Board of Directors (in Public)
24 July 2025
Agenda Item: 23

Report Title	Assurance Committees' Annual Reports: 2024/25
Author	Lynsey Ryder, Head of Corporate Governance David O'Brien, Director of Corporate Services and Company Secretary
Accountable Director(s)	Committee Chairs (Non-Executive Directors) Committee Lead Directors (Executive Directors)
Previous committees/groups	People Committee 08 July 2025 Quality Committee 12 June 2025 Finance and Performance Committee 19 June 2025 Audit and Risk Committee: 22 July 2025
Recommended action(s)	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

Executive Summary

What?

As part of the Trust's corporate governance arrangements each of the Board assurance committees has prepared and approved an annual report for 2024/25. Amongst other things, these annual reports provide assurance regarding the extent to which each committee fulfilled its purpose and remit in 2024/25 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: People Committee Annual Report
Appendix B: Quality Committee Annual Report
Appendix C: Finance and Performance 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. Workplans and Terms of Reference have been reviewed and approved by each committee.

So What?

These annual reports provide assurance that 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.

As a result of these annual reviews, the Terms of Reference and Workplans for committees have been strengthened for 2025/26, and the associated reporting and assurance flows clarified and improved.

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 2025/26 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 annual self-evaluation processes.

Recommendation(s)	The Board receives assurance via the 2024/25 annual reports of the Finance and Performance Committee, the Quality Committee, the People Committee, and the Audit and Risk Committee.
Link to Board Assurance Framework Risks (board and level 2 committees only)	All Strategic Risks

APPENDIX A

People Committee
Annual Report 2024-25

1.0 INTRODUCTION

1.1 The purpose of this annual report is to provide a summary of the activity of the People Committee from April 2024 to March 2025, an evaluation of the Committee's effectiveness, and an assessment of compliance against all areas of the terms of reference (ToR).

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 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 2024 to March 2025, 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, has been the Committee Chair over the reporting period. Mandy Wilcock, Director of People and Organisational Development, was the Executive Lead for the Committee.

3.2 During 2024-2025 the Committee met formally on six occasions.

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. For the purposes of quoracy, the Director of People and Organisational Development is considered an executive director. This has been further clarified in the 2025-2026 ToR for the Committee. The table at the end of this report shows attendance of the Committee during 2024-2025:

3.4 In addition to the formal membership and director-level attendees of the Committee, the following individuals were in regular attendance during the year at the Committee's meetings:

Clare Ashby	Deputy Director of Quality and Nursing
Nabila Ayub	Head of Diversity and Inclusion
Mussarat Suleman	Head of Employee Health and Wellbeing

3.5 Other managers have also been requested to attend the Committee throughout the year to discuss specific items including staff survey, investing in volunteers and employee relations.

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 62 areas to be considered regarding the compliance or non-compliance of the Committee, against its terms of reference. The Committee was compliant with 48 areas. There were two areas of partial-compliance and twelve areas which were not applicable, as follows:

4.2.1 Partial Compliance

48. 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.

Agenda items were mostly received with seven days prior notice. Any amendments to agendas were agreed by the Committee Chair and Lead Director.

50. 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.

Adherence to timescales was inconsistent throughout the year.

4.2.2 Not Applicable

3. Development of workforce submissions relating to national, system-level or other financial and operational planning processes.

This work has been undertaken outside the People Committee meetings and through other Board-Level groups. Consideration to be given to the appropriateness of this item in the People Committee ToR.

16. Oversight of improvement plans or individual actions arising from internal or external assurance processes, including internal audit reviews and regulatory inspections (CQC, Ofsted).

There has been one relevant audit relating to staff expenses, the oversight of actions has been undertaken at the Audit and Risk Committee.

20. Identify new risks for the attention of the Board of Directors.

No new risks were identified in the meetings of the Committee during 2024-25.

28. Individuals from external organisations may be invited to attend as and when required to support the work of the Committee.

There were no attendees from external organisations.

