/D)	Description of Change(s)
1.0	**July 2024**	**David O'Brien**	**D**	New document for 2024/25
Document Status		A = Approved / **D = Draft**		
Document Author		**David O'Brien** Director of Corporate Services and Company Secretary		
This document is controlled in accordance with the Management of Procedural Documents Policy. If you would like to suggest amendments to this document, please contact the document author.				

Associated Policies and Procedural Documents

External Documents

NHS Code of Governance (2023)

HFMA NHS Audit Committee Handbook (2024)

Trust Documents

Trust Standing Orders

Corporate Governance Guide: The Board of Directors

TABLE OF CONTENTS

1. INTRODUCTION

A set of Committees supports the Board of Directors in the discharge of its duties. These Committees are an extension of the Board and not separate to it.

Appendix A shows the Trust's committee structure.

The committees of the Trust are:

- Trust Executive Committee (known as the Trust Executive Group, TEG)
- Audit and Risk Committee
- Quality Committee
- Finance and Performance Committee
- People Committee
- Remuneration and Nominations Committee
- Charitable Funds Committee

This document sets out the Terms of Reference for each of the above committees for the year 2024-25.
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TRUST EXECUTIVE COMMITTEE
(known as the Trust Executive Group)

Approved by Committee	03 July 2024
Approved by Board of Directors	

TRUST EXECUTIVE COMMITTEE
(Known as the Trust Executive Group)

Terms of Reference

1.0 Constitution

1.1 The Trust Executive Committee, known as the Trust Executive Group (TEG), is a standing Committee of the Yorkshire Ambulance Service NHS Trust (the Trust). It is formally constituted by the Board of Directors (the Board) in accordance with Section 4.6.8 of the Trust's Standing Orders.

1.2 TEG is accountable to the Board.

1.3 The Trust Standing Orders, including the Scheme of Powers Delegated by and Reserved to the Board, the Scheme of Financial Delegation, and the Standing Financial Instructions, will apply to the work of TEG.

1.4 This statement of Terms of Reference applies to formal TEG meetings only (see 7.1 below). TEG as a whole, or subsets of TEG, may hold other less formal meetings (see 7.2 below) to which these Terms of Reference do not apply.

2.0 Authority

2.1 TEG is authorised by the Board to act within its Terms of Reference and will be provided with Trust resources to do so. TEG has no executive powers other than those set out in these Terms of Reference.

2.2 All members of Trust staff are directed to co-operate with any request made by TEG.

2.3 TEG has the right of access to all information produced by or available to the Trust that it deems relevant to fulfil its duties. This may require any Trust colleague to attend a meeting of TEG to present information or to answer questions on a specific matter.

2.4 TEG is authorised by the Board to instruct professional advisors and request the attendance of individuals and authorities from outside of the Trust with relevant experience and expertise if it considers this necessary.

2.5 TEG is authorised to meet via a virtual / remote arrangement if it deems this to be necessary, either as an ad hoc arrangement or on a regular basis.

2.6 TEG is authorised, in exceptional circumstances, to conduct discrete business outside its scheduled meetings where it is not practicable to convene a full meeting.

3.0 Purpose and Duties

3.1 In accordance with Section 4.6.8 of the Trust Standing Orders, TEG is formally designated as the senior operational decision-making body of the Trust. In this role TEG will oversee:

- The development and delivery of the Trust's strategy, enabling strategies, and business plan priorities.
- The delivery of the Trust's clinical, operational, workforce and financial objectives.
- The achievement of the required statutory duties, regulatory compliance, clinical standards, and performance targets.
- The development and determination of key operational policies, development proposals, and business cases.
- Other decisions which need to be made at Trust level, but which are not matters reserved for decision by the Board or delegated to a TEG Management Group.

3.2 TEG will ensure that there is appropriate integration, co-ordination and co-operation between individual service lines within the Trust; between service lines and corporate functions within the Trust; and with the Trust's key external stakeholders and partners.

3.3 TEG will discharge its duties through oversight and assurance regarding the following:

- The delivery of the Trust's strategy, enabling plans and business plans following approval by the Board, with reviews undertaken at regular intervals.
- The design, implementation and effectiveness of processes relating to the management of risk to the achievement of strategic and operational objectives.
- The planning and delivery of activities and objectives relating to the Trust's clinical, operational, workforce and financial management priorities, allocating resource where necessary to deliver the Trust's objectives or other obligations.
- Oversight and assurance regarding processes for the development, review and approval of policies.
- The provision of a forum for individual directors to deliver their delegated responsibilities, where they can provide briefings, exchange information and resolve issues.
- The promotion and embedding of an open and supportive culture of continuous innovation, improvement, and organisational development.
- The promotion and active demonstration of the Trust's values and behaviours, including promotion of equality, diversity and inclusion.

3.4 In accordance with the Trust's Risk Management and Assurance Strategic Framework, TEG will:

- Review risks identified in relation to its remit.
- Review the Board Assurance Framework risks and corporate risk register

and make recommendations to the Board or Board committees regarding any required changes of risk score, assurances, controls, mitigations or other related content.

- Identify new risks for the attention of the Board of Directors.
- Escalate existing risks for the attention of the Board of Directors.

4.0 Membership

4.1 TEG membership will consist of the following roles:

- Chief Executive (Accountable Officer)
- Deputy Chief Executive
- Chief Operating Officer
- Executive Director of Quality and Chief Paramedic
- Executive Director of Finance
- Executive Medical Director
- Director of People and Organisational Development
- Directors of Partnerships and Operations (x3)
- Director of Strategy, Planning and Performance
- Director of Corporate Services and Company Secretary
- Chief Digital Information Officer
- Deputy Director of Quality and Nursing
- Director of Fleet and Estates
- Head of Communications and Community Engagement

4.2 The Chief Executive will be the TEG Chair.

4.3 The Deputy Chief Executive will be the TEG Vice Chair.

4.4 In exceptional situations, in the absence of both the Chief Executive and the Deputy Chief Executive, any other Executive Director may chair the meeting.

5.0 Attendees

5.1 Subject to agreement with the Chair, other senior officers of the Trust may be invited to attend meetings of TEG to present or support the presentation of specific agenda items.

5.2 TEG attendees may not propose items for inclusion on the meeting agenda. Only TEG members may propose items for inclusion on the meeting agenda and accountability for those items rests with the TEG member doing so.

6.0 Quorum

6.1 Meetings will be quorate when a minimum of six members are present.

6.2 At least two of the five voting Executive Director Board Members as defined by the Trust's Standing Orders must be present. These five roles are:

- Chief Executive
- Chief Operating Officer
- Executive Director of Finance
- Executive Director of Quality and Chief Paramedic
- Executive Medical Director

6.3 At least one of the following postholders must be present to ensure Executive-level representation of patient-facing services:

- Chief Operating Officer
- Executive Director of Quality and Chief Paramedic
- Executive Medical Director

6.4 No decisions shall be taken by TEG unless a quorum is present.

6.5 Members unable to attend a meeting may nominate a deputy to attend on their behalf, with the agreement of the TEG Chair. Nominated deputies will not count towards the quorum.

6.6 Deputies should be fully briefed on agenda items to support them to contribute effectively to discussion of relevant issues. Full access to meeting papers will be provided for all deputies.

6.7 Members may attend TEG meetings in person or remotely by telephone or other electronic means.

6.8 Members in attendance by electronic means will count towards the quorum.

7.0 Meetings Administration

7.1 Formal TEG meetings will normally be held on a fortnightly basis.

7.2 TEG shall have the power to establish additional meetings for the purpose of discussing strategic or other major issues requiring detailed consideration, or for informal discussion of routine business. These may be arranged as an established schedule of meetings throughout the year or on an ad hoc basis.

7.3 In order to facilitate a more flexible decision-making process between formal meetings, TEG may, where deemed appropriate by the Chair, and if there is quorum, consider a matter circulated via email and record its decisions by email correspondence. An official record of the decision will be reported to the next formal TEG meeting.

7.4 The TEG Chair will set the agenda and will agree which papers will be presented at each meeting. Agendas can only be amended by the agreement of the Chair.

7.5 The TEG Chair will determine the process by which items for inclusion on the agenda shall be proposed, accepted and submitted. This process will be administered via the Trust's Executive Office.

7.6 The agenda and papers for each meeting shall be made available to each member of TEG no less than two working days before the date of the meeting in electronic form, unless agreed otherwise by the Chair.

7.7 The Executive Office will act as the secretariat to TEG. The Senior Executive Officer (Chief Executive support) will normally be the main point of contact regarding the administration of TEG meetings. This will include circulating agenda papers, taking minutes and recording actions.

7.8 Draft minutes will be produced within two working days of each meeting. These will be reviewed and approved by the TEG Chair before the subsequent meeting.

8.0 Interests and Voting

8.1 The TEG Chair has the final decision on any actions required to comply with these Terms of Reference, or where a potential conflict may arise with the Trust's Board of Directors, or with their responsibilities as Accountable Officer.

8.2 At the beginning of each meeting the Chair will establish the existence of any conflicts of interest and ensure that these are recorded in the minutes accordingly.

8.3 Decisions will normally be reached by consensus. Members of TEG may be invited to vote on matters on which consensus cannot be achieved or to give an indication of where differences of opinion lie. Any such vote is advisory to the Chief Executive and is not binding.

8.4 Where voting does take place, only those members present at a meeting of TEG may vote. This includes members attending the meeting remotely. Each member is allowed one vote.

8.5 The votes of individual TEG members will be recorded in the minutes of the meeting.

9.0 Accountability and Reporting

9.1 TEG is accountable to the Board.

9.2 TEG will report to the Board, including to Board assurance committees, through reports presented by the Chief Executive, by Executive Directors, and by other TEG members.

9.3 A report to summarise recent TEG agenda items will be presented to each meeting of the Board of Directors held in Private.

9.4 TEG shall have the power to establish formally constituted sub-committees, called reporting committees, to which to delegate responsibility for specific functions (see section 10 below).

9.5 TEG shall have the power to establish time-limited task and finish groups for the purpose of addressing specific matters or areas of responsibility.

10.0 Reporting Committees

10.1 TEG shall have the power to establish formally constituted reporting committees to which to delegate responsibility for specific functions. No reporting committee can be established or disestablished without formal approval by TEG.

10.2 The Terms of Reference of each reporting committee, including its membership, will be reviewed and approved by TEG at least annually.

10.3 Each reporting committee will be chaired by a member of TEG or their designated deputy.

10.4 The Chairs of the reporting committees are required to submit a highlight report to TEG following each meeting of their group.

10.5 For 2024/25 the formally constituted TEG reporting committees are as follows:

- Clinical Governance
- Patient Safety Learning
- Risk and Assurance
- Strategic Health and Safety
- People and Culture
- Operational Leadership
- Organisational Efficiency
- Resilience Governance
- Capital Planning
- Digital Management (or equivalent)

10.6 TEG will receive reporting and assurance with other relevant governance groups or processes, including:

- Performance Review Meetings

11.0 Monitoring and Review

11.1 The Terms of Reference of TEG will be reviewed at least annually and submitted to the Board for approval.

11.2 TEG will undertake an annual review of its performance, via self-assessment by its members and any agreed actions, will be reported to the Board.

AUDIT AND RISK COMMITTEE

Approved by Committee	16 April 2024
Approved by Board of Directors	

Audit and Risk Committee

Terms of Reference 20245/45

1.0 Constitution

1.1 The Audit and Risk Committee (the Committee) is a standing Board Committee that has been formally constituted by the Board of Directors of the Yorkshire Ambulance Service NHS Trust (the Trust) in accordance with its Standing Orders (4.6.1)

1.2 The Scheme of Powers Delegated by and Reserved to the Board, the Scheme of Financial Delegations, and the Standing Financial Instructions of the Trust will apply to the work of the Committee.

2.0 Authority

2.1 The Committee is authorised by the Board of Directors to act within its terms of reference and will be provided with Trust resources to do so. All members of Trust staff are directed to co-operate with any request made by the Committee.

2.2 The Committee has no executive powers other than those set out in these Terms of Reference.

2.3 The Committee has the right of access to all information that it deems relevant to fulfil its duties. This may require any Trust colleague to attend a meeting of the Committee to present information or to answer questions on a matter under discussion.

2.4 The Committee is authorised by the Board of Directors to instruct professional advisors and request the attendance of individuals and authorities from outside of the Trust with relevant experience and expertise if it considers this necessary.

2.5 The Committee is authorised to meet via a virtual / remote arrangements if it deems this to be necessary.

2.6 The Committee is authorised, in exceptional circumstances, to conduct discrete business outside its scheduled meetings where it is not practicable to convene a full meeting.

3.0 Purpose and Duties

3.1 The purpose and duties of the Committee are consistent with the NHS Audit Committee Handbook (HFMA) and other relevant guidance for public sector audit and risk committees.

3.2 The purpose and duties of the Committee are to:

- 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 Trust's objectives.

- Ensure that there is an effective internal audit function that meets the mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Chief Executive, this Committee and the Board.

- Review the work and findings of the external auditors and consider the implications and management responses to their work.

- Review the work of other committees within the organisation whose work can provide relevant assurance to the Committee's own scope of work. In particular this will include the review of assurances provided to the Committee by the Quality Committee, the Finance and Performance Committee, and the People Committee, and in respect of their role in the assurance of the Board Assurance Framework.

- Review the findings of other significant sources of assurance, both internal and external to the organisation, and consider the implications of these for the governance, risk management and internal control of the organisation.

