Yorkshire Ambulance Service NHS Trust

Organisation Code: RX8

Governance Statement

1. Scope of responsibility

1.1 The Board is accountable for internal control. As Accountable Officer, and Chief Executive of this Board, I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives. I also have responsibility for safeguarding the public funds and the organisation's assets for which I am personally responsible as set out in the Accountable Officer Memorandum.

1.2 I am supported in my role as Accountable Officer by a clearly defined management structure and governance arrangements, as described in the Trust's Governance Handbook. The Executive Director Portfolios and associated management structures have been refined during the year, to ensure effective strategic and operational leadership and to provide greater clarity on accountability across all areas of Trust business.

1.3 The corporate risk management framework is set out in our Risk Management and Assurance Strategy. I ensure that this document, which describes our strategic approach the processes and monitoring arrangements for managing risk, is reviewed and updated on an annual basis. The strategy describes the strategic and operational risks faced by the Trust and the mechanisms for providing the Trust Board with assurance that these risks managed efficiently and effectively.

1.4 The Trust meets with the NHS North of England and our lead commissioner, Bradford, Airedale and Leeds Primary Care Cluster on a regular basis to reassure that both the national and local targets are being met and that risks are mitigated to tolerable levels. The Trust also works with its partners through membership of clinical networks across Yorkshire, contractual arrangements with other NHS providers, membership of Resilience Forums and active liaison with local scrutiny committees and involvement networks (LINks).

2. The governance framework of the organisation

2.1 The Trust Board adheres to and is compliant with, the principles outlined in the *Combined Code on Corporate Governance (2003).* The Board recognises its accountabilities and provides leadership within a framework of prudent and effective controls which enables risk to be assessed and managed.

2.2 The Board sets the strategic aims for the organisation and ensures that resources are in place to meet its objectives. It receives reports at each

meeting on the principal risks and associated actions as detailed in the Trust's Board Assurance Framework.

2.3 The Trust Board meets on a two monthly basis and consists of; the Chair and 5 other Non Executive Directors (NEDs), the Chief Executive Officer, the Executive Director of Finance and Performance, and 4 other Executive Directors (3 voting and 1 non-voting) . In addition; the Board functions are co-ordinated and supported by the Director of Corporate Affairs/Trust Secretary. The Board is primarily responsible for:

- Formulating strategy – vision, values, strategic plans and decisions
- Ensuring accountability – pursuing excellent performance and seeking assurance
- Shaping culture – patient focus, promoting and embedding values
- Engagement with internal and external stakeholders to support delivery of Trust aims and objectives.

2.4 Over the year, the Trust Board has significantly developed its ability to focus on strategic issues whilst assuring itself of the performance of the whole organisation. It has achieved this by the following:

- Longer range agenda planning approach to ensure a focus on key decision and governance dates during the year
- Regular Board Strategic Development Sessions, in addition to the bi-monthly public meetings, to cover key strategic and development issues which have included:
  - Our Foundation Trust Application
  - The Trust's 5-year integrated business plan
  - Strategic Development of the Trust including stakeholder engagement and workforce
  - Financial Priorities
  - Quality governance
  - Board governance and committee arrangements.

2.5 Attendance sheets are signed by board members at every meeting and attendance is recorded in the minutes, with apologies noted. In an executive director's absence a suitable nominated associate director attends. Attendance at Board meetings is monitored by the Director of Corporate Affairs/Trust Secretary on behalf of the Chairman and any notable exceptions are addressed by the Chairman or Chief Executive as appropriate.

2.6 This year, as an aspirant Foundation Trust, the Trust has completed a self assessment using the Board Governance Assurance Framework (BGAF), commissioned by the Department of Health. The self assessment will be complemented by an external review to be conducted in 2012/13. The Board Governance Assurance Framework deploys a standardised process to help the Board build on strengths and address weaknesses. It supports the Trust in the development of robust governance arrangements in line with Foundation Trust requirements.

2.7 During 2011/12 the Trust has commissioned external assessments in relation to its quality governance arrangements, its financial reporting procedures and as part of phase 1 of the Foundation Trust Historical Due Diligence exercise. These assessments have supported the Trust in strengthening its governance arrangements during the year. A key focus has been on development of quality governance structures, systems and processes, in line with the Foundation Trust quality governance framework.