39, 40 and 41 relate to the process in the event of a vote being called.

A vote has not been held in this Committee cycle.

43. 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.

No additional meetings were convened during 2024-25.

51 and 52 relate to urgent decisions and decision-making between meetings.

This did not occur in this Committee cycle.

59 and 60 relate to the establishment of and reporting from task-and-finish groups.

No task and finish groups have been established in 2024-25.

5.0 COMMITTEE WORKINGS

5.1 The Committee had a work plan for 2024-25 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 Organisational Development 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.

6.0 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:

<u>Administration</u>

Meeting papers were mostly circulated on time, however, multiple packs were received on occasions.

Chairing of the meeting

The chairing of the meetings was effective, with appropriate time for debate. Discussion was encouraged and supported to deepen understanding of topics. Agenda items were helpfully introduced, clarifying the time allowed and the ask of the group. Assurance was sought and provided with actions clarified. The chair facilitated meaningful debate on key areas.

Content and appropriateness of agenda

The agendas were relevant and balanced, covering strategic issues and operational plans. They included a focus on both strategic cultural issues and more detailed matters.

Engagement

There was some evidence of wider staff involvement through consultations and forums, though patient involvement was not always clear.

Quality and quantity of papers

Meeting papers were generally concise and relevant, with improved quality of information and reduced jargon, however, use of acronyms and YAS/HR terminology could be improved. Overall, the content covered the appropriate areas for providing assurance, key risks and impact on business delivery plans and demonstrated alignment with the Trust values. Some papers lacked clarity on actions and explicit evidence to provide assurance rather than reassurance by the presenter.

Risk

The committee covers risk on each agenda and received reports and has in depth discussions on emerging risks e.g. minimum wage.

Appropriate challenge

The meetings demonstrated constructive challenge among members, with no defensive responses. Both executive directors and non-executive directors participated actively, ensuring thorough discussions and appropriate questioning regarding assurance, however, there was little executive to executive challenge. The Chair fostered a supportive and collaborative environment, so challenge is done in a supportive way.

Appropriate debate

There was active participation from members, allowing time for appropriate debate. Discussions were focused and productive, with good contributions from all attendees. Good discussions were led by the Highlight and Low Light reports to help focus the debate.

Unitary Board assurance

The meeting demonstrated good practice of NEDs and Executive Directors seeking assurance. Unitary support was sought for items going to the Trust Board for approval, and the Chair confirmed where the committee was assured.

7.0 WORK OF THE COMMITTEE

7.1 During 2024-2025, 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
- Recruitment and Retention
- YAS Together
- Staff Survey Engagement and Results
- Health and Wellbeing including absence reduction

PEOPLE COMMITTEE MEETING ATTENDANCE 2024/25

Committee Members and Attendees	2024				2025	
	14 May	09 July	10 Sept	19 Nov	21 Jan	18 March
Tim Gilpin Non-Executive Director		✓	✓	✓		✓
Jeremy Pease Non-Executive Director	✓					
Amanda Moat Non-Executive Director	✓	✓	✓	✓	✓	✓
Andrew Chang Non-Executive Director	✓	✓	✓	✓	✓	✓
Mandy Wilcock Director of People and Organisational Development	✓		✓	✓	✓	✓
Nick Smith Chief Operating Officer	✓	✓	✓		✓	✓
Rebecca Randell Associate Non-Executive Director						✓
Marc Thomas Deputy Chief Executive						
Suzanne Hartshorne Deputy Director of People and Organisational Development	✓	✓	✓			✓
Dawn Adams Associate Director of People Development	✓	✓	✓	✓	✓	✓
David O'Brien Director of Corporate Services and Company Secretary	✓		✓	✓	✓	✓
Rachel Gillott Director of Partnerships and Operations	✓		✓	✓	✓	✓

APPENDIX B

Quality Committee
Annual Report 2024-25

1.0 INTRODUCTION

1.1 The purpose of this annual report is to provide a summary of the activity of the Quality Committee from April 2024 to March 2025 and an assessment of compliance against all areas of the terms of reference (ToR).

