Yorkshire Ambulance Service NHS
NHS Trust

Risk Management & Assurance Strategy

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1. STATEMENT

The Trust has a statutory responsibility to patients, public and commissioners to ensure that it has effective processes, policies and people in place to deliver its objectives and to control any risks that it may face in achieving these objectives.

The Trust is committed to the active management of risk and takes a rounded approach to risk across the organisation embracing strategic and operational risks. The *Risk Management and Assurance Strategy* (Strategy) describes this approach.

The risk management process described in the *Risk Management & Assurance Strategy* and supporting *Risk Escalation and Reporting Procedure* is influenced by the existing structure of NHS, the services provided, and the specific procedures and practices employed.

The view of the Trust Board is that the management of risk is the business of everybody in the organisation. It is recognised that risk management is an integral part of good management practice and as such it should be embedded in the organisation's culture. The Trust will also promote good risk management in its relationship with stakeholders, including organisations and individuals who contract with the Trust.

A system of internal control has been designed to manage, and where appropriate eliminate risk in order to provide assurance to the Trust Board. The Trust Board will refer to independent reviews and assessments to gain assurance on the effectiveness of these measures.

The Trust Board acknowledges its responsibility to monitor the implementation and progress of this strategy and to formally review it accordingly on an annual basis.

Signed:…………………………………………………… Chief Executive

Date: ………………

Signed …………………………………………………… Chairman

Date: ……………...

2. PURPOSE

To establish the risk management strategy, aligned to the requirements of the Integrated Business Plan, and to set out the systems, processes and responsibilities for the management of risk in Yorkshire Ambulance Service NHS Trust; taking account of the requirements of the Department of Health and relevant external regulatory bodies.

3. INTRODUCTION

Risk is inherent in all Trust activities. Failure to manage risks can lead to harm to patients, staff or others, loss or damage to the Trust's reputation, financial loss and potential for complaints, litigation and adverse publicity.

The Strategy describes a framework which enables implementation and promotes continuous improvement of the processes and cultures which are essential to the delivery of effective risk management. The Strategy also describes a systematic corporate process for evaluating and addressing the impact of risk in a cost effective way, utilising staff with the appropriate knowledge and skills to identify and assess the potential for risk to arise. The Chief Executive Officer (as Accountable Officer) can thereby be assured that risks to the Trust's strategic objectives are identified and managed effectively.

The Strategy applies to all directly employed staff, agency staff and contractors engaged in work on behalf of the Trust.

4 AIMS

The aims of the Strategy are:

- to have robust risk management arrangements in place to support and facilitate an effective system of integrated governance
- to provide a framework for the recognition and management of risks to the effective delivery of the Integrated Business Plan
- to encourage the highest possible standards of safe service delivery, where the numbers of serious errors are few relative to the volume and complexity of activity undertaken.

5. STRATEGIC RISKS

The Trust Board identified, agreed and published the strategic risks to the Trust's five year Integrated Business Plan 2012-2017 and the Annual Business Plan for 2012-13 in May 2012. The context of the strategic risks have been identified and agreed by the Trust Board against four strategic goals and eight associated strategic objectives;

Continuously Improving Patient Care

- To improve clinical outcomes for key conditions
- To deliver timely emergency and urgent care in the most appropriate setting

High Performing

- To provide clinically effective services which exceed regulatory and legislative standards
- To provide services which exceed patient and commissioner expectations

Always Learning

- To develop culture, systems and processes to support continuous improvement and innovation
- To create, attract and retain an enhanced and skilled workforce to meet service needs now and in the future

Value for Money and Provider of Choice

- To be at the forefront of healthcare resilience and public health
- To provide cost-effective services that contribute to the objectives of the wider health economy.

Strategic risks are captured in the Board Assurance Framework and form the basis of the Board's risk management agenda.

6. RISK MANAGEMENT OBJECTIVES

Strategic objectives will be disseminated through directorate and local business areas. The Standards and Compliance Directorate will take the lead in the delivery of risk management objectives and will include the following objectives with its annual workplans to deliver further development of Trust risk management systems and processes;

- to embed effective systems and processes for the identification, management and control of risk throughout all business areas of the Trust
- to secure robust assurance arrangements, in order to facilitate the achievement and maintenance of Monitor's governance risk rating of Green and financial risk rating of 3 or above
- to augment a range of educational initiatives to equip all grades of managers and staff, to effectively manage risks pertinent to their roles and level of responsibility
- to attain and secure the highest levels of compliance against all external regulatory standards and the registration requirements of the Care Quality Commission.