2.8 The Trust arrangements for quality governance are fully aligned to the requirements of the foundation trust quality governance framework and are designed to ensure compliance with the *Essential Standards of Quality and Safety*.

2.9 A Clinical Quality Strategy sets out the priorities for clinical quality and this is underpinned by annual implementation plans for each of the key work streams.

2.10 Quality is a central element of all Board meetings. The Integrated Performance report focuses on key quality indicators, and this is supplemented by more detailed reports containing both qualitative and quantitative information on specific aspects of clinical quality.

2.11 The Trust Board has been underpinned throughout 2011/12 by four key committees/groups:

- The Audit Committee (see Section 5)
- The Finance and Investment Committee
- The Trust Executive Group; and
- The Senior Management Group.

2.12 Reporting directly to the Trust Board, the Trust Executive Group (TEG) is accountable for the operational management of the Trust and the delivery of objectives set by the Board. One of its primary functions is the management of organisational governance arrangements, and as such, it provides a formal route to support the Chief Executive Officer in effectively discharging his responsibilities as Accountable officer. The TEG assists in the delivery of operational success and value for money by reviewing information on operational and financial performance and quality. It has also focused on the broad range of human resource and workforce development issues.

2.13 The Senior Management Group (SMG), which was established in May 2011, supports the Trust Board in developing an integrated approach to governance. The group provides the Trust Board with assurances that a comprehensive risk registers process is maintained and that the established relationship between the Corporate Risk Register and Board Assurance framework is functioning effectively. The SMG is responsible for monitoring achievement against the Trust's strategic objectives, specifically those relating

to performance, risk, compliance, quality and safety. The SMG also oversees the performance management of the Trust's operating systems and procedures to provide assurance to the Board on governance and compliance. Throughout 2011/12 the SMG has been routinely provided with risk management information and assurance from:

- Operational management groups in the Accident and Emergency and Patient Transport services
- Risk and Assurance Group
- Health and Safety Committee
- Infection Prevention and Control Committee
- Information Governance Group
- Clinical Governance Committee

2.14 The Finance and Investment Committee (F&IC) was introduced from May 2011, following a review of Trust committees conducted in 2010/11. The F&IC is a sub-committee of the Board and is chaired by a Non-Executive Director. It provides a vehicle for scrutiny of Trust budgets and significant business cases, and supports the Board with assurance on financial governance and risk issues.

2.15 A further review of the Trust corporate governance review was undertaken in 2011/12, resulting in further development of Board committee and management group arrangements. As a result of this exercise, a Quality Committee was introduced as a sub-committee of the Board in March 2012. This committee is chaired by a Non Executive Director and supports the Board with assurance on issues of clinical governance and quality, workforce, risk and safety.

2.16 In addition to the introduction of the Quality Committee, significant changes were made following the review, to the Trust's management groups, to rationalise and streamline the arrangements. These changes have helped to reduce duplication and have increased the clarity of accountability and flow of information within the management groups.

2.17 To strengthen the management of key Trust change programmes and projects aligned to the 5-year business plan, including delivery of the cost improvement programme, the Trust has also agreed the establishment of a Programme Management Group. This will commence in April 2012, with executive leadership and Non Executive Director involvement.

2.18 As Chief Executive Officer (CEO), I lead on the maintenance of an effective risk management system within the Trust, for meeting all statutory requirements and adhering to guidance issued by the Department of Health in respect of governance. Leadership is also provided by the directors and

managers at all levels in the managerial hierarchy, who ensure that risk management is implemented within their areas of responsibility.

2.19 The Executive Director of Standards and Compliance has lead responsibility for managing the development and implementation of risk management (excluding financial risk management) and integrated governance. The Director routinely provides the Trust Board, the Quality Committee, Audit Committee and other management groups with expert advice and reports on risk management and assurance. The Director ensures that the Board has access to regular and appropriate risk management information, advice, support and training where required.

2.20 The Executive Director of Finance and Performance has lead responsibility for financial risk management. The Director advises the Trust Board, the Audit Committee and Finance and Investment Committee, the Trust Executive Group and Senior Management Group on an ongoing basis, about risks associated with the Trust's financial procedures, and the financial elements (capital and revenue) of its activities, through the integrated governance framework.