- Satisfy itself that the organisation has adequate arrangements in place for countering fraud, and review the outcomes of counter fraud work.

- Monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance.

- Ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided to the Board. A primary source of assurance in this regard shall be the Finance and Performance Committee.

4.0 Responsibilities

4.1 Governance, Risk Management and Internal Control

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

- All risk and control related disclosure statements. In particular these will include the Annual Governance Statement, Board memoranda and self- certification statements to the Regulator, and declarations of

compliance with the NHS Code of Governance and the Essential Standards of Quality and Safety, together with any accompanying Head of Internal Audit Opinion, External Audit opinion, and other appropriate independent assurance, prior to endorsement by the Board;

- The statements contained within the Quality Account, together with review of any associated external audit assurance opinion as directed by NHS England;

- The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks, the Board Assurance Framework, and the appropriateness of the above disclosure statements;

- The Trust's framework of policies for ensuring compliance with the relevant regulatory, legal and code of conduct requirements;

- The policies and procedures for all work related to fraud, bribery and corruption as set out by NHS Counter Fraud Authority; and

- Arrangements by which staff of the Trust may raise, in confidence, concerns about the service in matters of financial reporting and control, clinical quality, patient safety or other matters, with the aim of ensuring that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow up action.

4.1.2 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 (including the Board Assurance Framework) 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.

4.2 Internal Audit

4.2.1 The Committee shall ensure that there is an effective internal audit function established by management that meets the mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Committee, Chief Executive and the Board. This will be achieved by:

- Consideration of the provision of an Internal Audit service, the tendering procedure for any change in audit provider, the cost of the audit service and any questions of resignations and dismissal of internal auditors;

- Review and approval of the Internal Audit strategy, the annual Internal Audit plan and more detailed programmes of work as required, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework;

- Consideration of the major findings of internal audit work and management response thereto, including seeking assurance regarding the timely and appropriate response to recommendations arising from internal audit work.

- Consideration of the Head of Internal Audit Opinion and management response thereto.

- Ensuring appropriate coordination between internal and external audit work to optimise the effective and efficient use of audit resource;

- Ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation; and

- Undertaking an annual review of the effectiveness of Internal Audit.

4.3 External Audit

4.3.1 The Committee shall review the work and findings of the External Auditor and consider the implications of and management responses to their work. This will be achieved by:

- Through the establishment of the Auditor Panel in accordance with Standing Orders (4.6.2), recommend to the Board of Directors the appointment of the external auditor.

- Discussion and agreement with the External Auditor, before audit work commences, of the nature and scope of the audit as set out in theAnnual Plan, and ensure coordination as appropriate, with other External Auditors in the local health economy;

- Discussion with External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee;

- Ensuring appropriate coordination between internal and external audit work to optimise the effective and efficient use of audit resource;

- Approve the Annual Plan and associated fees;

- Review all external audit reports, including agreement of the annual audit letter before submission to the Board and any work carried outside the Audit Plan, together with the appropriateness of the management response;

- Consideration of the major findings of internal audit work and management response thereto, including seeking assurance regarding the timely and appropriate response to recommendations arising from internal audit work.

- Development and implementation of a policy on the engagement ofthe External Auditor to supply non-audit services, taking into account relevant ethical guidance and in context of the role of the Auditor Panel

to advise the Board on the selection and appointment of the External Auditor;

- Undertake an annual review of the effectiveness of the External Auditor.

4.4 Other assurance functions

4.4.1 The Committee shall review the findings of other significant sources of assurance, both internal and external. These may include but are not limited to:

- Any reviews by the Department of Health Arm's Length Bodies or Regulators/Inspectors, e.g. the Care Quality Commission, NHS England.
- Any reviews by other government departments or regulatory bodies (e.g. Office of the Information Commissioner; Office of the National Guardian; Ofsted)
- Professional Bodies with the responsibility for the performance of staff (e.g. Royal Colleges, accreditation bodies etc.)

4.4.2 The Committee will review the work of other Board Committees in the Trust, whose work can provide relevant assurance to this Committee's own scope of work. In particular, this will include the review of assurances provided to the Committee by the Quality Committee, the Finance and Performance Committee, and the People Committee.

4.5 Management

4.5.1 The Committee will request and review reports and assurances from directors and managers of the organisation regarding the overall arrangements for governance, risk management and internal control.

4.5.2 The Committee may request specific reports from individual functions within the organisation as it may deem to be appropriate.

4.6 Financial reporting

4.6.1 The Committee will monitor the integrity of the financial statements of the organisation and any formal announcements relating to theTrust's financial performance.

4.6.2 The Committee will 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.

4.6.3 The Committee will review the Annual Report and Financial Statements before submission to the Board of Directors

4.6.4 The Committee will review the Annual Governance Statement and other disclosures relevant to the terms of reference of the Committee.

4.6.5 The Committee will review changes in, and compliance with, accounting policies, practice and estimation techniques, including the following:

- Unadjusted misstatements in the financial statements;
- Significant judgements made in the preparation of the financial statements;
- Significant adjustments resulting from the annual external audit;
- The letter of management representation to external audit; and
- Qualitative aspects of financial reporting.

4.7 **Standing Orders and Standing Financial Instructions**.

4.7.1 The Committee will:

- Seek assurance regarding compliance with the organisation's Standing Orders and Standing Financial Instructions.
- Consider any proposed changes to the organisation's Standing Orders and Standing Financial Instructions, prior to presentation to the Board of Directors for approval.
- Review schedules of losses and special payments and make recommendations as required to the Board of Directors.
- Review retrospectively every decision to suspend the Standing Orders of the organisation.
- At least once every twelve months, review the Register of Interests of the Board of Directors as maintained by the Chief Executive.
- If so directed by the Board of Directors, conduct a detailed review of annual or period budgets including proformas prepared for the Department of Health and Social Care, but these are to be returned to the Board of Directors for approval.
- Receive reports from the Charitable Funds Committee regarding governance, risk management, control, audit and financial reporting matters.

4.7.2 Consider any other matters of financial accountability, probity, compliance and/or value for money as and when requested by the Board of Directors.

4.7.3 Other matters may be considered when directed to do so by the Board of Directors.

5.0 Relationships

5.0 The Committee will seek the views of Board Committees to gain assurance on Trust systems to provide timely and on-going assurance regarding the effectiveness of systems of integrated governance, risk management and

internal control within those Committees' areas of concern as per their respective terms of reference.

5.1 The Committee will oversee the relationship of the organisation with external and internal audit functions. It will seek their views on the Trust's systems of control and will consider the management response to the auditors' work.

6.0 Membership

6.1 The Membership of the Committee will be agreed by the Board of Directors.

6.2 Membership of the Committee will consist of three Non-Executive Directors (excluding the Chair of the Trust who will not be a member of the Committee):

6.3 The Board of Directors will appoint the Chair and the Vice Chair of the Committee.

7.0 Attendees

7.1 Attendees of meetings of the Committee will include:

- Executive Director of Finance
- Executive Director of Quality and Chief Paramedic
- Company Secretary
- A representative of the internal auditors
- A representative of the external auditors
- The local counter fraud specialist

7.2 The Executive Director of Finance will be the Director Lead for the Committee.

7.3 The Chief Executive and other Executive Directors may be invited to attend at the discretion of the Chair, particularly when the Committee is discussing areas of governance, risk or control that is the responsibility of that director.

7.4 Where reports of the internal auditors reflect 'no' or 'limited assurance' the relevant director should assume that their attendance at the next meeting of the Committee is required.

7.5 The Chief Executive shall attend meetings to discuss with the Committee the process for assurance that supports the Annual Governance Statement, to review each year's draft internal audit plan and the draft annual accounts.

7.6 At least once a year the Committee will meet with each of the External and Internal Auditors without any Executive Director of the Board present.

7.7 Additional Trust members of staff or external attendees will be invited as and when required to support the workings of the meeting.

7.8 An attendance record will be held for each meeting.

8.0 Quorum

8.1 Meetings of the Committee will be declared quorate when at least two Committee members are present.

8.2 No business shall be transacted by the Committee unless a quorum is present.

8.3 Members are able to attend Committee meetings in person, by telephone, or by other electronic means.

8.4 Members in attendance by electronic means will count towards the quorum.

9.0 Committee Administration

9.1 The Committee will meet at least five times each year. These meetings will comprise four quarterly ordinary meetings plus a fifth meeting to review the Trust's Annual Accounts.

9.2 The Committee Chair, the External Auditor, or the Head of Internal Audit may request an additional meeting of the Committee if they consider this necessary, in order to allow the Committee to discharge all of its responsibilities.

9.3 Additional meetings will be convened by the Committee Chair as necessary. The Committee Chair will ensure that, if additional meeting(s) are held virtually, these must be recorded and the minutes reviewed and approved by the Board of Directors.

9.4 The Chair of the Committee and the Director Lead will meet to agree the agenda for each meeting. The agenda will be based on the Committee Annual Work Plan and any agreed additional items.

9.5 The Director Lead for the Committee will be the Executive Director of Finance. The Company Secretary or their nominated designate will support the Chair of the Committee and Lead Director in the management of the Committee's business and for drawing attention to good practice, national guidance and other relevant documents, as appropriate.

9.6 Notice of each meeting shall be made available to each member of the Committee no fewer than four clear working days before the date of the meeting in electronic form unless agreed otherwise by the Chair and the Lead Director.

9.7 Administrative support to the Committee shall be provided by the appropriate committee secretary. The committee secretary will take minutes and clearly record actions.

9.8 Items for inclusion on the agenda shall be submitted to the secretary no fewer than ten days prior to the meeting. Agendas may only be amended by the agreement of the Committee Chair and Director Lead.

9.9 The Chair shall establish, at the beginning of each meeting, the existence of any conflicts of interest and ensure that these are recorded in the minutes accordingly.

9.10 The committee secretary shall minute the proceedings of all Committee meetings and provide draft minutes within five working days, reviewed by the Executive Lead and then approved by the Committee Chair within 10 working days of the meeting.

9.11 An urgent decision be exercised by Chair after having consulted with at least one other Committee member and the Executive Director Lead. The exercise of such powers by the Chair will be reported to the next formal meeting of the Committee.

9.12 In order to facilitate a more flexible decision-making process between formal meetings the Committee may, where deemed appropriate by the Chair, and as long as there is quorum, consider a matter circulated via email and record their decision by email correspondence. A record of the decision will be created and reported to the next formal meeting of the Committee.

10.0 Reporting and Accountability

10.1 The Committee is accountable to the Board of Directors.

10.2 The Chair will report to the Board of Directors following each meeting on how it has discharged its responsibilities. The Chair of the Committee shall provide the Board with a Chair's Assurance Report following each Committee meeting, providing assurance or highlighting risks or issues that require executive action. The approved minutes of Committee meetings shall be formally recorded and submitted to the Board.

10.3 The Committee will report to the Board annually on its work in support of the Annual Governance Statement. The Annual Report should also describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the Committee has considered and how these were addressed.

10.4 The Committee Chair shall attend the Annual General Meeting to respond to any stakeholder questions on the Committee's activities.

11.0 Monitoring and Review

11.1 The Terms of Reference of the Committee will be reviewed at least annually and submitted to the Board of Directors for approval.

11.2 The Committee will undertake an annual review of its performance, via self-assessment by its members and any agreed actions, will be reported to the Board of Directors.

QUALITY COMMITTEE

Approved by Committee	21 June 2024
Approved by Board of Directors	

QUALITY COMMITTEE

Terms of Reference

2.0 Constitution

1.1 The Quality Committee (the Committee) is a standing Board Assurance Committee that has been formally constituted by the Board of Directors of the Yorkshire Ambulance Service NHS Trust (the Trust) in accordance with its Standing Orders.

1.2 The Scheme of Powers Delegated by and Reserved to the Board, the Scheme of Financial Delegations, and the Standing Financial Instructions of the Trust will apply to the work of the Committee.

2.0 Authority

2.1 The Committee is authorised by the Board of Directors to act within its terms of reference and will be provided with Trust resources to do so. All members of Trust staff are directed to co-operate with any request made by the Committee.

2.2 The Committee has no executive powers other than those set out in these Terms of Reference.

2.3 The Committee has the right of access to all information that it deems relevant to fulfil its duties. This may require any Trust colleague to attend a meeting of the Committee to present information or to answer questions on a matter under discussion.

2.4 The Committee is authorised by the Board of Directors to instruct professional advisors and request the attendance of individuals and authorities from outside of the Trust with relevant experience and expertise if it considers this necessary.

2.5 The Committee is authorised to meet via a virtual/remote arrangement if it deems that necessary.

2.6 The Committee is authorised, in exceptional circumstances, to conduct discrete business outside its scheduled meetings where it is not practicable to convene a full meeting.

3.0 Purpose and Duties

3.1 The purpose of the Committee is to gain assurance, on behalf of the Board of Directors that the Trust is making sufficient progress towards its Quality priorities to support the delivery of the Trust's strategic objectives and Operational Plan whilst being assured as to compliance with appropriate regulatory and statutory requirements.

3.2 The purpose of the Committee is to seek and obtain assurance on behalf of the Board of Directors to demonstrate that the Trust:

- Is making sufficient progress towards improving patient safety, patient experience, and clinical outcomes, and reducing health inequalities.
- Is making sufficient progress towards the delivery of the Trust's strategic ambitions and business plan priorities in respect of the remit of the Quality Committee, specifically those items set out at 3.2 below.
- Has in place the appropriate plans, policies, systems, data and intelligence and processes to support delivery of the above.
- Can be assured regarding compliance with appropriate policy, regulatory, and statutory requirements.
- Can be assured regarding the operation and effectiveness of systems of governance, risk management and internal control as they apply to the remit of the Committee.