7. GOVERNANCE

7.1 Corporate Governance and Management

The Audit Commission has defined corporate governance in healthcare as '*The systems and processes by which health bodies lead, direct and control their functions, in order to achieve organisational objectives, and by which they relate to their partners and wider community'.*

Corporate governance is the system by which the Trust is directed and controlled, at its most senior levels, in order to achieve its objectives and meet the necessary standards of accountability, probity and openness. The Director of Corporate Affairs/ Trust Corporate Secretary plays 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.

7.2 Other Types of Governance

Various terms are used within the NHS to describe types of governance. The types of governance recognised by the Trust include;

- Integrated Governance
- Clinical Governance
- Quality Governance
- Information Governance
- Financial Governance

(Further detail on governance, types of governance and how these are applied in the Trust can be found in the Trust's *Governance Handbook*)

8. RISK MANAGEMENT

8.1 Corporate and Local Risk Management

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 will shift and change. Assessment of risk is therefore a dynamic and on-going process.

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

8.2 Types of Risk

The types of risk facing the Trust fall into two categories; strategic risks and operational risks.

8.2.1 Strategic risks

Strategic risks are those related to the delivery of the Trust's strategic objectives. They have the highest potential for external impact including engagement with the wider health and social care community and with external stakeholders.

The strategic risks are annually reviewed and modified by the Trust Board and are to be managed as complex processes as opposed to discrete events. The Trust Board will ensure that strategic risks are properly identified and correctly managed, by review of the Board Assurance Framework and performance management.

8.2.2 Operational risks

Operational risks consist of risks to the Trust's on-going day-to-day business delivery, such as clinical (patient safety), staff safety, security, information, financial and litigation. Whilst they may have some external impact, they mostly impact on the internal functioning and services of the Trust.

Operational risks will be managed within the local, directorate and committee structures, as appropriate, dependant on the level of risk identified. Significant operational risks, which are not effectively managed, impact on the delivery of strategic objectives are therefore the Trust has put into place a process to escalate risk, as required.

(Comprehensive detail describing the Trust approach to the identification, escalation, management and control of risk can be found in the *Risk Escalation and Reporting Procedure*)

8.3 Risk Appetite

The Institute of Internal Auditors defines 'risk appetite' as "The level of risk that an organisation is willing to accept". The appropriate level will depend on the nature of the work undertaken and the objectives pursued.

Precise measurement is not always possible and risk appetite may be defined by a broad statement of approach. The Trust has an appetite for some types of risk and may be averse to others, depending on the context of the risk and the potential for losses or gains.

The Trust will develop measures for different categories of risk. For example, it may aid a project to know what level of delay or financial loss it is permitted to bear, or alternatively using measures described in the *Risk Escalation and Reporting Procedure* to define the impact and likelihood of risks, this can be used to define the maximum level of risk tolerable before action should be taken to lower it.

By defining its risk appetite, the Trust can arrive at an appropriate balance between uncontrolled innovation and excessive caution. It can used to guide managers on the level of risk permitted and encourage consistency of approach across the Trust, and ensure that resources are not spent on further reducing risks that are already at an acceptable level.

8.4 Recognition of Emerging Risks

8.4.1 Learning from adverse events

The Trust risk data management system captures information arising from incidents and near miss events that are routinely reported across all business areas of the organisation. The data management system also captures information relating to complaints and claims reported both internally and by external stakeholders. All types of adverse events are subject to the investigation and organisational learning processes, from which risks are identified, recorded and escalated according to the rated level of risk.

8.4.2 Performance Management Group

The Performance Management Group meets bi-monthly and is chaired by the Director of Finance and Performance and attended by members of the executive team. The Group enables the Executive Directors to hold the service divisions to account for delivery of key performance indicators and measures, and to share and explore issues associated with delivering service improvement in the context of the business plan. In the course of its business it is anticipated that the Group will identify risks that are operational or strategic in context.