2.21 The Executive Medical Director has lead responsibility for clinical risk management, and patient safety, ensuring that all clinical procedural documents are maintained and current. The Director advises the Trust Board, Quality Committee, Clinical Governance Committee (to March 2012, and subsequently the Clinical Governance Group), and the other management groups as appropriate, on risks associated with the Trust's clinical procedures and practices.

2.22 External consultants have been commissioned to provide the Trust Board with risk management education in the context of their roles and responsibilities. The Trust has developed and delivered a range of risk management training programmes and other education and development initiatives to all grades of management and staff, where applicable. The Trust utilises the Knowledge and Skills Framework (KSF) which prescribes that risk management forms part of the core competences for managers.

2.23 The Standards and Compliance directorate has developed monitoring arrangements to ensure that, in addition to learning lessons from adverse events, a proactive approach is also taken to learning from examples of good practice.

2.24 The Trust has also appointed a Corporate Affairs Director/Trust Secretary to play a pivotal role in ensuring the Trust Board, its Sub Committees and other executive groups operate effectively within their Terms of Reference with no

gaps in governance arrangements.

3. Risk assessment

3.1 Risk assessment is the overall process of risk identification, risk analysis and risk evaluation. The process assists the Trust to manage, reduce or eradicate identified risks in order to protect the safety of patients, staff, visitors and the organisation as a whole. The identification of risk takes many forms and involves both a pro-active approach and one which reviews risks retrospectively. Assessment of risk is therefore a dynamic and on-going process.

3.2 Risks are identified proactively by the Board and senior management team as part of the 5-year and annual business planning cycles.

3.3 in addition, risks can be identified on a daily basis throughout the Trust by any employee. The identified risks vary significantly in scope, content, likelihood and impact and hence the measures for addressing them have also varied. Having identified a risk, a thorough risk assessment is carried out following the guidance for ongoing risk assessment, described in the Trust Risk Escalation and Reporting Procedure.

3.4 When risks have been identified, each one is analysed in order to assess what the likely impact would be, the likelihood of this impact occurring and how often it is likely to re-occur. When evaluating risks; consideration is given to any existing controls for that risk and importantly the adequacy and effectiveness of those controls.

3.5 Risks that cannot be managed locally are passed up through the line of management, to the Trust Executive Group and ultimately to the Trust Board, which is notified of all significant (extreme level) risks within the organisation that cannot be adequately eliminated or controlled. The Trust Board has ultimate responsibility for deciding how the Trust then manages those risks.

3.6 The organisation's major risks are separately identified: those that have been managed in year and also those that will be managed in the future. The Trust identifies risk to its annual business plan and five year Integrated Business Plan, and aims to prioritise and manage the principal risks that may impact on the achievement of the Trust's strategic objectives and implementation plans.

3.7 The principal risks to the strategic objectives identified in the Board Assurance Framework 2011/12, were:

- Failure to maintain financial viability

- Increased competition, resulting in loss of service and income
- Inability to improve the effectiveness of clinical care and patient outcome
- Inability to innovate against a changing commissioner landscape
- Inability to secure the capacity and capability required to deliver the clinical and financial improvements required
- Inability to deliver organisational change management programmes required to sustainably perform against changing service demands
- Non-compliance with regulatory or legislative standards, either causing or leading to an adverse impact on service delivery.

Mitigation plans were in place for each of these principal risks and the Audit Committee has scrutinised the controls and assurances as part of its annual work programme, through reports from the accountable Executive Directors.

3.8 A number of new operational risks with a potential impact on the strategic goals emerged during the year and required additional management action. These have been reported to the Audit Committee and to each meeting of the public Board via the Integrated Performance Report. The most significant risks were as follows:

- Delayed activation/response to red emergency calls, through loss of the CAD system associated with essential IT or electrical upgrade work. A significant event in 2011/12 highlighted the need for a review of the change control process for the management of maintenance or repair work involving key Trust systems. These cross-departmental processes have since been significantly strengthened to reduce future risks to business continuity.

- Non-compliance with elements of the *Essential Standards of Quality and Safety,* relating to aspects of mandatory training and personal development review completion, cleaning of station premises and medicines management. These issues were recognised and being addressed through the Trust risk management system, but were also highlighted following the Trust's inspection by the Care Quality Commission in October 2011. Subsequently the Trust has successfully implemented actions to improve operational performance, which led to the Trust being found to be fully compliant with all standards in a follow up inspection in January 2012.