3.3 The Committee will discharge its duties through oversight and assurance regarding the following:

- The development and operation of appropriate systems and processes to review and monitor the quality and effectiveness of care delivered across the Trust.
- The delivery of quality functions and clinical services through effective strategies, plans, and work programmes
- The Trust's capacity and capability to support and sustain delivery of high-quality services.
- The timely and effective use of relevant and robust data and intelligence to drive improvement in the quality of care.
- The production of the annual Quality Account in line with national guidance and timeframes.
- The management and delivery of information governance and health related IT clinical safety compliance across the Trust's functions.
- The development, review, and implementation of Trust policies and procedures governing the use of clinical data and patient identifiable information, ensuring compliance with relevant legislation and guidance.
- The quality of patient experience, including the identification and application of learning from the experience of patients, families, and carers.
- The development and application of effective mechanisms to capture and learn from the experience of Trust staff and volunteers.
- The identification and management of risk relating to clinical care.
- The oversight of the enabling plan for Quality Improvement across the Trust.
- Oversight of the performance and compliance information regarding the delivery of key statutory and regulatory requirements in relation to quality and clinical care.
- Recommendations to the Audit and Risk Committee on additions to the annual internal audit plan work in relation to the scope of this Committee's remit, and progress in the implementation of recommendations arising from internal audit.
- The oversight of the annual Clinical Audit programme.

- The health and safety of Trust employees, contractors, volunteers, and others using the Trust's premises, services, and equipment.
- The oversight of effective systems for reporting, investigating, and learning from incidents, complaints and concerns, claims, Coroners' inquests ,and other adverse events.
- The oversight of effective systems and processes for managing and learning from all significant adverse events.
- The oversight of quality impact assessment of Trust service developments, projects and programmes, and other initiatives
- The effectiveness of the Trust's safeguarding arrangements.
- The effectiveness of the Trust's infection prevention and control arrangements.
- The effectiveness of medicines management and optimisation, including the management of controlled drugs.
- The effectiveness and safety of research carried out by the Trust, either alone or in partnership with others.

3.4 The Committee may seek appropriate review of and input into the development, governance and approval of business cases, contracts or other forms of investment proposal or service agreements that relate to the remit of this Committee.

3.5 In accordance with the Trust's Risk Management and Assurance Strategic Framework the Committee will:

- Review risks identified in relation to its remit.
- Review the Board Assurance Framework risks delegated to the Committee (see Appendix C of this document) and make recommendations to the Board of Directors regarding any required changes of risk score, assurances, controls, mitigations or other related content.
- Review the corporate risks relating specifically to the remit of the Committee as reported in the Corporate Risk Register.
- Identify new risks for the attention of the Board of Directors.
- Escalate existing risks for the attention of the Board of Directors.
- Provide assurance to the Audit and Risk Committee regarding the management of risks in relation to it the Committee's remit.

4.0 Committee Membership

4.1 The Committee membership will be agreed by the Board of Directors.

4.2 The Committee membership will consist of:

- Three Non-Executive Directors
- Executive Director of Quality and Chief Paramedic
- Executive Medical Director

4.3 The Board of Directors will appoint the Chair and Vice Chair of the Committee.

4.4 The Chair and Vice Chair of the Committee will be Non-Executive Directors

5.0 Committee Attendees

5.1 Routine attendees at meetings of the Committee will include:

- Director of Corporate Services and Company Secretary
- Director of Partnerships and Operations
- Deputy Director of Quality and Nursing
- Associate Chief Operating Officer Remote Care

5.2 Any additional members of Trust staff will be invited as and when required to support the work of the Committee.

5.3 Individuals from external organisations may be invited to attend as and when required to support the work of the Committee.

5.4 An attendance record will be held for each meeting.

6.0 Quoracy

6.1 Meetings of the Committee will be declared quorate when at least three Committee members are present. For the purposes of quoracy, the three Committee members present must include at least two Non-Executive Directors and one Executive Director.

6.2 No business shall be transacted by the Committee unless a quorum is present.

6.3 Members unable to attend a meeting may nominate a deputy to attend on their behalf, with the prior agreement of the Committee Chair. Nominated deputies shall not count towards the quorum.

6.4 Members of the Committee do not represent or advocate for their respective area of the Trust; they act in the interests of the Trust as a whole.

6.5 Members of the Committee are able to attend meetings of the Committee either in person, by telephone, or by other electronic means.

6.6 Members of the Committee in attendance by electronic means will count towards the quorum.

6.7 Members of the Committee must demonstrably consider, and take appropriate positive action in respect of, the equality and diversity implications of decisions taken by the Committee.

7.0 Decision Making and Voting

7.1 The Committee will take decisions in accordance with the Trust's Standing Orders.

7.2 The Committee will ordinarily reach conclusions by consensus. When it is not possible to reach a decision by consensus the Committee Chair may call a vote.

7.3 In the event of a vote being called, only Committee members present at a meeting of the Committee may participate. Each Committee member is allowed to cast one vote.

7.4 In the event of a vote being called, a simple majority of votes cast will be sufficient to determine any given matter.

7.5 In the event that the totality of votes cast does not produce a simple majority, the Chair of the Committee will hold the casting vote.

8.0 Committee Administration

8.1 The Committee will ordinarily meet at least ten times a year. By exception, and in the event of extraordinary circumstances, this number may be varied upwards or downwards.

8.2 The Committee shall meet at any other time that the Chair of the Committee, in consultation with the Lead Director, shall require, in order to enable the Committee to discharge its responsibilities in full as required.

8.3 The Chair of the Committee and the Lead Director will meet to agree the agenda for each meeting. The agenda will be based on the Committee Annual Work Plan and any agreed additional items.

8.4 The Company Secretary or their nominated designate will support the Chair of the Committee and the Lead Director in the management of the Committee's business.

8.5 Notice of each meeting shall be made available to each member of the Committee, no less than four working days before the date of the meeting in electronic form unless agreed otherwise by the Chair and Lead Director.

8.6 Administrative support to the Committee shall be provided by the committee secretary, who will normally be a member of the Trust's corporate governance team. The committee secretary will take minutes and clearly record actions.

8.7 Items for inclusion on the agenda shall be submitted to the secretary at least seven days prior to the meeting. Agendas can only be amended by the agreement of the Committee Chair and Lead Director.

8.8 The Committee Chair shall establish, at the beginning of each meeting, the existence of any conflicts of interest and ensure that these are recorded in the minutes accordingly.

8.9 The committee secretary shall minute the proceedings of all Committee meetings and provide draft minutes within five working days, reviewed by the Lead Director and then approved by the Committee Chair within 10 working days of the meeting.

8.10 An urgent decision be exercised by Chair after having consulted with at least one other Committee member and the Lead Director. The exercise of such powers by the Chair will be reported to the next formal meeting of the Committee.

8.11 In order to facilitate a more flexible decision-making process between formal meetings the Committee may, where deemed appropriate by the Chair, and as long as there is quorum, consider a matter circulated via email and record their decision by email correspondence. A record of the decision will be created and reported to the next formal meeting of the Committee.

9.0 Reporting and Accountability

9.1 The Committee is accountable to the Board of Directors.

9.2 Following each meeting of the Committee the Chair will report to the Board of Directors on how the Committee has discharged its responsibilities. Such reports will alert the Board to any matters that require action, advise the Board on other important matters, and assure the Board about the routine business transacted by the Committee.

9.3 The approved minutes of meetings of the Committee shall be formally recorded and submitted to the next available meeting of the Board of Directors.

9.4 The Chair of the Committee shall provide the Audit and Risk Committee with a risk assurance report. This report will provide assurance regarding the strategic and corporate risks considered by the Committee, highlight strategic or corporate risks and issues that may require further action, and escalate any concerns regarding risk management processes, controls. and mitigations.

9.5 The Committee will report to the Board annually on its work. The Committee's Annual Report should describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the Committee has considered and how these were addressed.

9.6 The Committee Chair shall attend the Annual General Meeting of the Trust to respond to any stakeholder questions regarding the Committee's work during the year.

9.7 The Committee shall have the power to establish task-and-finish groups for the purpose of addressing specific tasks for a time-limited period.

9.8 The Chair from each task-and-finish group will provide meetings of the Committee with:

- a progress report on the work of their group
- the most recent approved minutes from their group

10.0 Monitoring and Review

10.1 The Terms of Reference of the Committee will be reviewed at least annually and submitted to the Board of Directors for approval.

10.2 The Committee will undertake an annual review of its performance, via self-assessment by its members and any agreed actions will be reported to the Board.

FINANCE AND PERFORMANCE COMMITTEE

Approved by Committee	23 May 2024
Approved by Board of Directors	

FINANCE AND PERFORMANCE COMMITTEE

Terms of Reference

1.0 Constitution

1.1 The Finance and Performance Committee (the Committee) is a standing Board Assurance Committee that has been formally constituted by the Board of Directors of the Yorkshire Ambulance Service NHS Trust (the Trust) in accordance with its Standing Orders.

1.2 The Scheme of Powers Delegated by and Reserved to the Board, the Scheme of Financial Delegations, and the Standing Financial Instructions of the Trust will apply to the work of the Committee.

2.1 Authority

2.1 The Committee is authorised by the Board of Directors to act within its terms of reference and will be provided with Trust resources to do so. All members of Trust staff are directed to co-operate with any request made by the Committee.

2.2 The Committee has no executive powers other than those set out in these Terms of Reference.

2.3 The Committee has the right of access to all information that it deems relevant to fulfil its duties. This may require any Trust colleague to attend a meeting of the Committee to present information or to answer questions on a matter under discussion.

2.4 The Committee is authorised by the Board of Directors to instruct professional advisors and request the attendance of individuals and authorities from outside of the Trust with relevant experience and expertise if it considers this necessary.

2.5 The Committee is authorised to meet via a virtual/remote arrangement if it deems that necessary.

2.6 The Committee is authorised, in exceptional circumstances, to conduct discrete business outside its scheduled meetings where it is not practicable to convene a full meeting.

3.0 Purpose and Duties

3.1 The purpose of the Committee is to seek and obtain assurance on behalf of the Board of Directors to demonstrate that, in the context of the matters set out in 3.2 below, the Trust:

- Is making sufficient progress towards the delivery of the Trust's strategic ambitions and operational plan priorities.
- Is making sufficient progress regarding the Trust's financial and performance targets, indicators, and outcomes.
- Has in place the appropriate plans, policies, systems, and processes to support delivery of the above.
- Can be assured regarding compliance with appropriate policy, regulatory, and statutory requirements.
- Can be assured regarding the operation and effectiveness of systems of governance, risk management and internal control as they apply to the remit of the Committee.

3.2 The Committee will discharge its duties through oversight and assurance regarding the following:

- Implementation of the Trust's in-year operational priorities and financial objectives against agreed milestones.
- The development and operation of the Trust's performance management framework.
- The development and operation of the Trust's business planning cycle and processes.
- The Trust's financial planning processes, relating to revenue and capital.
- The Trust's budget setting processes.
- The Trust's actual and forecast operational performance against plan, including performance against key operational targets and indicators (and see 3.5 below)
- The Trust's actual and forecast financial performance against plan, including performance against key financial targets and indicators.
- The planning and delivery of the Trust's efficiency programme.
- Progress regarding the implementation of audit actions in relation to the Committee's duties.
- Key policies, systems, and processes in relation to the Committee's duties, including finance, procurement, digital technology, fleet and estates.
- Development and delivery of the Trust's business continuity and EPRR priorities, including seasonal plans.
- Development and delivery of the Trust's plans and priorities relating to digital technology, data management, business intelligence and cyber security.
- Development and delivery of the Trust's plans relating to fleet, estates and facilities management.
- Development and delivery of the Trust's plans relating to sustainability, net zero or other environmental concerns.

- Development and delivery of Trust recovery programmes, as required.
- Management of the Trust's contractual arrangements.
- Management of the Trust's procurement arrangements.
- Management of Trust assets: both the acquisition of assets and their disposal.

3.3 In accordance with the Trust's Standing Orders, Scheme of Financial Delegation and Standing Financial Instructions, the Committee will review and make recommendations to the Trust Board regarding:

- Business plans or other forms of investment justification.
- Tenders and contracts for approval by the Board.
- Contract variations, including variations in income and expenditure.
- Commercial or investment activity e.g., proposed joint ventures or partnerships.

3.4. In accordance with the Trust's Risk Management and Assurance Strategic Framework the Committee will:

- Review risks identified in relation to its remit.
- Review the Board Assurance Framework risks delegated to the Committee (see Appendix C of this document) and make recommendations to the Board of Directors regarding any required changes of risk score, assurances, controls, mitigations or other related content.
- Review the corporate risks relating specifically to the remit of the Committee as reported in the Corporate Risk Register.
- Identify new risks for the attention of the Board of Directors.
- Escalate existing risks for the attention of the Board of Directors.
- Provide assurance to the Audit and Risk Committee regarding the management of risks in relation to it the Committee's remit.

3.5 In the discharge of its duties relating to operational or financial performance, including performance against key targets and indicators, the Committee may:

- Receive outputs from the Trust's performance review and improvement process.
- Refer issues and concerns for by the Trust's performance review and improvement process.
- Refer issues and concerns to other assurance committees, including Trust Executive Group, for investigation and resolution.
- Request additional information or assurance from other committees.
- Escalate performance issues for the attention of the Board of Directors.