2.0 BACKGROUND

2.1 The Quality 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 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.

2.3 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
- 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.

3.0 MEMBERS AND MEETINGS

3.1 Anne Cooper, Non-Executive Director, has been the Committee Chair over the reporting period. Dave Green, Executive Director of Quality and Chief Paramedic, was the Executive Lead for the Committee.

3.2 During 2024-25,the Committee met formally on eleven occasions.

3.3 The quoracy 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. The table at the end of this report shows the attendance at Committee meetings during 2024-25:

3.4 In addition to the formal membership and director-level attendees of the Committee, the following additional individuals were in regular attendance during the year at the Committee's meetings

Phil Gleeson, Critical Friends Network member
Lesley Butterworth, Head of Nursing and Patient Experience
John Thompson, Head of Infection, Prevention and Control
Hazel O'Neill, Head of Safeguarding
Ruth Crabtree, Public Health Lead
Mark Millins, Associate Director of Paramedic Practice
Jonathan Turnbull-Ross, Associate Director of Quality Improvement

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 68 areas to be considered regarding the compliance or non-compliance of the Committee, against its terms of reference. The Committee was compliant with 60 areas. There were two areas of partial compliance and six areas which were not applicable, as follows:

4.2.1 Partial Compliance

54. 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

Agenda items were mostly received with 10 days prior notice. Any amendments to the agendas were agreed by the Committee Chair.

56. 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.

Adherence to timescales was inconsistent throughout the year.

4.2.2 Not applicable

34. Individuals from external organisations may be invited to attend as and when required to support the work of the Committee.

There were no attendees from external organisations.

45, 46 and 47 relate to the process in the event of a vote being called.

A vote has not been held in this Committee cycle.

57 and 58 relate to urgent decisions and decision-making between meetings.

This did not occur in this Committee cycle.

5.0 COMMITTEE WORKINGS

5.1 The Committee had a workplan for 2024-25 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 audits were made to the Audit Committee on controlled drugs and the complaints process.

5.3 Prior to each meeting the Chair formally reviewed the agenda separately with both the 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 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 Administration

Generally, papers were distributed on time. There were instances of multiple packs being distributed due to late papers and one occasion where two papers were distributed on the day of the meeting.

6.1.2 Chairing of the meeting

The meetings have been chaired professionally, enabling a good level of debate and discussion, and an inclusive approach encouraging participation. The timing of agendas was managed effectively, allowing flexibility. There was clear articulation of actions.

6.1.3 Content and appropriateness of agenda

The agendas have had a clear focus on patient and quality issues. The agendas have been appropriate and informed directly by the Committee workplan and terms of reference, covering the Trust's strategy and business plan priorities, along with

items relating to day-to-day governance and assurance activity and current issues. Operational elements were examined through a quality and patient safety lens

6.1.4 Engagement

The committee encouraged patient engagement and involvement, with patient stories and patient representative present at meetings. There was a focus on patient and staff experiences however, further work could be done on this to have more extensive and clearer evidence of wider patient engagement.

6.1.5 Quality and quantity of papers

The overall quality of the papers was good. Acronyms should be avoided in papers and presentations/verbal updates. Papers were detailed and of appropriate length given the complexity; presenters guided the committee through key report elements well. The recommendations often referred to 'approval' which is not a role of this Committee. Papers in AAA format helped guide discussions effectively without losing assurance.

6.1.6 Risk

The committee has taken risks seriously, papers highlighted risks effectively and provided updates to each of the BAF strategic risks covered by this committee. New risks were discussed, and the register updated regularly.

6.1.7 Appropriate challenge

The meetings were marked by lively and balanced discussions with constructive challenges among members, including director to director challenge, with no negative reactions.

6.1.8 Appropriate debate

Meetings were characterised by well-managed debates, where all members engaged actively. The Chair facilitated discussions effectively, allowing flexibility in timing for important topics. Constructive challenges and contributions were made, ensuring a balanced and productive meeting.