3.9 All corporate risks subject to ongoing risk management plans will be recorded on the 2012/13 iteration of the Board Assurance Framework and will continue to be managed through the Corporate Risk Register.

3.10 The Trust achieved its operational target for immediately life threatening calls in 2011/12. The achievement of this target will continue to pose a challenge to the Trust risk in the future, however, with potential financial and regulatory consequences.

3.11 Reference is made, within the Risk Management and Assurance Strategy to the Information Governance Policy which describes, in detail, the arrangements within the Trust for managing and controlling risks to data security. The Senior Information Risk Officer role for the Trust is undertaken by the executive Director of Standards and Compliance, supported by the Trust's Executive Medical Director as the Caldicott Guardian. During the past year there have been no reported serious incidents involving lapses of data security.

4. The risk and control framework

4.1 The Trust is subject to constant change in its core business and the wider environment; the risk environment is constantly changing too, therefore priorities and the relative importance of risks for the Trust shift and change.

4.2 The Trust recognises that in order to be most effective, risk management must become part of the organisation's culture. The Trust strives to embed risk management into the organisation's philosophy, practices and business processes rather than be viewed or practiced as a separate activity. Our aim is for everyone in the Trust to become proactively involved in the management of risk.

4.3 The Risk Management and Assurance Strategy and supporting Risk Escalation and Reporting Procedure defines the process which specifies the way risk (or change in risk) is identified, evaluated and controlled. The Trust risk management process adheres to the guidance provided by the Australia/New Zealand (ASNZS: 4360) Risk Management Standards, the NHS Litigation Authority Risk Management Standards for Ambulance Trusts and the National Patient Safety Agency (NPSA).

4.4 The Corporate Risk Register and Board Assurance Framework enables the Board to examine how it is managing the risks that are threatening the achievement of strategic objectives. Both of these documents are closely aligned and subject to comprehensive executive review on a quarterly basis. Any significant gaps in controls on the Board Assurance Framework are identified and routinely managed through the Corporate Risk Register.

4.5 The Risk Management and Assurance Strategy and associated procedural documents are actively promoted by managers to ensure that risk management is embedded through all sections of the Trust.

4.6 Close liaison between the risk and safety managers and business planning managers has ensured that business planning informs and is informed by risk management.

4.7 A quality impact assessment process ensures that all decisions on efficiency savings and expenditure on new developments are objective, risk based and balanced, taking account of costs and savings, impact on quality and ease of implementation.

4.8 Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

4.9 As an employer with staff entitled to membership of the NHS Pension scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments in to the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

4.10 The Trust has undertaken a climate change risk assessment and developed an Adoption Plan, to support its emergency preparedness and civil contingency requirements, as based on UK Climate projections 2009 (UKCP09), to ensure that this organisation's obligations under the Climate Change Act are met.

4.11 The Trust is fully compliant with the CQC essential standards of quality and safety.

4.12 The Trust has in place an annual counter fraud work programme, which is monitored via the Audit Committee. During the year the Trust also approved and introduced a new anti bribery policy and procedures in line with new legislation.

5. Review of the effectiveness of risk management and internal control

5.1 As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways;

- The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Board Assurance Framework and on the controls reviewed as part of the internal audit work. (See section 5.11)

- Executive Directors and senior managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance.

- The Board Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed.

My review is also informed by:

- Care Quality Commission *Essential Standards for Quality and Safety* – Provider Compliance Assessments

- the Care Quality Commission inspection process

- NHSLA risk management standards compliance inspections

- NHS Connecting for Health Information Governance Toolkit.
- ongoing self assessment (utilising the Auditors' Local Evaluation methodology)

- Internal Audit reports

- External audit reports

- External consultancy report on key aspects of Trust governance.

5.2 I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, Audit Committee and the Senior Management Group. A plan to address weaknesses and ensure continuous improvement of the system is in place.

5.3 The Trust Board seeks assurance that risk management systems and processes are identifying and managing risks to the organisation appropriately through the following:

- At least annually; a review of the effectiveness of the Trust's system of internal control. The Trust Board ensures that the review covers all material controls, including financial, clinical, operational and compliance controls, and risk management systems

- An annual review of the Risk Management and Assurance Strategy

- Reviews in each Audit Committee meeting of controls and assurances in relation to the principal risks in the Board Assurance Framework, via scrutiny and challenge sessions involving the accountable Executive Directors.