4.0 Committee Membership

4.1 The Committee membership will be agreed by the Board of Directors.

4.2 The Committee membership will consist of:

- Three Non-Executive Directors.
- Executive Director of Finance, who will be the Executive Lead for the Committee.
- Chief Operating Officer.

4.4 The Board of Directors will appoint the Chair and Vice Chair of the Committee.

4.4 The Chair and Vice Chair of the Committee will be Non-Executive Directors.

5.0 Committee Attendees

5.1 Routine attendees at meetings of the Committee will include:

- Chief Digital Information Officer.
- Director of Strategy, Planning and Performance.
- Director of Corporate Services and Company Secretary.
- One Director of Partnerships and Operations.
- Deputy Director of Finance.

5.2 Any additional members of Trust staff will be invited as and when required to support the work of the Committee.

5.3 Individuals from external organisations may be invited to attend as and when required to support the work of the Committee.

5.4 An attendance record will be held for each meeting.

6.0 Quoracy

6.1 Meetings of the Committee will be declared quorate when at least three Committee members are present. For the purposes of quoracy, the three Committee members present must include at least two Non-Executive Directors and one Executive Director.

6.2 No business shall be transacted by the Committee unless a quorum is present.

6.3 Members unable to attend a meeting may nominate a deputy to attend on their behalf, with the prior agreement of the Committee Chair. Nominated deputies shall not count towards the quorum.

6.4 Members of the Committee do not represent or advocate for their respective area of the Trust; they act in the interests of the Trust as a whole.

6.5 Members of the Committee are able to attend meetings of the Committee either in

person, by telephone, or by other electronic means.

6.6 Members of the Committee in attendance by electronic means will count towards the quorum.

6.7 Members of the Committee must demonstrably consider, and take appropriate positive action in respect of, the equality and diversity implications of decisions taken by the Committee.

7.0 Decision Making and Voting

7.1 The Committee will take decisions in accordance with the Trust's Standing Orders.

7.2 The Committee will ordinarily reach conclusions by consensus. When it is not possible to reach a decision by consensus the Committee Chair may call a vote.

7.3 In the event of a vote being called, only Committee members present at a meeting of the Committee may participate. Each Committee member is allowed to cast one vote.

7.4 In the event of a vote being called, a simple majority of votes cast will be sufficient to determine any given matter.

7.5 In the event that the totality of votes cast does not produce a simple majority, the Chair of the Committee will hold the casting vote.

8.0 Committee Administration

8.1 The Committee will ordinarily meet at least ten times a year. By exception, and in the event of extraordinary circumstances, this number may be varied upwards or downwards.

8.2 The Committee shall meet at any other time that the Chair of the Committee, in consultation with the Executive Lead, shall require, in order to enable the Committee to discharge its responsibilities in full as required.

8.3 The Chair of the Committee and the Executive Lead will meet to agree the agenda for each meeting. The agenda will be based on the Committee Annual Work Plan and any agreed additional items.

8.4 The Company Secretary or their nominated designate will support the Chair of the Committee and the Executive Director in the management of the Committee's business.

8.5 Notice of each meeting shall be made available to each member of the Committee, no less than four working days before the date of the meeting in electronic form unless agreed otherwise by the Chair and Executive Lead.

8.6 Administrative support to the Committee shall be provided by the committee secretary, who will normally be a member of the Trust's corporate governance team. The committee secretary will take minutes and clearly record actions.

8.7 Items for inclusion on the agenda shall be submitted to the secretary at least seven

days prior to the meeting. Agendas can only be amended by the agreement of the Committee Chair and Executive Lead.

8.8 The Committee Chair shall establish, at the beginning of each meeting, the existence of any conflicts of interest and ensure that these are recorded in the minutes accordingly.

8.9 The committee secretary shall minute the proceedings of all Committee meetings and provide draft minutes within five working days, reviewed by the Executive Lead and then approved by the Committee Chair within 10 working days of the meeting.

8.10 An urgent decision may be exercised by the Chair after having consulted with at least one other Committee member and the Executive Director Lead. The exercise of such powers by the Chair will be reported to the next formal meeting of the Committee.

8.11 In order to facilitate a more flexible decision-making process between formal meetings the Committee may, where deemed appropriate by the Chair, and as long as there is quorum, consider a matter circulated via email and record their decision by email correspondence. A record of the decision will be created and reported to the next formal meeting of the Committee

9.0 Reporting and Accountability

9.1 The Committee is accountable to the Board of Directors.

9.2 Following each meeting of the Committee the Chair will report to the Board of Directors on how the Committee has discharged its responsibilities. Such reports will alert the Board to any matters that require action, advise the Board on other important matters, and assure the Board about the routine business transacted by the Committee.

9.3 The approved minutes of meetings of the Committee shall be formally recorded and submitted to the next available meeting of the Board of Directors.

9.4 The Chair of the Committee shall provide the Audit and Risk Committee with a risk assurance report. This report will provide assurance regarding the strategic and corporate risks considered by the Committee, highlight strategic or corporate risks and issues that may require further action, and escalate any concerns regarding risk management processes, controls. And mitigations.

9.5 The Committee will report to the Board annually on its work. T he Committee's Annual Report should describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the Committee has considered and how these were addressed.

9.6 The Committee Chair shall attend the Annual General Meeting of the Trust to respond to any stakeholder questions regarding the Committee's work during the year.

9.7 The Committee shall have the power to establish task-and-finish groups for the purpose of addressing specific tasks for a time-limited period.

9.8 The Chair from each task-and-finish group will provide meetings of the Committee

with:

- a progress report on the work of their group
- the most recent approved minutes from their group

10.0 Monitoring and Review

10.1 The Terms of Reference of the Committee will be reviewed at least annually and submitted to the Board of Directors for approval.

10.2 The Committee will undertake an annual review of its performance, via self-assessment by its members and any agreed actions, will be reported to the Board.

PEOPLE COMMITTEE

Approved by Committee	09 July 2024
Approved by Board of Directors	

PEOPLE COMMITTEE

Terms of Reference

1.0 Constitution

1.1 The People Committee (the Committee) is a standing Board Assurance Committee that has been formally constituted by the Board of Directors of the Yorkshire Ambulance Service NHS Trust (the Trust) in accordance with its Standing Orders.

1.2 The Scheme of Powers Delegated by and Reserved to the Board, the Scheme of Financial Delegations, and the Standing Financial Instructions of the Trust will apply to the work of the Committee.

2.0 Authority

2.1 The Committee is authorised by the Board of Directors to act within its terms of reference and will be provided with Trust resources to do so. All members of Trust staff are directed to co-operate with any request made by the Committee.

2.2 The Committee has no executive powers other than those set out in these Terms of Reference.

2.3 The Committee has the right of access to all information that it deems relevant to fulfil its duties. This may require any Trust colleague to attend a meeting of the Committee to present information or to answer questions on a matter under discussion.

2.4 The Committee is authorised by the Board of Directors to instruct professional advisors and request the attendance of individuals and authorities from outside of the Trust with relevant experience and expertise if it considers this necessary.

2.5 The Committee is authorised to meet via a virtual/remote arrangement if it deems that necessary.

2.6 The Committee is authorised, in exceptional circumstances, to conduct discrete business outside its scheduled meetings where it is not practicable to convene a full meeting.

3.0 Purpose and Duties

3.1 The purpose of the Committee is to gain assurance, on behalf of the Board of Directors that the Trust is making sufficient progress towards its People priorities to support the delivery of the Trust's strategic objectives and Operational Plan whilst being assured as to compliance with appropriate regulatory and statutory requirements. The Committee will discharge this purpose through the following duties:

3.1 The purpose of the Committee is to seek and obtain assurance on behalf of the Board of Directors to demonstrate that the Trust:

- Is making sufficient progress towards the delivery of the Trust's strategic ambitions and business plan priorities in respect of all aspects of Our People, as set out in 3.2 below.
- Has in place the appropriate plans, policies, systems, and processes to support delivery of the above.
- Can be assured regarding compliance with appropriate policy, regulatory, and statutory requirements.
- Can be assured regarding the operation and effectiveness of systems of governance, risk management and internal control as they apply to the remit of the Committee.

3.2 The Committee will discharge its duties through oversight and assurance regarding the following:

- Planning and implementation of the Trust's bold ambition relating to Our People (with reference to the national People Plan)
- Planning and delivery of the Trust's annual business plan priorities relating to Our People.
- Development of workforce submissions relating to national, system-level or other financial and operational planning processes.
- Performance against the Trust's key performance indicators relating to our People.
- The development and implementation of strategies and plans relating to workforce recruitment and retention.
- The development and implementation of strategies and plans relating to training and development, including statutory and mandatory training compliance and staff appraisal and career conversations.
- The development and implementation of strategies and plans relating to workforce planning, including succession planning, leadership development, talent management, and the Trust's apprenticeship programme.
- The development and implementation of strategies and plans relating to the physical and mental health and well-being of staff, including the effective management of sickness and attendance.

- The development and implementation of strategies and plans relating to equalities, diversity and inclusion.
- The development and implementation of strategies and plans to improve and embed a positive and open workforce culture, including Freedom To Speak Up.
- The development and implementation of strategies and plans to improve and embed staff engagement, including the NHS Staff Survey.
- The development and implementation of strategies and plans to improve and embed the contribution to the Trust of volunteers.
- Compliance with the Fit and Proper Person Framework.
- Compliance with statutory, regulatory and policy requirements relating to any of the above.
- Compliance with statutory and regulatory reporting requirements, including statutory returns and publishable datasets (such as WRES, DES and Gender Pay Gap reporting)
- Oversight of improvement plans or individual actions arising from internal or external assurance processes, including internal audit reviews and regulatory inspections (CQC, Ofsted)

3.3 The Committee may seek appropriate review of and input into the development, governance and approval of business cases, contracts or other forms of investment proposal or service agreements that relate to the remit of this Committee.

3.4 In accordance with the Trust's Risk Management and Assurance Strategic Framework the Committee will:

- Review risks identified in relation to its remit.
- Review the Board Assurance Framework risks delegated to the Committee (see Appendix C of this document) and make recommendations to the Board of Directors regarding any required changes of risk score, assurances, controls, mitigations or other related content.
- Review the corporate risks relating specifically to the remit of the Committee as reported in the Corporate Risk Register.
- Identify new risks for the attention of the Board of Directors.
- Escalate existing risks for the attention of the Board of Directors.
- Provide assurance to the Audit and Risk Committee regarding the management of risks in relation to it the Committee's remit.

4.0 Committee Membership

4.1 The Committee membership will be agreed by the Board of Directors.

4.2 The Committee membership will consist of:

- Three Non-Executive Directors.
- Director of People and Organisational Development, who will be the Lead

Director for the Committee.

- Chief Operating Officer.

4.3 The Board of Directors will appoint the Chair and Vice Chair of the Committee.

4.4 The Chair and Vice Chair of the Committee will be Non-Executive Directors

5.0 Committee Attendees

5.1 Routine attendees at meetings of the Committee will include:

- Deputy Director of People and Organisational Development.
- Associate Director of People Development
- Director of Corporate Services and Company Secretary.
- One Director of Partnerships and Operations.

5.2 Any additional members of Trust staff will be invited as and when required to support the work of the Committee.

5.3 Individuals from external organisations may be invited to attend as and when required to support the work of the Committee.

5.4 An attendance record will be held for each meeting.

6.0 Quoracy

6.1 Meetings of the Committee will be declared quorate when at least three Committee members are present. For the purposes of quoracy, the three Committee members present must include at least two Non-Executive Directors and one Executive Director.

6.2 No business shall be transacted by the Committee unless a quorum is present.

6.3 Members unable to attend a meeting may nominate a deputy to attend on their behalf, with the prior agreement of the Committee Chair. Nominated deputies shall not count towards the quorum.

6.4 Members of the Committee do not represent or advocate for their respective area of the Trust; they act in the interests of the Trust as a whole.

6.5 Members of the Committee are able to attend meetings of the Committee either in person, by telephone, or by other electronic means.

6.6 Members of the Committee in attendance by electronic means will count towards the quorum.

6.7 Members of the Committee must demonstrably consider, and take appropriate positive action in respect of, the equality and diversity implications of decisions taken by the Committee.

7.0 Decision Making and Voting

7.1 The Committee will take decisions in accordance with the Trust's Standing Orders.

7.2 The Committee will ordinarily reach conclusions by consensus. When it is not possible to reach a decision by consensus the Committee Chair may call a vote.

7.3 In the event of a vote being called, only Committee members present at a meeting of the Committee may participate. Each Committee member is allowed to cast one vote.

7.4 In the event of a vote being called, a simple majority of votes cast will be sufficient to determine any given matter.

7.5 In the event that the totality of votes cast does not produce a simple majority, the Chair of the Committee will hold the casting vote.

8.0 Committee Administration

8.1 The Committee will ordinarily meet at least six times a year. By exception, and in the event of extraordinary circumstances, this number may be varied upwards or downwards.

8.2 The Committee shall meet at any other time that the Chair of the Committee, in consultation with the Lead Director, shall require, in order to enable the Committee to discharge its responsibilities in full as required.

8.3 The Chair of the Committee and the Lead Director will meet to agree the agenda for each meeting. The agenda will be based on the Committee Annual Work Plan and any agreed additional items.

8.4 The Company Secretary or their nominated designate will support the Chair of the Committee and the Lead Director in the management of the Committee's business.