6.1.9 Unitary Board assurance

NEDs and Executives sought appropriate and relevant assurance through constructive challenge. Referencing to the assurance work of other committees was evident.

7.0 WORK OF THE COMMITTEE

7.1 During 2024-25 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:

- Board Assurance Framework and Corporate Risk Register
- Clinical Audit

- Clinical Supervision
- Complaints/Concerns/Comments/Compliments
- Coroners/Claims
- Health and Safety
- Health Inequalities
- Incidents and investigations including serious incident investigations.
- Infection, Prevention and Control
- Learning from incidents
- Medicines Optimisation and Controlled Drugs
- Patient experience
- Patient safety
- Safeguarding

QUALITY COMMITTEE MEETING ATTENDANCE 2024/25

Committee Members and Attendees	2024								2025		
	11 Apr	16 May	21 Jun	18 Jul	17 Sep	17 Oct	21 Nov	17 Dec	16 Jan	20 Feb	20 Mar
Anne Cooper Non-Executive Director		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Jeremy Pease Non-Executive Director	✓	✓	✓	✓	✓		✓	✓	✓		
Andrew Chang Non-Executive Director	✓	✓	✓			✓		✓	✓	✓	✓
Dave Green Executive Director of Quality and Chief Paramedic	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Julian Mark Executive Medical Director	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Katie Lees Associate Non-Executive Director										✓	✓
Marc Thomas Deputy Chief Executive											✓
David O'Brien Director of Corporate Services and Company Secretary	✓	✓	✓	✓	✓	✓	✓		✓		✓
Adam Layland Director of Partnerships and Operations	✓		✓	✓	✓				✓	✓	✓
Clare Ashby Deputy Director of Quality and Nursing	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓
Julia Nixon Associate Chief Operating Officer – Remote Care	✓	✓	✓				✓	✓	✓		✓

APPENDIX C

Finance and Performance Committee
Annual Report 2024-2025

1.0 INTRODUCTION

1.1 The purpose of this annual report is to provide a summary of the activity of the Finance and Performance Committee from April 2024 to March 2025 and an assessment of compliance against all areas of the terms of reference (ToR).

2.0 BACKGROUND

2.1 The Finance and Performance 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 seek and obtain assurance on behalf of the Board of Directors to demonstrate that, in the context of the matters set 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.

3.0 MEMBERS AND MEETINGS

3.1 Amanda Moat, Non-Executive Director, has been the Committee Chair over the reporting period. Kathryn Vause, Executive Director of Finance, has been the Executive Lead Director for the Committee

3.2 During 2024-25 the Committee met formally on twelve occasions.

3.3 The quorum for the Committee is 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. The

meetings were quorate at all times. A table showing attendance at Committee meetings during 2024/25 is shown as an appendix to this report.

3.4 In addition to the formal membership of the Committee, the following individuals were in regular attendance during the year at the Committee's meetings:

Andrew Chang, Non-Executive Director
Marc Thomas, Deputy Chief Executive
Sam Robinson, Chief Digital Information Officer
Jeevan Gill, Director of Partnership and Operations
Louise Engledow, Deputy Director of Finance
David O'Brien, Director of Corporate Services and Company Secretary
Carol Weir, Director of Strategy, Planning and Performance

3.5 Other managers have also been requested to attend the Committee throughout the year to discuss specific items including contracts, Patient Transport Service, Integrated Urgent Care, remote care, procurement, fleet, and estates.

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 69 areas to be considered regarding the compliance or non-compliance of the Committee, against its terms of reference. The Committee was compliant with 59 areas. There were three areas of partial compliance and seven areas that were not applicable, as follows:

4.2.1 <u>Partial Compliance</u>

55. 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.

Agenda items were mostly received with ten days prior notice. Any amendments to the agendas were agreed by the Committee Chair and lead Director.

57. 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.