8.4.3 Integrated Performance Report (IPR)

The Trust Board is presented with an Integrated Performance Report (IPR) at each meeting. The IPR contains a range of metrics relating to performance, workforce, finance and quality analysis. The metrics, including key performance indicators relevant to Trust objectives, are presented in a format to facilitate effective quality analysis and the identification of themes and trends. Board level monitoring of the various metrics will continue to improve the Trust's ability to recognise and act on emerging risks.

8.4.4 Dashboards

The vision for Board performance reporting within an aspirant Foundation Trust (FT) is of a single overarching dashboard comprising a combination of key relevant national priority indicators and regulatory requirements together with locally agreed quality requirements. Further dashboards, encompassing functional and departmental review processes provide a greater level of granularity. Performance monitoring at individual/team level, service line, functional, directorate and up to Trust Board will provide the opportunity to identify and act on emerging risks at an appropriate level.

8.4.5 Quality Impact Assessment (QIA)

The Trust routinely faces challenges to improve its quality of service whilst also improving efficiency and reducing the costs of its services. The decisions the Trust makes 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.

Those projects considered complex or high risk that are agreed for development, are subject to a full quality impact assessment which is undertaken as part of the project implementation planning process. Risks emanating from this process are escalated through the risk management process described in the *Risk Escalation and Reporting Procedure.*

8.4.6 Internal Audit Reviews

Each year the Trust Board approves an agreed internal audit programme to provide them with assurance on internal controls and risk areas. Internal Audit also acts as business assurance support reviewing financial systems and processes and other critical business areas, and include ad-hoc reviews of Declarations for the Essential Standards of Quality and Safety and Quality Governance Framework (self-certification), and consider areas of concern raised by Directors and Senior Managers.

Internal Audit reports carry one of four possible opinions. These give the recipient an indication of the level of assurance that can be taken and that the processes of control within the area audited are adequate. The four opinions are “Full Assurance”, “Substantial Assurance”, “Limited Assurance” and “No Assurance”. The reports also provide guidance on the actions required to improve performance and mitigate risk.

8.5 Risk Registers

Risks are recorded on risk registers, developed and maintained within all local business areas, directorates and centrally on the Corporate Risk Register, appropriate to the level of risk identified. Nominated risk leads co-ordinate the management of risks recorded at local business area and directorate levels.

8.6 Corporate Risk Register

The Trust’s Corporate Risk Register is held centrally within the Standards and Compliance Directorate. The Corporate Risk Register contains the detail of all extreme level business risks which have either escalated up from local business area and directorate level, or from gaps in control identified in the Board Assurance Framework.

The Corporate Risk Register and associated action plans are reviewed and updated on a monthly basis, with performance management and exception reports provided for consideration to Executive Groups, and the Trust Board as required.

8.7 Board Assurance Framework (BAF)

The Board Assurance Framework provides the Trust with a simple but comprehensive method for the effective management of the principal risks to its strategic objectives. It also provides a structure for the evidence to support the Annual Governance Statement.

The Board Assurance Framework is reviewed and updated on a monthly basis, with performance management and exception reports provided for consideration to Executive Groups and the Trust Board.

The Board Assurance Framework has two key diagnostic purposes:

- It is a high level management assessment process and record of the principal risks to the delivery of strategic objectives and the strength of internal control to prevent these risks occurring

- It identifies sources of assurance and evaluates them for suitability. It then receives and reviews actual assurances (i.e. published reports) and uses the findings to confirm or modify management's opinion of the adequacy of internal control.

8.8 Relationship between the Board Assurance Framework and Corporate Risk Register

The results of risk identifications; gaps in control or assurances and gaps in necessary action should be clearly noted on the Board Assurance Framework. Identified gaps are routinely considered for inclusion in the Corporate Risk Register. By managing Board Assurance Framework derived risks through the Corporate Risk Register, then prioritised action processes and progress reports can be generated to effectively strengthen the controls on the Board Assurance Framework.

As the Corporate Risk Register gathers risk details from various assessment sources it is very important that the risk identification process determines the relevance and significance of such risks to corporate objectives. Without this link material risks impacting the delivery of strategic objectives may be overlooked and could lead to failure to achieve objectives if controls are not strengthened sufficiently to prevent or minimise the occurrence of risks.