8.5 Notice of each meeting shall be made available to each member of the Committee, no less than four working days before the date of the meeting in electronic form unless agreed otherwise by the Chair and Lead Director.

8.6 Administrative support to the Committee shall be provided by the committee secretary, who will normally be a member of the Trust's corporate governance team. The committee secretary will take minutes and clearly record actions.

8.7 Items for inclusion on the agenda shall be submitted to the secretary at least seven days prior to the meeting. Agendas can only be amended by the agreement of the Committee Chair and Lead Director.

8.8 The Committee Chair shall establish, at the beginning of each meeting, the existence of any conflicts of interest and ensure that these are recorded in the minutes accordingly.

8.9 The committee secretary shall minute the proceedings of all Committee meetings and provide draft minutes within five working days, reviewed by the Lead Director and then approved by the Committee Chair within 10 working days of the meeting.

8.10 An urgent decision be exercised by Chair after having consulted with at least one other Committee member and the Lead Director. The exercise of such powers by the Chair will be reported to the next formal meeting of the Committee.

8.11 In order to facilitate a more flexible decision-making process between formal meetings the Committee may, where deemed appropriate by the Chair, and as long as there is quorum, consider a matter circulated via email and record their decision by email correspondence. A record of the decision will be created and reported to the next formal meeting of the Committee.

9.0 Reporting and Accountability

9.1 The Committee is accountable to the Board of Directors.

9.2 Following each meeting of the Committee the Chair will report to the Board of Directors on how the Committee has discharged its responsibilities. Such reports will alert the Board to any matters that require action, advise the Board on other important matters, and assure the Board about the routine business transacted by the Committee.

9.3 The approved minutes of meetings of the Committee shall be formally recorded and submitted to the next available meeting of the Board of Directors.

9.4 The Chair of the Committee shall provide the Audit and Risk Committee with a risk assurance report. This report will provide assurance regarding the strategic and corporate risks considered by the Committee, highlight strategic or corporate risks and issues that may require further action, and escalate any concerns regarding risk management processes, controls. and mitigations.

9.5 The Committee will report to the Board annually on its work. The Committee's Annual Report should describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the Committee has considered and how these were addressed.

9.6 The Committee Chair shall attend the Annual General Meeting of the Trust to respond to any stakeholder questions regarding the Committee's work during the year.

9.7 The Committee shall have the power to establish task-and-finish groups for the purpose of addressing specific tasks for a time-limited period.

9.8 The Chair from each task-and-finish group will provide meetings of the Committee with:

- a progress report on the work of their group
- the most recent approved minutes from their group

10.0 Monitoring and Review

10.1 The Terms of Reference of the Committee will be reviewed at least annually and submitted to the Board of Directors for approval.

10.2 The Committee will undertake an annual review of its performance, via self-assessment by its members and any agreed actions, will be reported to the Board.

REMUNERATION AND NOMINATIONS COMMITTEE

Approved by Committee	03 May 2023
Approved by Board of Directors	

Remuneration and Nomination Committee

Terms of Reference

1.0 Constitution

1.1 The Remuneration and Nominations Committee (the Committee) is a standing Committee that has been formally constituted by the Board of Directors of Yorkshire Ambulance Service NHS Trust (the Trust) in accordance with its Standing Orders.

1.2 The Scheme of Powers Delegated and Reserved to the Board, the Scheme of Financial Delegation, and the Standing Financial Instructions of the Trust will apply to the conduct of the working of the Committee.

2.0 Authority

2.1 The Committee is authorised by the Board of Directors to act within its terms of reference and will be provided with Trust resources to do so. All members of Trust staff are directed to co-operate with any request made by the Committee.

2.2 The Committee has the right of access to all information that it deems relevant to fulfil its duties, which may require any Trust colleague to attend a meeting of the Committee to present information or answer questions on a matter under discussion.

2.3 The Committee is authorised by the Board of Directors to instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary.

2.4 The Committee has no executive powers other than those set out in these Terms of Reference.

2.5 The Committee is authorised to meet via a virtual / remote arrangement if it deems that necessary.

2.6 The Committee is authorised, in exceptional circumstances, to conduct discrete business outside its scheduled meetings where it is not practicable to convene a full meeting.

3.0 Purpose and Duties

3.1 The purpose and duties of the Committee include the following:

3.2 <u>Nomination Duties</u>

The Committee shall:

- Identify suitable candidates to fill Executive Director and other senior leadership vacancies (e.g. Very Senior Manger roles) as required.

- Review on a regular basis the structure, size, diversity and composition (including skills, knowledge and experience) required of the Board and agree any changes.
- Consider and make plans for succession planning in relation to senior leadership roles, particularly the Chief Executive, Deputy Chief Executive, and Executive Director roles.
- Keep the leadership needs of the Trust under review at Executive Level to ensure the continued ability of the Trust to operate effectively within the health and care system.
- Where a vacancy is identified, agree a role description, person specification and other particulars required for the post. In identifying suitable candidates, the Committee shall use open advertising and may engage the services of external advisors to facilitate the search.
- Consider whether suitable candidates meet the "fit and proper persons test" criteria set out in Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- Be responsible for agreeing the appointment of suitable candidates to fill posts following the recruitment process.
- Be responsible for identifying and agreeing the appointment of a suitable candidate for the position of Chief Executive.

3.3 Performance Duties

- Agree the performance assessment frameworks for individual Executive Directors and the Board of Directors as a whole
- Receive reports on the performance of the Chief Executive, Executive Directors and other senior roles (e.g. Very Senior Manager roles) against their agreed objectives.
- Receive confirmation from the Chair regarding the completion of the annual appraisal of the Chief Executive and of any issues that may have been identified by the appraisal process.
- Receive confirmation from the Chief Executive regarding the completion of the annual appraisal of the Executive Directors and other Very Senior Manager roles and of any issues that may have been identified by the appraisal process.
- Consider any matters relating to the continuation in office of the postholder of any Executive Director or other Very Senior Manager role at any time, including the suspension or termination of service, subject to the provisions of law and their contract or service contract.
- Review the ongoing appropriateness and relevance of the Trust's Remuneration Policy.
- Set the parameters of the remuneration package for all Executive Director and other Very Senior Manager roles within the terms of the agreed Remuneration Policy and following consultation with the Chief Executive. This will include basic salary, pension rights (insofar as these fall within the Committee's powers), any benefits of any kind, any incentive arrangements and compensation commitments on early termination arrangements.

- Receive confirmation from the Chief Executive of the terms of the remuneration package offered to and accepted by appointees to all Executive Director and other Very Senior Manager roles.
- Consider the performance criteria and any upper limits for annual bonuses and incentive schemes including in the remuneration for Executive Director and other Very Senior Manager roles.
- Ensure the Committee is adequately informed of comparative levels of remuneration for Executive Director roles, other Very Senior Manager roles, and other Trust roles where the postholder may be contracted on terms which are not part of the national NHS terms and conditions.
- Establish levels of remuneration which are sufficient to attract, retain and motivate candidates for Executive Director and other Very Senior Manager roles of the quality and with the skills and experience required to lead the Trust successfully.
- Monitor compliance with IR35 / off payroll requirements.
- Agree any discretionary supplementary payments made by the Trust to Non-Executive Directors in respect of their duties and special responsibilities. (For the avoidance of doubt, the remuneration and terms of appointment of the Chairman and Non-Executive Directors are not within the remit of this Committee. These are determined by the Secretary of State for Health and Social Care delegated as appropriate to NHS England.)

3.4 Payments Outside of Contractual Obligations

The Committee must ensure compliance with the requirements of government agencies and departments - including but not limited to HMRC, HM Treasury, and NHS England - regarding severance pay and other payments outside of contractual obligations, including and any off-payroll payments (in respect of Executive Director and other Very Senior Manager posts). The Committee must be satisfied that such payments are in the best interest of the Trust and represent value for money. The Committee must therefore:

- Satisfy itself that is has received and understood all available relevant information, including financial information and formal legal advice where needed, to approve payments outside of contractual obligations.
- Consciously discuss and assess the merits of the case.
- Consider the payment or payment range being proposed and address whether it is appropriate, considering all relevant issues. The Committee should only approve such payments which it considers to be in the public interest and in accordance with the current version of the HM Treasury guidance “Managing Public Money”.
- Keep an appropriately detailed written record summarising its discussions.
- Keep an appropriately detailed written record of its decisions, including the rationale for (a) selecting the preferred option and (b) discounting any other options.
- Monitor redundancy and other exit payments and capitalised pension costs for all staff groups; and approve any redundancy and capitalised pension costs in excess of £100,000.

4.0 Membership

4.1 The Committee membership will be agreed by the Board of Directors and will consist of:

- Chair of the Trust (Chair of the Committee)
- All other Non-Executive Directors
- Chief Executive (when appointing or appraising Executive Directors)

5.0 Attendees

5.1 Attendees will include:

- Associate Non-Executive Directors (where applicable)
- Director of People and Organisational Development
- Company Secretary

5.2 Additional Trust members of staff or external people will be invited as and when required to support the workings of the meeting.

5.3 An attendance record will be held for each meeting.

6.0 Quorum

6.1 The Committee will be deemed quorate with three members of the Committee in attendance, including the Chair or the Chair's nominated deputy.

6.2 No business shall be transacted by the Committee unless a quorum is present.

6.3 Members may attend Committee meetings in person, by telephone, or by other electronic means.

6.4 Members in attendance by electronic means will count towards the quorum.

6.5 Members must demonstrably consider, and take appropriate positive action in respect to, the equality and diversity implications of decisions taken by the Committee.

7.0 Decision Making and Voting

7.1 Decisions will be taken in accordance with the Trust's Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Committee Chair may call a vote.

7.2 Only members present at a meeting of the Committee may vote. Members in attendance by electronic means are entitled to vote.

7.3 Each member is allowed one vote. A simple majority will be considered conclusive on any matter.

7.4 In the case that an equality of votes arises, the Chair of the Committee will hold the casting vote.

8.0 Committee Administration

8.1 The Committee will meet at least twice per annum. The Committee shall meet at any other time that the Chair of the Committee and Chief Executive shall require in order to allow the Committee to discharge all of its responsibilities.

8.2 The Chair of the Committee, the Chief Executive, the Director Lead and the Company Secretary will agree the agenda for each meeting. The agenda will be based on the Committee Annual Work Plan and any agreed additional items.

8.3 The Company Secretary will support the Chair of the Committee and the Chief Executive in the management of the Committee's business.

8.4 Notice of each meeting shall be made available to each member of the Committee, no fewer than four working days before the date of the meeting in electronic form unless agreed otherwise by the Chair and Lead Director.

8.5 Administrative support to the Committee shall be provided by the Company Secretary or their nominated deputy.

8.6 Items for inclusion on the agenda shall be submitted to the Company Secretary no fewer than seven days prior to the meeting. Agendas can only be amended by the agreement of the Committee Chair and Director Lead.

8.7 The Chair shall establish, at the beginning of each meeting, the existence of any conflicts of interest and ensure that these are recorded in the minutes accordingly.

8.8 The meetings and any other formal proceedings of the Committee will be minuted. Draft minutes will be produced within five working days of each meeting, reviewed by the Lead Director and then approved by the Committee Chair within 10 working days of the meeting.

8.9 An urgent decision may be exercised by the Chair after having consulted with at least one other Committee member and the Director Lead. The exercise of such powers by the Chair will be reported to the next formal meeting of the Committee.

8.10 In order to facilitate a more flexible decision-making process between formal meetings the Committee may, where deemed appropriate by the Chair, and as long as there is quorum, consider a matter circulated via email and record their decision by email correspondence. A record of the decision will be created and reported to the next formal meeting of the Committee.

9.0 Reporting and Accountability

9.1 The Committee is accountable to the Board of Directors.

9.2 The Chair will report to the Board of Directors (in Private) at least twice per year on how the Committee has discharged its responsibilities.

9.3 The Committee will report to the Board annually on its work. The Annual Report should also describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the Committee has considered and how these were addressed.

9.4 There are no sub-Committees/Groups reporting into the Committee.

10.0 Monitoring and Review

10.1 The Terms of Reference of the Committee will be reviewed at least annually and submitted to the Board for approval.

10.2 The Committee will undertake an annual review of its performance, via self-assessment by its members and any agreed actions, will be reported to the Board.

CHARITABLE FUNDS COMMITTEE

Approved by Committee	11 January 2024
Approved by Board of Directors	

Charitable Funds Committee

Terms of Reference

1.0 Constitution

1.1 The Charitable Funds Committee (the Committee) is a standing Committee that has been formally constituted by the Board of Directors of Yorkshire Ambulance Service NHS Trust (the Trust).

2.0 Authority

2.1 The Committee is authorised by the Board of Directors to act within its terms of reference. All members of Trust staff are directed to co-operate with relevant requests made by the Committee.

2.2 The Committee has the authority to commit charitable fund resources. The Committee supports the fundraising activities of the Trust's Charity. The Charity is a charitable trust and the corporate trustee is Yorkshire Ambulance Service Trust. All Board members act as trustees of the Charity.

2.3 The Committee is authorised by the Board of Directors to instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary.