Adherence to timescales was inconsistent throughout the year.

58. 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.

One urgent decision was taken by the Chair during the Committee cycle which was subsequently reported to the Board of Directors. However, the decision was not

formally recorded in the minutes of the following Committee meeting. This has since been rectified.

4.2.2 Not applicable

26. Identify new risks for the attention of the Board of Directors.

No new risks were identified during the 2024-25 meetings.

46, 47 and 48. relate to the process in the event of a vote being called.

A vote was not held during the 2024-2025 meetings.

59. Quorum approval by email correspondence.

This did not occur in the 2024-2025 meeting cycle.

66 and 67. relating to the establishment of and reporting from task and finish groups.

The Committee did not establish any task and finish groups in the 2024-2025 meeting cycle.

5.0 COMMITTEE WORKINGS

5.1 The Committee had a workplan for 2024-2025 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, with the People Committee regarding management of increased levels of sickness, governance and assurance of recruitment relating to the implementation of NHS Pathways and retention of the EMD workforce; and with the Quality Committee regarding a joined up approach to quality and performance concerns, patient safety aspects of hospital handover times and adherence to clinical guidance.

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 generally distributed on time with revised packs circulated closer to the meeting on occasions.

Chairing of meeting

The Chair effectively managed the meetings, ensuring flexibility and efficient use of time for discussion of important issues.

Content and appropriateness of agenda

The agendas demonstrated balanced content relating to finance and performance current issues and future strategic matters. Agendas have included assurance of matters not often considered in depth such as digital, fleet and the green plan.

Engagement

There was limited evidence of patient involvement. However, papers and discussions often referenced benefits, staff engagement, system partners and the impact of performance data on patients. NEDs and EDs effectively highlighted patient perspectives in performance and financial decisions.

Quality and quantity of papers

Reports were well written and provided thorough assurance. Papers were clear, detailed, and appropriately linked to strategic priorities and risks. Presenters effectively highlighted key issues and updates.

Risk

Risk discussions were thorough, with links to the Board Assurance Framework (BAF). New risks were identified and discussed appropriately. Constructive challenge and participation from colleagues ensured robust consideration of risks across financial, fleet, and operational matters.

Appropriate challenge

There was excellent participation and constructive challenge by attendees which was supportive, and improvement focused. Effective questioning ensured thorough discussions and robust consideration of issues. NED and director led challenge was evident. All challenge and debate was conducted in line with the Trust values.

Appropriate debate

Appropriate debate was evident in all meetings, reflecting the Trust's values. Discussions were detailed where necessary. Patient care and safety were central to financial decisions, with a focus on risk to patients.

Unitary Board assurance

The meeting demonstrated effective challenge and debate with appropriate participation from all members. Appropriate assurance was sought from NEDs and Executive Directors. Assurance was linked to evidence, and decisions were made by consensus, supporting the unitary board. There was also cross-referencing to other committees.

7.0 WORK OF THE COMMITTEE

7.1 During 2024-2025 the Committee sought assurance of 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. Examples of the work carried out in relation to the purpose of the Committee as defined in the ToR are reviews of:

- Financial performance review
- Operational performance review
- Performance management
- Business planning
- Revenue and Capital planning
- Financial/budget planning
- Review of contracts and variations
- Review of business cases and tenders
- Digital/ICT performance review

FINANCE AND PERFORMANCE COMMITTEE ATTENDANCE 2024/25

Committee Members	2024									2025		
	23 Apr	23 May	25 Jun	23 Jul	9 Aug	24 Sep	22 Oct	26 Nov	19 Dec	28 Jan	25 Feb	25 Mar
Amanda Moat Non-Executive Director	X	X	X	X	X	X	X	X	X	X	X	X
Jeremy Pease Non-Executive Director	X	X	X	X	X	X		X	X	X		
Tim Gilpin Non-Executive Director						X	X		X	X		X
Kathyrn Vause Executive Director	X	X	X		X	X	X	X	X	X	X	X
Nick Smith Executive Director	X	X	X	X	X	X	X	X	X	X	X	X

APPENDIX D

Audit and Risk Committee
Annual Report 2024/25

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 2024/25. However the report also includes an initial commentary on the Audit and Risk Committee's year-end work during 2025/26 to conclude the governance, assurance and reporting associated with the 2024/25 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 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 2024/25 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 2024/25 the Audit and Risk Committee met formally on seven occasions as shown below.