- A biennial comprehensive review of the Board Assurance Framework

- Monthly integrated performance reports outlining achievement against key performance, safety and quality indicators

- Assurance reports at each meeting, providing information on progress against compliance with National Standards

- Assurance from internal and external audit reports that the Trust's risk management systems are being implemented

5.4 The risk assurance infrastructure closely scrutinises assurances on controls to assess their validity and efficiency. A key element of this work will be to ensure that all procedural documents are subject to monitoring compliance against the detail described within them; that they meet with regulatory requirements; and that they have considered all current legislation and guidance.

5.5 The Risk and Assurance Group carries out a detailed analysis of assurances received, to identify any gaps in the assurance mechanisms and to provide an evaluation of the effectiveness of them, reporting findings to the Senior Management Group through to the Trust Board.

5.6 The Audit Committee provides overview and scrutiny of risk management. The Committee independently monitors, reviews and reports to the Trust Board on the processes of governance and, where appropriate, facilitates and supports through its independence, the attainment of effective processes. The Audit Committee concludes upon the adequacy and effective operation of the organisation's overall internal control system. In performing this role the Committee's work will predominantly focus upon the framework of risks, controls and related assurances that underpin the delivery of the organisation's objectives; the Board Assurance Framework.

5.7 The Audit Committee reviews all risk and control related disclosure statements and memoranda, together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board.

5.8 The Audit Committee primarily utilises the work of internal audit, external audit and other assurance functions, but is not limited to these audit functions. It also seeks reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of governance, risk management and internal control, together with indicators of their effectiveness.

5.9 The Trust is required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare a Quality Account for each financial year. The Trust Quality Account for 2011/12 reports on key indicators of quality relating to patient safety, clinical effectiveness and patient experience. The Quality Account includes comments from key stakeholders which are a positive reflection on developments over the year and of the Trust's engagement with partners. The Quality Account has been subject to Internal Audit review and scrutiny by the Audit Committee and I am satisfied that they present a balanced and accurate view of quality within the Trust.

5.10 On final review and closure of the 2011/12 iteration of the Board Assurance Framework, a significant control issue was identified relating to the failure to deliver against contracted Key Performance Indicators (KPI's) in the Patient Transport Service (see Section 6).

5.11 **Head of Internal Audit Opinion**

The overall opinion of the Head of Internal Audit is that: '***Significant assurance*** *can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weaknesses in the design and/or inconsistent application of controls put the achievement of particular objectives at risk, most notably in relation to evidencing CQC standards within the Clinical Business Units, PDR's and the efficiency savings programme'.*

5.12 Mitigating action has been taken to address the specific concerns identified in the Head of Internal Audit opinion, and other risks emerging during the year through the Trust's risk management processes. Assurance on the controls in place to manage these issues in 2012/13 will be reviewed through the risk management and committee arrangements outlined in section 2 of this statement.

6. Significant Issues

6.1 The 2011/12 review of the Trust's system of internal control has identified one significant control issue relating to the Patient Transport Service provision and its failure to fully achieve contracted KPI's.

6.2 A multi-faceted risk treatment plan is in place to address this risk. Key elements include strengthening the PTS management team and engaging with a strategic commercial partner to undertake a diagnostic exercise and to take forward a significant programme of service transformation in the PTS service during 2012/13.

6.3 Management of this risk will be monitored during 2012/13 through the Trust Executive Group, Finance and Investment Committee and Board. Additional monitoring and assurance will be provided through the Trust Transformation Programme Group which is being established in April 2012, to oversee the delivery of key developments aligned to the Trust 5-year business plan.

With the exception of the internal control issues that I have outlined in this statement, my review confirms that Yorkshire Ambulance Service has a generally sound system of internal controls that supports the achievement of its policies, aims and objectives and that those control issues have been or are being addressed.

Accountable Officer : Mr David Whiting
Chief Executive Officer
Organisation: Yorkshire Ambulance Service NHS Trust

Signature:

Date:

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Accountable Officer : Mr David Whiting
Chief Executive Officer
Organisation: Yorkshire Ambulance Service NHS Trust

Signature:

Date: 19 April 2012