2.4 The Committee has no powers other than those set out in these Terms of Reference.

2.5 The Committee is authorised to meet via a virtual/remote arrangement if it deems that necessary.

3.0 Purpose and Duties

3.1 The Committee's purpose is to give additional assurance to the Board that the Trust's charitable activities are within the law and regulations set by the Charity Commissioners for England and Wales and to ensure compliance with the charity's governing documents. The Committee is charged by the Board to:

- Oversee the delivery of the strategy for the charity approved by the Corporate Trustee.
- Oversee the formulation and delivery of an investment policy and any other policies that are required to be developed to support the effectiveness of the charity.
- Review quarterly updates and performance reports including the expenditure and investment decisions of funds and balances held.
- Support, guide and encourage the fundraising activities of the Trust.
- Monitor charitable and fundraising income.

- Oversee the administration, investment and financial systems relating to all charitable funds held by the charity.
- Develop policies for fundraising and for the use of funds.
- Ensure compliance with all relevant Charity Commission regulations, legislation and other relevant items of guidance and best practice.
- Review the work of other Committees within the Trust, whose work can provide relevant assurance to the Committee's own scope of work.
- Consider and approve any urgent requests in advance of any formal meeting, on an exceptional basis through the approval of the named Executive Director and the Committee Chair in accordance with governing documents.
- Oversee and advise on the running of major fundraising campaigns.
- Honour as far as practicably possible wishes expressed by donors of unrestricted funds.

3.2 Receive assurance on the following:

- Adequate internal controls and procedures to ensure that the power is being exercised properly and prudently;
- Banking arrangements for the charitable funds are kept entirely distinct from all of the Trust's NHS other funds; and
- Separate current and deposit accounts are minimised consistent with meeting expenditure obligations.

4.0 Membership

4.1 The Committee membership will be agreed by the Board of Directors and will consist of:

- 2 Non-executive Directors
- The Executive Director of Finance, who will be the Lead Director of the Committee
- Executive Medical Director

4.2 The Board will appoint a Chair and Vice Chair of the Committee.

5.0 Attendees

5.1 Attendees will include:

- Associate Non-executive Director
- Company Secretary
- Head of Communications and Community Engagement
- Head of YAS Charity

5.2 The finance representative will be regularly invited to attend Committee meetings and additional Trust members of staff or external people will be invited as and when required to support the workings of the meeting.

5.3 An attendance record will be held for each meeting.

6.0 Quorum

6.1 The Committee will be deemed quorate with 2 members, comprising at least one Non-executive Directors and one Executive Director present.

6.2 No business shall be transacted by the Committee unless a quorum is present.

6.3 Members unable to attend a meeting may nominate a deputy to attend on their behalf, agreed with the Committee Chair. (*Nominated deputies shall not count towards the quorum*.)

6.4 Members are able to attend Committee meetings in person, by telephone, or by other electronic means.

6.5 Members in attendance by electronic means will count towards the quorum.

6.6 Members must demonstrably consider, and take appropriate positive action in respect to, the equality and diversity implications of decisions taken by the Committee.

7.0 Decision Making and Voting

7.1 The Committee will ordinarily reach conclusions by consensus. When this is not possible the Committee Chair may call a vote.

7.2 Only members present at a meeting of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

7.3. In the case that an equality of votes arises, the Chair of the Committee will hold the casting vote.

8.0 Committee Administration

8.1 The Committee will meet at least four times each year, on a quarterly basis and at least 14 days prior to the Board of Directors meetings. The Committee shall meet at any other time that the Chair of the Committee, in consultation with the Director Lead, shall require, in order to allow the Committee to discharge all of its responsibilities.

8.2 The Chair of the Committee and the Director Lead will meet to agree the agenda for each meeting and will be supported by either the Head of YAS Charity or Head of Communications and Community Engagement. The agenda will be based on the Committee's Annual Work Plan and any agreed additional items.

8.3 The Director Lead for the Committee will be the Executive Director of Finance. The Company Secretary or their nominated designate will support the Chair of the Committee and Lead Director in the management of the Committee's business and for drawing attention to good practice, national guidance and other relevant documents, as appropriate.

8.4 Notice of each meeting, shall be made available to each member of the Committee, no less than four working days before the date of the meeting in electronic form unless agreed otherwise by the Chair and Lead Director.

8.5 Administrative support to the Committee shall be provided by the secretary. The secretary will take minutes and clearly record actions. Items for inclusion on the agenda shall be submitted to the secretary 10 days prior to the meeting. Agendas can only be amended by the agreement of the Committee Chair and Director Lead.

8.6 The Chair shall establish, at the beginning of each meeting, the existence of any conflicts of interest and ensure that these are recorded in the minutes accordingly.

8.7 The Secretary shall minute the proceedings of all Committee meetings and provide draft minutes within five working days, reviewed by the Lead Director and then approved by the Committee Chair within 10 working days of the meeting.

9.0 Reporting and Accountability

9.1 The Board of Directors acting in its role as corporate trustee is responsible for directing the affairs of the Charity, through the Charitable Funds Committee, ensuring activities and funds are managed in accordance with relevant legislation, regulations and the specific charitable objects and trust deed. The Charity operates under the Corporate Trustee model and is bound by both charity law and by NHS legislation.

9.2 The Chair will report to the Board of Directors, as Corporate Trustee on how it has discharged its responsibilities. The Chair of the Committee shall provide the Trustee with a Chair's Assurance Report , providing assurance or highlighting risks or issues that require executive action. The approved minutes of Committee meetings shall be formally recorded and submitted to the Trustee.

9.3 The Committee will report to the Board annually on its work. The Annual Report should also describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the Committee has considered and how these were addressed.

9.4 The Committee Chair shall attend the Annual General Meeting to respond to any stakeholder questions on the Committee's activities.

9.5 The Committee shall have the power to establish sub-Committees/Groups and/or task and finish groups for the purpose of addressing specific tasks or areas of responsibility.

9.6 The Chair from any sub-Committees/Groups and/or task and finish groups formed will provide:

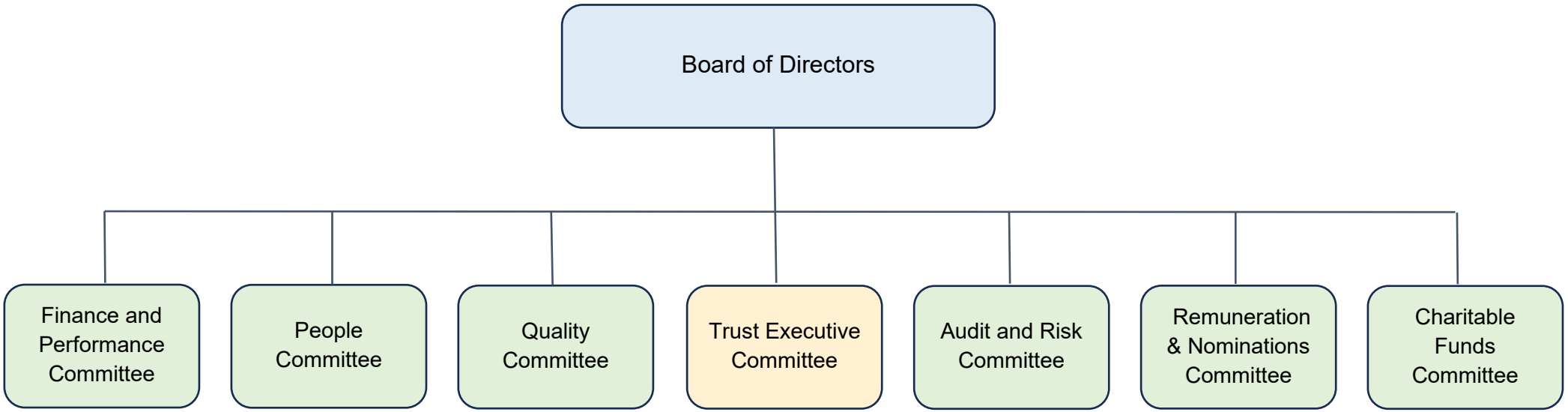
- a report to the next meeting of the Committee; and
- the minutes from the group's meeting to the Committee following approval of the minutes at the next group.

10.0 Monitoring and Review

10.1 The Terms of Reference of the Committee will be reviewed at least annually and submitted to the Board for approval.

10.2 The Committee will undertake an annual review of its performance, via self-assessment by its members and any agreed actions, will be reported to the Board.

APPENDIX A: BOARD AND COMMITTEE STRUCTURE



APPENDIX B: CALENDAR OF BOARD AND COMMITTEE MEETING DATES 2024/25 (some dates subject to change)

	Board of Directors Meetings			Committee Meetings						
	Board Meeting in Public	Board Meeting in Private	Board Strategic Forum	Trust Executive Committee	Audit and Risk Committee	Quality Committee	Finance and Performance Committee	People Committee	Remuneration & Nominations Committee	Charitable Funds Committee
Apr	25	25	25	03 and 17	16	11	23			11
May	30	30		01 and 15		16	23	14	30	
Jun		27	20	05 and 19		13	25			
Jul	25	25	25	03 and 24	16	18	23	09	tbc	11
Aug				07 and 21						
Sep	26 (+AGM)	26		04 and 18		19	24	10	26	
Oct		24	24	02 and 16		17	22			10
Nov	28	28		06 and 20	12	21	26	19		
Dec		12	12	04 and 18			19		12	
Jan	30	30		15 and 29	21	16	28	21		23
Feb		27	27	05 and 19		20	25		27	
Mar	27	27		05 and 19		20	25	18		

APPENDIX C: BOARD ASSURANCE FRAMEWORK RISKS BY COMMITTEE

Bold Ambition	Strategic Risk: The Trust is unable to...		Committee
Our Patients	1	Deliver a timely response to patients	Finance and Performance
	2	Provide access to appropriate care	Quality
	3	Support patient flow across the urgent and emergency care system	Finance and Performance
	4	Strengthen quality governance and medicines management to develop a culture of improvement, safety, and learning.	Quality
	5	Develop and maintain effective emergency preparedness, resilience, and response arrangements.	Finance and Performance
Our People	6	Develop and sustain an open and positive workplace culture	People
	7	Support staff health and well-being effectively	People
	8	Deliver and sustain improvements in recruitment and retention.	People
	9	Develop and sustain improvements in leadership and staff training and development.	People
Our Partners	10	Act as a collaborative, integral, and influential system partner.	TEG / Board
	11	Collaborate effectively to improve population health and reduce health inequalities.	Quality
Our Planet and Pounds	12	Secure sufficient revenue resources and use them wisely to ensure value for money.	Finance and Performance
	13	Secure sufficient capital resources and use them wisely to ensure value for money.	Finance and Performance
	14	Deliver safe and effective digital technology developments and cyber security arrangements.	Finance and Performance
	15	Act responsibly and effectively in response to climate change.	Finance and Performance

Meeting Title: Board of Directors (in Public)
Meeting Date: 25 July 2024
Agenda Item. 6.4

Report Title	**Corporate Governance Guide: The Board of Directors**
Author (name and title)	David O'Brien, Director of Corporate Services and Company Secretary
Accountable Director	David O'Brien, Director of Corporate Services and Company Secretary
Previous committees/groups	Not applicable
Recommended action(s) Approval, Assurance, Information	Approval
Purpose of the paper	To present for approval a guide to various aspects of the Trust's Board-level governance arrangements.
Recommendation(s)	The Board approves the Corporate Governance Guide: The Board of Directors

Executive Summary

What?

The enclosed document sets out guidance and information regarding various aspects of Board-level governance in the Trust including an overview of specific roles and responsibilities. Sources of information for this document include the NHS Code of Governance and the Trust Standing Orders. Board members will receive an overview of this document at the Board Strategic Forum on 25 July.

So What?

The NHS Code of Governance (2023) requires that the Trust should make available a document setting out the responsibilities of the Chair, the Chief Executive, the Senior Independent Director, and the Board of Directors more generally. This information should be clear, set out in writing, agreed by the Board of Directors, and be publicly available. The enclosed document supports the Trust to comply with the NHS Code of Governance.

What Next?

The final approved document will be published on Pulse and on the Trust's website. The document will be included in the induction materials to support the future onboarding of new Board members. The document will be reviewed regularly and updated as required.

Strategic ambition(s) this supports. Provide brief bullet point details of link to Trust strategy.	Our Patients	All priorities
	Our People	All priorities
	Our Partners	All priorities
	Our Planet and Pounds	All priorities
Link with the BAF Include reference number. (board and level 2 committees only)		All strategic risks

Yorkshire Ambulance Service NHS Trust

Corporate Governance Guide: The Board of Directors

Version 1.0: June 2024

DOCUMENT CONTROL INFORMATION

Document name	**Corporate Governance Guide: The Board of Directors**
Version	1.0
Responsible Committee	Board of Directors
Responsible Director	Director of Corporate Services and Company Secretary
Document Owner (title)	Director of Corporate Services and Company Secretary
Document Lead (title)	Director of Corporate Services and Company Secretary
Approved By	Board of Directors
Date Approved	tbc 2024
Review Date	May 2025
Equality Impact Assessed (EIA)	Not applicable
Protective Marking	Not Protectively Marked

DOCUMENT CONTROL INFORMATION

Version	Date	Author	Status (A/D)	Description of Change(s)
0.1	**May 2024**	**David O'Brien**	**D**	**New Document**
Document Status		A = Approved / **D = Draft**		
Document Author		**David O'Brien** Director of Corporate Services and Company Secretary		
This document is controlled in accordance with the Management of Procedural Documents Policy. If you would like to suggest amendments to this document, please contact the document author.				