- 16 April 2024

- 26 June 2024
- 27 June 2024
- 16 July 2024
- 12 November 2024
- 02 December 2024
- 21 January 2025

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 The meeting held on 27 June 2024 was an extraordinary meeting convened to consider changes to the Audit Completion Report that had been presented to the Committee at its meeting the previous day.

3.5 The meeting held on 02 December 2024 was an extraordinary meeting convened to consider the annual report and accounts of the YAS Charity.

3.6 The attendance record of the principal and regular attendees for the above-mentioned meetings is shown in the table at the end of this report

3.7 Throughout the year the Committee held meetings in private with internal and external auditors, in accordance with good practice and the requirements of the NHS Code of Governance (2023).

4.0 Audit Committee Governance Arrangements

4.1 The Audit and Risk Committee operated in accordance with its Terms of Reference. For the 2024/25 financial year the Terms of Reference were reviewed and approved by the committee at its meeting held on 29 June 2024 and ratified by the Board on 25 July 2025.

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 workplan.

4.3 The Audit and Risk Committee works with other assurance committees and the Trust Board, and regularly receives matters for its consideration from those bodies or refers matters to those governance bodies 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

HFMA Committee Effectiveness Self-Assessment

5.1 During 2024/25 the Committee undertook a self-assessment review based on the Healthcare Financial Management Association audit committee effectiveness framework and facilitated by 360 Assurance.

5.2 The assessment demonstrated that the Committee was in a stronger position compared to the most recent equivalent assessment carried out in 2022/23. Identified areas of strength included:

- The Committee's clarity of purpose, objectives, and planning.
- The balance of skills, knowledge, and experience provided by Committee members and other regular attendees.
- The Committee's culture of openness, high level of engagement, and high quality of discussion.
- The strength of assurance provided by reports and information received by the Committee.
- The Committee's relationship with other committees and the Board.
- The Committee's relationships with internal audit, external audit, and counter fraud.
- The Committee's agenda, administration, and cycle of business.

5.3 The effectiveness exercise identified two areas about which the Committee might review its current arrangements:

- The extent to which assurance regarding financial and non-financial matters have (or should have) equal prominence in the Committee's work.
- The extent to which the Committee should receive assurances from third party sources other than internal and external audit.

Compliance with Terms of Reference

5.4 This annual report process included an assessment of the Committee's compliance with its own Terms of Reference for 2024/25. Overall the committee demonstrated a significant level of compliance with its terms of reference during 2024/25.

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(f)	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.	Partial
4.7.1(g)	The Committee will receive reports from the Charitable Funds Committee regarding governance, risk management, control, audit, and financial reporting matters	Partial
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 2024/25:

- 16 April 2024
- 12 November 2024
- 21 January 2025

5.7 The main consistent themes emerging from these evaluation forms was:

- The chairing of meetings is effective, inclusive and engaging.
- Meeting agendas provide a good balance of strategic and operational issues.
- Papers are of good quality, providing the right level of detail (reflecting the complexity of the organisation) but also signposting 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

2023/24 Annual Report and Accounts

6.1 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 (Audit Completion Report)
- Auditor's Annual Report
- Letter of Representations to the External Auditor
- NHS Code of Governance Compliance
- Board Members' Register of Interests
- Provider Licence Declarations
- Quality Account

6.2 Completion of the 2023/24 audit work on the annual report and accounts was achieved on time. The Committee reviewed the 2023/24 annual report and accounts at its meeting held on 26 June 2024. Upon the Committee's recommendation, the Board of Directors approved the annual report and accounts on 28 June 2024.