9. ASSURANCE

9.1 Assurance Infrastructure

An assurance infrastructure, including the Risk & Assurance Group, Trust Executive Group and other executive committees, closely scrutinises key controls and assurances on controls to assess their validity and efficiency. A key element of this work is 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.

A key role is undertaken by the Risk and Assurance Group who carry out detailed analysis of assurances received, identify any gaps in the assurance mechanisms and provide an evaluation of the effectiveness of them, reporting findings to the Senior Management Group, Quality Committee, Trust Executive Group through to the Board.

9.2 Board Assurance

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

- Board Assurance Framework
- Trust's progress against its strategic and corporate objectives
- Performance reports to the Board outlining achievement against key performance, safety and quality indicators
- Compliance with National Standards
- Assurance from internal and external audit reports that the Trust's risk management systems are being implemented
- Annual review of this Strategy.

9.3 Independent Assurance

In addition to the scrutiny afforded by the Trust Audit Committee; independent sources of assurance on the effectiveness of the Trust's risk management and internal control systems include:

- CQC Registration
- NHS Litigation Authority Risk Management Standards assessment process
- Internal Audit annual review of risk management and the BAF
- Lead commissioner performance monitoring, and annual governance and assurance arrangements.

9.4 System of Internal Control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an on-going process designed to:

- identify and prioritise the risks to the achievement of the organisation's policies, aims and objectives; and
- evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

An Annual Governance Statement is produced on an annual basis by the Trust as a requirement of the Department of Health. The Annual Governance Statement, which includes a Head of Internal Audit opinion, covers any significant control issues faced by the Trust and is submitted to NHS Yorkshire and the Humber. The role of the SHA is in reporting and providing assurances on significant control issues across the region.

10. DUTIES

This section of the Strategy provides a brief synopsis of the roles, responsibilities and accountabilities of key individuals and committees. The organisational structure aims to ensure that there is both a coordinated and holistic approach to the management of risk throughout the Trust.

10.1 Trust Board

The Trust Board adheres to the principles outlined in the *Combined Code on Corporate Governance (2003)*. The Board recognises its accountabilities and provides leadership within a framework of practical and effective controls which enables risk to be assessed and managed. The Board sets the strategic aims and ensures that resources are in place to meet its objectives. It receives reports at each meeting on the highest principal risks and associated actions as detailed in the Trust's Board Assurance Framework.

The Trust Board conducts, at least annually, a review of the Board Assurance Framework and on the effectiveness of the Trust's system of internal control.

The Board also reports on its approach to clinical governance and its plan for the improvement of clinical quality in accordance with the guidance set out by the Department of Health, the Care Quality Commission and Monitor (following authorisation as a Foundation Trust).

Formal reporting to the Trust Board will involve receipt of minutes from the Audit Committee, Finance and Investment Committee, Quality Committee, Charitable Funds Committee and the Remuneration and Terms of Service Committee. The Board will also receive a written report from the Trust Executive Group, to give assurance to the Board on the implementation of agreed strategy, including engagement with internal and external stakeholders. This report will also highlight significant risks and the associated management plans.

10.2 Audit Committee

The Audit Committee is a formal sub-committee of the Trust Board and comprises of all of the Non-Executive Directors, with the exception of the Chair. The Executive Director of Finance and Performance and the Executive Director of Standards and Compliance are in attendance at all meetings. The Audit Committee provides overview and scrutiny of risk management. It meets quarterly and has an annual work plan which has been refined to reflect the increased focus on quality governance.

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.

The Committee reviews all risk and control related disclosure statements and memoranda (in particular the Annual Governance Statement, declarations of compliance with the Essential Standards of Quality and Safety and the Board Memorandum on Quality Governance Arrangements), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board.

10.3 Finance and Investment Committee

The Finance and Investment Committee is a formal sub-committee of the Trust Board and includes three Non-Executive Directors, the Executive Director of Finance and Performance, the Chief Executive and senior managers. The Committee undertakes objective scrutiny of the Trust's financial plans, investment policy and major investment decisions, and as such plays a pivotal role in financial risk management. It reviews proposals for major business cases and reports on the commercial activities of the Trust, and also scrutinises the content and delivery of the Trust cost improvement programme.