Associated Policies and Procedural Documents

External Documents

NHS Code of Governance (2023)

The Seven Principles of Public Life (Committee on Standards in Public Life)

Trust Documents

Trust Standing Orders

Standards of Business Conduct Policy

Fit and Proper Person Policy

Trust Code of Conduct

Corporate Governance Guide: Senior Independent Director

Corporate Governance Guide: Committee Terms of Reference

Corporate Governance Guide: Route to Board (Governance and Approvals) (available August 2024)

TABLE OF CONTENTS

INTRODUCTION

The NHS Code of Governance (2023) requires that the Trust should make available the responsibilities of the Chair, the Chief Executive, the Senior Independent Director, the Board of Directors, and the Board Committees. This information should be clear, set out in writing, agreed by the Board of Directors, and publicly available.

1. THE BOARD OF DIRECTORS

The NHS Code of Governance requires that every trust should be led by an effective and diverse board that is innovative and flexible, and whose role it is to promote the long-term sustainability of the trust, generating value for patients, service users and the public.

In accordance with the NHS Code of Governance and the NHS Provider License, the Board of Directors has the following main duties:

Vision and Strategy

- The Board of Directors should develop, embody and articulate clear vision, values and strategy for the Trust.
- The Board of Directors should ensure alignment of the Trust's vision, values and strategy with Integrated Care Boards' strategies
- The Board of Director should ensure that decision-making complies with the triple aim duty of better health and wellbeing for everyone, better quality of health services for all individuals and sustainable use of NHS resources.

System Collaboration

- The Board of Directors should ensure effective engagement with stakeholders, including patients, staff, the community and system partners,
- The Board of Directors should encourage collaborative working at all levels with system partners.
- The board should ensure that the Trust actively addresses opportunities to work with other providers to tackle shared challenges through entering partnership arrangements such as provider collaboratives.
- The Board of Directors should give particular attention to the Trust's role in reducing health inequalities in access, experience and outcomes.

Resource Management

- The Board of Directors should ensure that the necessary resources are in place for the Trust to meet its objectives.
- The Board of Directors should establish a framework of prudent and effective controls that enable risk to be assessed and managed.

Performance and Effectiveness

- The Board of Directors is collectively responsible for the performance of the Trust.

- The Board of Directors should ensure that adequate systems and processes are maintained to measure and monitor the Trust's effectiveness, efficiency and economy, and the quality of its healthcare delivery.
- The Board Directors should regularly review the Trust's performance against regulatory and contractual obligations, and approved plans and objectives, including those agreed through place-based partnerships and provider collaboratives.

Workforce and Culture

- The Board of Directors should ensure that workforce policies and practices are consistent with the Trust's values and support its long-term sustainability.
- The Board of Directors is responsible for ensuring effective workforce planning aimed at delivering high quality of care.
- The Board of Directors should assess and monitor culture

The Trust's Standing Orders include a schedule of powers reserved to the Board of Directors. The current schedule of powers reserved to the Board of Directors is set out at Appendix F.

2. COMPOSITION OF THE BOARD OF DIRECTORS

The NHS Code of Governance requires that the Board of Directors should be of sufficient size for the requirements of its duties but should not be so large as to be unwieldy. Membership of the Board of Directors and its committees should have a diversity of skills, experience and knowledge.

The membership of the Board of Directors is determined in statute by the Trust Establishment Order (2006) and is set out in the Trust's Standing Orders.

The Board of Directors is composed of Executive Directors and Non-Executive Directors. The NHS Code of Governance states that 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.

The fundamental principle is that the Board of Directors should function as a unitary decision-making body. Executive and Non-Executive Directors are full and equal members of the board. The NHS Code of Governance states that all members of the Board of Directors have joint responsibility for every board decision regardless of their individual skills or status.

Under its current Establishment Order the Trust's Board of Directors can have a maximum of twelve voting directors, of whom the majority must be Non-Executive Directors and no more than five may be Executive Directors.

The voting members of the Board of Directors are as follows:

- Chair (Non-Executive)
- Non-Executive Directors x 5
- Chief Executive
- Chief Operating Officer
- Executive Director of Finance
- Executive Director of Quality and Chief Paramedic
- Executive Medical Director

The Board of Directors has two non-voting members. These are:

- Deputy Chief Executive
- Director of People and Organisational Development

The Board of Directors has six Contributing Directors who fulfil Board-level leadership roles but who generally do not attend all Board meetings. These are:

- Directors of Partnerships and Operations x3
- Director of Strategy, Planning and Performance
- Director of Corporate Services and Company Secretary
- Chief Digital Information Officer

All members of the Board (Non-Executive Directors, Executive Directors, and Contributing Directors) must meet the requirements of the Fit and Proper Person test framework. These requirements, and the Trust's arrangements for compliance with them, are set out in the Trust's Fit and Proper Person Policy.

All members of the Board (Non-Executive Directors, Executive Directors, and Contributing Directors) must always demonstrate the Principles of Standards in Public Life. These are enshrined in the Trust's Standing Orders and are set out in Appendix G.

3. MEETINGS OF THE BOARD OF DIRECTORS

The NHS Code of Governance requires that the Board of Directors should meet sufficiently regularly to discharge its duties effectively. The arrangements for meetings of the Board of Directors of this Trust are as follows:

- The Board of Directors meets formally in public every two months.
- The Board of Directors also holds formal meetings in private.
- Throughout the year the Board of Directors holds a series of informal Strategic Fourm sessions.
- The Board of Directors holds the Annual General Meeting of the Trust at which the Annual Report and Accounts are published.

Appendix B sets out the calendar of Board of Directors meetings for 2024/25.

Appendix C set out the attendee lists for the different types of Board of Directors meetings.

The rules and regulations regarding the proceedings of Board of Directors meetings are set out in the Trust's Standing Orders.

4. THE ROLE OF THE CHAIR

The Chair of the Trust is a Non-Executive Director who is appointed by and accountable to the Secretary of State for Health and Social Care (via NHS England). The Chair leads the Board of Directors and is responsible for its overall effectiveness in leading and directing the Trust.

The Chair facilitates constructive board relations and the effective contribution of all Non-Executive directors.

The Chair is responsible for leading on setting the agenda for the Board of Directors and ensuring that adequate time is available for discussion of all agenda items, in particular strategic issues.

The Chair is responsible for ensuring that directors receive accurate, timely and clear information that enables them to perform their duties effectively.

The Chair should promote a culture of honesty, openness, trust and debate by facilitating the effective contribution of Non-Executive directors and ensuring a constructive relationship between Executive and Non-Executive directors.

The Chair and 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.

The Chair should ensure that the Board of Directors has a clear understanding of the views of all stakeholders including system partners.

The Chair should ensure that directors continually update their skills, knowledge and familiarity with the trust and its obligations for them to fulfil their role on the board and committees.

The Chair should ensure that new directors receive a full and tailored induction on joining the board.

The Chair should regularly review and agree with each director their training and development needs as they relate to their role on the board.

More details regarding the specific role and responsibilities of the Chair are set out in the Trust's Standing Orders.

5. NON-EXECUTIVE DIRECTORS

Non-Executive Directors should provide constructive challenge and strategic guidance, offer specialist advice and lead in holding the Executive to account

At least half the Board of Directors, excluding the Chair, should be Non-Executive Directors whom the board considers to be independent.

Non-Executive Directors have a prime role in appointing and removing Executive directors. They should scrutinise and hold to account the performance of individual Executive Directors against agreed performance objectives.

Non-Executive Directors should scrutinise the performance of the Executive management in meeting agreed goals and objectives, request further information if necessary, and monitor the reporting of performance.

Non-Executive Directors should satisfy themselves as to the integrity of financial, clinical and other information, and make sure that financial and clinical quality controls, and systems of risk management and governance, are robust and implemented.

Non-Executive Directors should consider whether they are receiving the necessary information in a timely manner and feel able to appropriately challenge board recommendations, by making full use of their skills and experience gained both as a director of the trust and in other leadership roles.

6. SENIOR INDEPENDENT DIRECTOR

The Senior Independent Director is a Non-Executive Director appointed by the Board of Directors to play a key role to support the Chair.

The main responsibilities of the Senior Independent Director are to:

- Support the Chair in leading the Board
- Act as a ‘sounding board’ and a source of advice for the Chair
- Be a focal point for any concerns of Board members that cannot be resolved by either the Chair or the Chief Executive.
- Carry out the annual appraisal of the Chair.

The role of the Senior Independent Director is enshrined in the Trust’s Standing Orders and is summarised in Appendix D.

The Trust maintains a separate guidance document regarding the role of the Senior Independent Director.

7. THE ROLE OF THE CHIEF EXECUTIVE

The Chief Executive is accountable to the Chair and reports to the Board of Directors more generally.

The Chief Executive is ultimately responsible for ensuring that the decisions of the Board of Directors are implemented.

The Chief Executive is ultimately responsible for ensuring that the Trust complies with its duties as required by the legal, regulatory, financial, operational and policy frameworks within which it operates.

All members of the Trust's management structure report through to the Chief Executive, either directly or indirectly.

More details regarding the specific role and responsibilities of the Chief Executive are set out in the Trust's Standing Orders.

8. THE CHIEF EXECUTIVE AS ACCOUNTABLE OFFICER

The Chief Executive is also the Trust's Accountable Officer who is accountable to Parliament for the management of the organisation and the preparation of its accounts.

The Accountable Officer is responsible for ensuring that the Trust has in place effective management systems and processes, sound corporate governance arrangements, and an effective system of internal controls. This role has a particular duty to ensure that the Board of Directors is provided with appropriate advice regarding matters of financial propriety.

The Accountable Officer carries a personal responsibility for:

- The propriety and regularity of the public finances for which they are answerable.
- The keeping of proper accounts.
- The prudent and economical administration of the organisation (in accordance with the HM Treasury guidance on Managing Public Money).
- The avoidance of waste and extravagance.
- The efficient and effective use of all resources in their charge.

In the absence for whatever reason of the Chief Executive the Trust may appoint an Acting Accountable Officer.

More details regarding the specific role and responsibilities of the Accountable Officer are set out in Appendix E.

9. EXECUTIVE DIRECTORS AS BOARD MEMBERS

In addition to, and separate from, the management of their functional or operational areas, Executive Directors have duties as Board members. These duties cover all aspects of the business of the Board of Directors, as set out in Section 1 of this document.

As members of the unitary board, each Executive Director shares individual and collective responsibility for all decisions of the Board of Directors. As members of the unitary board, Executive Directors are expected to hold each other to account, individually and collectively, for the delivery of the Trust's strategic objectives.

10. THE COMPANY SECRETARY

The NHS Code of Governance requires that 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.

The Company Secretary works closely with the Chair and the Chief Executive to ensure that effective and compliant corporate governance arrangements are in place and the board is supported to operate effectively and efficiently.

The company secretary is accountable to the Chair for matters of board governance and development.

The company secretary and is accountable to the Chief Executive for corporate governance matters relating to the Executive functions of the organisation.

A more detailed description of the role of the Company Secretary in and NHS trust is set out in Appendix X.

11. BOARD COMMITTEES

A set of Committees supports the Board of Directors in the discharge of its duties. These Committees are an extension of the Board and not separate to it. Appendix A shows the Trust's committee structure.

The committees of the Trust are:

- Trust Executive Committee (known as the Trust Executive Group, TEG)
- Audit and Risk Committee
- Quality Committee
- Finance and Performance Committee
- People Committee
- Remuneration and Nominations Committee
- Charitable Funds Committee

More details about the purpose and remit of these committees is set out in their Terms of Reference which are reviewed and approved by the Board of Directors annually.

The Terms of Reference for each of the above committees for 2024/25 are issued in a separate document.

12. GOVERNANCE AND APPROVALS: THE ROUTE TO BOARD

To ensure appropriate levels of review, assurance and due diligence, involving Executive Directors and Non-Executive Directors, any item that requires approval by the Board of Directors should normally follow the following governance route:

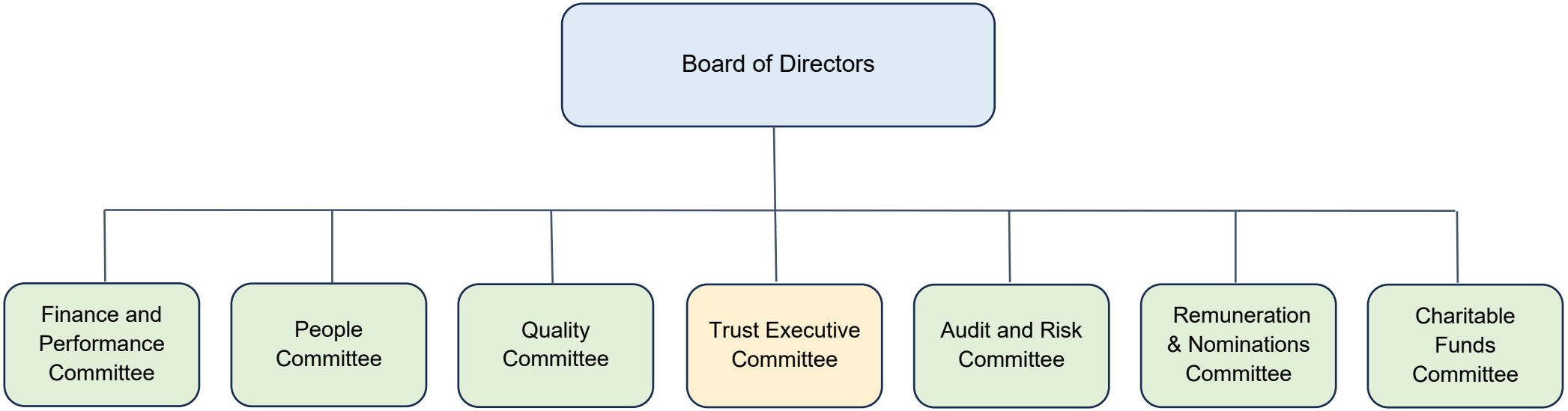
Stage	Governance Body	Purpose	Outcome
0	Directorate management teams or SME groups	Development and refinement	Recommend to TEG Reporting Committee
1	TEG Reporting Committee	Pre-TEG review and assurance	Recommend to TEG
2	Trust Executive Group	Executive review and assurance	Recommend to an Assurance Committee
3	Assurance Committee	Non-Executive review and assurance	Recommend to the Board of Directors
4	Board of Directors	Board approval	Approved for implementation

In certain circumstances this route to Board might require the transaction of review and assurance processes outside of the planned schedule of governance meetings. To facilitate this, TEG, Assurance Committees, and the Board of Directors are all granted powers of urgent and flexible decision-making that allow the required due diligence to be transacted quickly.