External Audit

6.3. Throughout 2024/25 the Committee was advised by and received reports and technical updates from Bishop Fleming in their capacity as the Trust's external auditors. The Committee received the external auditors reports regarding the planning, completion and findings of audit of the annual report and accounts

6.4 2024/25 was the first year in which Bishop Fleming had acted as the Trust's external auditors.

Internal Audit

6.5 Throughout 2024/25 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 2024/25 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 2023/24, including the Head of Internal Audit Opinion. For 2023/24 the Trust received an overall opinion of 'moderate' assurance.

6.7 During 2024/25 the Committee undertook an effectiveness review of its internal auditors. As a result of this review the committee recommended that the Trust join the 360 Assurance consortium as a full member. The Board of Directors accepted this recommendation.

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 2023/24 which confirmed full compliance with the Counter Fraud Functional Standard.

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.

6.13 Financial controls routinely reviewed by the committee include contracts, single tender waivers, and special payments.

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
- Charitable Funds Committee

6.15 During 2024/25 the committee received quarterly risk assurance reports from the Quality Committee, the People Committee, and the Finance and Performance Committee.

6.16 The Committee received the Annual Report and Accounts for the YAS Charity. The Committee did not receive an assurance report from the Charitable Funds Committee. This will be rectified during 2025/26.

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 2024/25 the Chair of the Audit and Risk Committee enacted two urgent or flexible decisions, as follows:

Date	Decision	Ratified
23 April 2024	Approval of the 2024/25 Counter Fraud Plan	16 July 2024
10 September 2024	Approval of variances to the 2024/25 Internal Audit Plan,	12 November 2024

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. From 2024/25 onwards all committee Terms of Refence include explicit clauses relating to urgent and flexible decision-making, consistent with the Trust's Standing Orders.

8.0 2024/25 YEAR-END

2024/25 Annual Report and Accounts

8.1 At its meeting held on 26 June 2025 the Committee reviewed the Annual Report and Accounts for 2024/25 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 2024/25 year-end items considered by the committee were:

- Annual Report
- Annual Accounts and Financial Statements
- Statement of Post-Balance Sheet Events
- Statement of Going Concern
- Annual Governance Statement
- Internal Audit Annual Report and Opinion

- External Audit ISA 260 (Audit Completion Report)
- External Audit Annual Report
- Letter of Representations to the External Auditor
- NHS Code of Governance Compliance
- Board Members' Register of Interests
- Quality Account

8.2 Upon the Committee's recommendation, the Board of Directors approved the annual report and accounts on 26 June 2025.

9. Forward Look

9.1 During 2025/26 there will be a change in membership of the Audit and Risk Committee. At its meeting held in June 2025 the Board of Directors confirmed the new membership to be as follows:

- Amanda Moat (Chair)
- Tabitha Arulampalam
- Saghir Alam

9.2 The Committee recognises and here formally records its thanks to Andrew Chang, outgoing Chair, for his service to the Audit and Risk Committee.

Audit and Risk Committee: Meeting Attendance 2024-25

Committee Members and Attendees	2024						2025
	16 April	26 June	27 June	16 July	12 November	02 December	21 January
Andrew Chang Non-Executive Director	✓	✓	✓	✓	✓	✓	✓
Anne Cooper Non- Executive Director	✓		✓	✓	✓	✓	✓
Amanda Moat Non- Executive Director	✓	✓	✓	✓	✓	✓	✓
Kathryn Vause Executive Director of Finance	✓	✓	✓	✓		✓	✓
Dave Green Executive Director of Quality	✓	✓		✓			✓
David O'Brien Company Secretary	✓	✓	✓	✓	✓		✓
Internal Audit 360 Assurance	✓	✓		✓	✓		✓
External Audit Bishop Fleming	✓	✓	✓	✓	✓		✓
Counter Fraud Specialist 360 Assurance	✓	✓		✓	✓		✓