However, powers of urgent and flexible decision-making should be used sparingly, only in exceptional and unavoidable circumstances, and always on the advice of the Company Secretary.

More details about the Route to Board are issued in a separate document.

APPENDIX A: BOARD GOVERNANCE FRAMEWORK



APPENDIX B: CALENDAR OF BOARD AND COMMITTEE MEETING DATES 2024/25

	Board of Directors Meetings			Committee Meetings						
	Board Meeting in Public	Board Meeting in Private	Board Strategic Forum	Trust Executive Group	Audit and Risk Committee	Quality Committee	Finance and Performance Committee	People Committee	Remuneration & Nominations Committee	Charitable Funds Committee
Apr	25	25	25	03 and 17	16	11	23			11
May	30	30		01 and 15		16	23	14	30	
Jun		27	20	05 and 19		13	25			
Jul	25	25		03 and 24	16	18	23	09		11
Aug				07 and 21						
Sep	26 (+AGM)	26		04 and 18		19	24	10	26	
Oct		24	24	02 and 16		17	22			10
Nov	28	28		06 and 20	12	21	26	19		
Dec		12	12	04 and 18			19		12	
Jan	30	30		15 and 29	21	16	28	21		23
Feb		27	27	05 and 19		20	25		27	
Mar	27	27		05 and 19		20	25	18		

APPENDIX C: BOARD MEETING ATTENDEES

Board Role	Board Meeting in Public	Board Meeting in Private	Board Strategic Forum	Annual General Meeting
Voting Board Directors				
Chair	✓	✓	✓	✓
Non-Executive Directors	✓	✓	✓	✓
Chief Executive	✓	✓	✓	✓
Chief Operating Officer	✓	✓	✓	✓
Executive Director of Finance	✓	✓	✓	✓
Executive Director of Quality and Chief Paramedic	✓	✓	✓	✓
Executive Medical Director	✓	✓	✓	✓
Non-Voting Board Directors				
Deputy Chief Executive	✓	✓	✓	✓
Director of People and Organisational Development	✓	✓	✓	✓
Contributing Directors				
Directors of Partnerships and Operations	✓	✗	✓	✗
Director of Strategy, Planning and Performance	✓	✗	✓	✗
Chief Digital Information Officer	✓	✗	✓	✗
Director of Corporate Services and Company Secretary	✓	✓	✓	✓
Other Attendees				
Head of Communications and Community Engagement	✓	✓	✓	✓

APPENDIX D: THE SENIOR INDEPENDENT DIRECTOR

4.1 The Trust Standing Orders set out the role of the Senior Independent Director (SID) in this organisation. Standing Order 1.2.24 provides a general definition of the SID as being:

> The Non-Officer member (i.e. the Non-Executive Director) appointed by the Board to play a key role in supporting the Chairman in leading the Trust Board.

4.2 Standing Order 2.6 (6) sets out the role of the SID in more detail:

> The Senior Independent Director (SID) will be appointed by the Board from among the Non-Executive Director Members, whose role is to:

i. Play a key role in supporting the Chair in leading the Board and acting as a 'sounding board' and a source of advice for the Chair.
ii. Be available to Board Members if they have concerns which have not or cannot be resolved through contact with the Chair or the Chief Executive. This will involve an obligation on the SID to respond to such contacts and to meet privately with members if appropriate and necessary.
iii. Be the focal point for Board Members for any concerns regarding the Chair's performance or the relationship between the Chair and Chief Executive.
iv. Co-ordinate among other Directors annually, feedback on the Chair's performance to contribute to his/her appraisal.
v. Act as a trusted intermediary for Non-Executive Directors where this is required to help them challenge and contribute effectively.
vi. Take the initiative in discussion with the Chair or other Board Members if it should seem that the Board is not functioning effectively.

APPENDIX E: THE ACCOUNTABLE OFFICER

The Accountable Officer carries a personal responsibility for:

- The propriety and regularity of the public finances for which they are answerable
- The keeping of proper accounts
- The prudent and economical administration of the organisation (in accordance with the HM Treasury guidance on Managing Public Money)
- The avoidance of waste and extravagance
- The efficient and effective use of all resources in their charge

The Accounting Officer must:

- Personally sign the accounts and, in doing so, accept personal responsibility for ensuring their proper form and content.
- Ensure that the Trust complies with the financial requirements of the NHS Provider License.
- Ensure that proper financial procedures are followed and that accounting records are maintained in a form suited to the requirements of the Trust's management and in a form prescribed for published accounts.
- Ensure that the resources for which they are responsible are properly and well managed, controlled and safeguarded, with independent and effective checks of cash balances in the hands of any official.
- Ensure that assets for which they are responsible, such as land, buildings and other property, and including stores and equipment, are properly and well managed, controlled and safeguarded, with checks as appropriate.
- Ensure that any protected property is not disposed of without the required consent.
- Ensure that conflicts of interest are avoided, whether in the proceedings of the Board of Directors or in the actions or advice of the Trust's staff.
- Ensure that in the consideration of policy proposals relating to expenditure, all relevant financial considerations, including any issues of propriety, regularity or value for money, are taken into account and are brought to the attention of the Board of Directors.

The Accounting Officer should also ensure that managers at all levels:

- Have a clear view of their objectives, and the means to measure and assess outputs or performance in relation to those objectives.
- Are assigned well-defined responsibilities for making the best use of resources and securing value for money.
- Have the information, training and access to expert advice that they need to exercise their responsibilities effectively.

APPENDIX F: THE COMPANY SECRETARY

The main duties of the Company Secretary regarding corporate governance are as follows:

- Support the Chair and Chief Executive to ensure that the Trust has robust corporate governance arrangements that take account of the NHS Code of Governance, the NHS Provider License, and other relevant sources of best practice.
- Provide advice to the Board of Directors, Committees, and individual directors on all governance matters.
- Ensure that the Board and Committees are properly constituted, operated and supported in accordance with the Trust's Standing Orders and relevant regulatory frameworks.
- Ensure there is appropriate co-ordination and good information flows between the Board, the Committees and Executive management.
- Ensure that the Trust complies with its Standing Orders; review and update the Standing Orders as appropriate.
- In conjunction with the Director of Finance, ensure that Standing Financial Instructions are in place, reviewed regularly, and complied with.
- Provide advice to the Chair, the Chief Executive, and the Board of Directors on constitutional matters and the correct and proper conduct of Trust business and meetings.
- Commission external advice, including legal advice, where necessary to ensure the effective and efficient resolution of corporate governance issues.
- Horizon-scan and scrutinise new and emerging corporate governance and regulatory matters, and brief the Chair, the Chief Executive, and the Board of Directors as appropriate.
- Ensure all registers of interests required by legislation or regulatory frameworks are established and maintained appropriately and are available for public inspection in line with statutory requirements.
- In conjunction with the Chief Executive and the Director of Finance, take a leading role in the preparation and publication of the annual report and accounts.
- Ensure compliance with regulatory frameworks, including the CQC Well-Led Framework, the Fit and Proper Person test framework, and the NHS Code of Governance.
- Support the Chair in the management of Non-Executive positions, including annual appraisals, succession planning, training and development, and recruitment.
- Support the Chair in planning and delivering a structured programme of Board development.

APPENDIX G: THE SEVEN PRINCIPLES OF STANDARDS IN PUBLIC LIFE

The seven principles of standards in public life apply to anyone who holds public office, including leadership roles in public services.

The principles should be upheld by the Board of Directors and by all employees of the Trust.

The principles are:

- **Selflessness:** holders of public office should act solely in terms of the public interest.
- **Integrity:** holders of public office must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions to gain financial or other material benefits for themselves, their family, or their friends. They must declare and resolve any interests and relationships.
- **Objectivity:** holders of public office must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias.
- **Accountability:** holders of public office are accountable to the public for their decisions and actions and must submit themselves to the scrutiny necessary to ensure this.
- **Openness:** holders of public office should act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for so doing.
- **Honesty:** holders of public office should be truthful.
- **Leadership:** holders of public office should exhibit these principles in their own behaviour. They should actively promote and robustly support the principles and be willing to challenge poor behaviour whenever it occurs.

APPENDIX H: POWERS RESERVED FOR THE BOARD OF DIRECTORS

General Enabling Provision

The Board may determine any matter within its statutory powers, for which it has delegated or statutory authority, in full session.

1. Regulations and Control

1. Approve Standing Orders (SOs), including a scheme of powers delegated and reserved to the Board, and Standing Financial Instructions for the regulation of its proceedings and business.
2. Suspend the Standing Orders.
3. Vary or amend the Standing Orders.
4. Retrospectively approve in public session any urgent decisions taken by the Chairman and Chief Executive.
5. Approve the scheme of delegation of powers delegated from the Board to committees**.**
6. Require and receive the declaration of Board members' interests that may conflict with those of the Trust and determine the extent to which that member may remain involved with the matter under consideration.
7. Require and receive the declaration of officers' interests that may conflict with those of the Trust.
8. Approve arrangements for dealing with complaints.
9. Adopt the organisational structures, processes and procedures to facilitate the discharge of business by the Trust and agree modifications thereto.
10. Receive reports from committees including those that the Trust is required by the Secretary of State or other regulation to establish and to take appropriate action on.
11. Confirm the recommendations of the Trust's committees where the committees do not have Executive powers.
12. Approve arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust.
13. Establish terms of reference and reporting arrangements of all committees and sub- committees that are established by the Board.
14. Approve arrangements relating to the discharge of the Trust's responsibilities as a bailer for patients' property.
15. Authorise use of the Trust Seal.
16. Retrospectively approve, or otherwise instances of failure to comply with Standing Orders brought to the Chief Executive's attention.
17. Discipline members of the Board or employees who are in breach of statutory requirements or Standing Orders.

2 - Appointments / Dismissal

1. Appoint the Deputy Chairman of the Board.
2. Appoint and dismiss committees (and individual members) that are directly accountable to the Board.
3. Appoint, appraise, discipline and dismiss Executive Directors.
4. Confirm appointment of members of any committee of the Trust as representatives on outside bodies.
5. Approve proposals of the Remuneration and Nominations Committee regarding directors and senior employees and the proposals of the Chief Executive for staff not covered by that committee.

3. Strategy, Plans and Budgets

1. Define the strategic aims and objectives of the Trust.
2. Approve proposals for ensuring quality and developing clinical governance in services provided by the Trust, having regard to any guidance issued by the Secretary of State.
3. Approve the Trust's policies and procedures for the management of risk.
4. Approve Outline and Final Business Cases for Capital Investment and Service Developments.
5. Approve budgets.
6. Approve annually the Trust's proposed organisational development proposals.
7. Approve, or otherwise, proposals for acquisition, disposal or change of use of land and/or buildings in line with the Standing Orders and Standing Financial Instructions.
8. Approve Private Finance Initiative proposals.
9. Approve the opening of bank accounts.
10. Approve proposals on individual contracts (other than NHS contracts) of a capital or revenue nature amounting to, or likely to amount to over £1m.
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.
12. Approve individual compensation payments (other than those delegated to the Remuneration and Nominations Committee).
13. Approve proposals for action on litigation against or on behalf of the Trust where the quantum exceeds the delegated budget authority of the Chief Executive.
14. Review use of NHS Litigation Authority risk pooling schemes.

4. Policy Determination

1. Approve management policies including workforce policies incorporating the arrangements for the appointment, removal and remuneration of staff.

5. Audit

1. Approve the appointment (and where necessary dismissal) of External Auditors recommended by the Auditor Panel. Approval of external auditors' arrangements for the separate audit of funds held on trust, and the submission of reports to the Audit and Risk Committee meetings which will take appropriate action.
2. Receive the annual management letter received from the external auditor and agreement of proposed actions, taking account of the advice, where appropriate, of the Audit and Risk Committee.
3. Receive an annual report from the Internal Auditor and agree action on recommendations where appropriate of the Audit and Risk Committee.

6. Annual Reports and Accounts

1. Receive and approve the Trust's Annual Report and Annual Accounts including the Quality Account.
2. Receive and approve the Annual Report and Accounts for funds held on trust.

7. Monitoring

1. Receive such reports as the Board sees fit from committees in respect of their exercise of powers delegated.
2. Continuous appraisal of the affairs of the Trust by means of the provision to the Board, as the Board may require, 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, NHS England and the Charity Commission shall be reported, at least in summary, to the Board.
3. Receive reports from the Director of Finance on financial performance against budget and the Trust's Financial Plan. Receive reports from the Chief Executive on actual and forecast income from contracts and Service Level Agreements.