10.4 Quality Committee

The Quality Committee consists of three Non-Executive Directors, the Executive Director of Standards and Compliance, Executive Medical Director, Executive Director of Workforce and Strategy and senior managers.

The Committee undertakes objective scrutiny of the Trust's clinical governance and quality plans, compliance with external quality regulations and standards and key functions associated with this, including processes to ensure effective learning from adverse events and infection prevention and control.

The Committee scrutinises the quality impact assessments of cost improvement plans prepared by the Executive team, to support the Board in gaining assurance on the safety of service changes. The Committee also scrutinises and supports the Board in gaining assurance on workforce governance, health and safety, and information governance issues.

10.5 Trust Executive Group

Reporting to the Trust Board, the Trust Executive Group meets fortnightly and is accountable for the operational management of the Trust and the delivery of objectives set by the Board. It is also the formal route to support the Chief Executive Officer in effectively discharging his responsibilities as Accountable Officer.

The functions of the group include;

- Management of organisational governance
- Investment and disinvestment
- Performance delivery, including delivery of cost improvement programmes
- Horizon scanning
- Policy development, implementation and interpretation
- Strategy development and implementation
- Stakeholder and partner engagement.

A progress report from the Trust Executive Group is presented by the Chief Executive, to each meeting of the Trust Board.

10.6 Senior Management Group

The Senior Management Group consists of the Executive Directors and Associate Directors and is chaired by the Chief Executive. Its role is to support the operational management of the Trust and the delivery of objectives set by the Trust Board. The Group carries delegated responsibility from the Trust Executive Group for:

- Monitoring and review of performance in relation to operational, quality, workforce and financial objectives
- Identification and management of key risks, including review of the Board Assurance Framework and Corporate Risk Register
- Action to address key risks to delivery and on operational issues and problems
- Overseeing delivery of the Trust service transformation programme and cost improvement programme
- Contributing to the development of strategy and policy
- Communication with the Trust's wider management community.

10.7 Risk and Assurance Group

The Trust manages risk operationally through its management structures. Selected representatives from each local business area across the Trust attend the monthly Risk and Assurance Group meeting, which is chaired by the Director of Standards and Compliance.

The Group receives reports on all directorate risk registers and specific risk issues from the members, including representatives from all other associated risk management groups. These groups include the Health and Safety Committee, which is a source of internal assurance on non-clinical risks and the Clinical Governance Group, which provides internal assurance on clinical risk issues. The Group also monitors and reviews the operation of risk management processes and advises the Trust Executive Group on any issues arising.

10.8 Health & Safety Committee

The Health & Safety Committee meets bi-monthly and is chaired by the Executive Director of Standards and Compliance. The Health & Safety Committee receives reports on health, safety and security issues from its membership, and makes a report to the Senior Management Group following each meeting.

10.9 Clinical Governance Group

The Clinical Governance Group meets monthly and is chaired by the Executive Medical Director. It receives reports on clinical governance and risk issues from four work stream leads, and makes a report to the Senior Management Group following each meeting. The Group has standing agenda items relating to; patient safety, clinical effectiveness, patient experience, infection, prevention and control, and safeguarding, and monitors delivery of the workplans relating to each of these areas. The Group oversees risks relating to clinical care and escalates these via the Trust risk management system to the Executives and the Board as appropriate.

10.10 The Chairman

The chairman provides leadership of the Trust Board, focusing on its effectiveness in all aspects of its role and setting its agenda. The chairman ensures effective communication, both with members of the Board and with stakeholders. The chairman also facilitates the effective contribution of non-executive directors in particular and ensures constructive relations between Executive and Non-Executive Directors.

10.11 Chief Executive Officer

Accountability for risk lies with the Chief Executive Officer (CEO) who has overall responsibility for establishing and maintaining an effective risk management system within the Trust for meeting all statutory requirements and adhering to governance related guidance issued by the Department of Health.

As the Accountable Officer the CEO has responsibility for maintaining a sound system of internal control and for safeguarding the public funds and the organisation’s assets, as set out in the Accountable Officer Memorandum. The Accountable Officer will sign the Annual Governance Statement on behalf of the Trust Board, after reviewing the effectiveness of the system of internal control.

10.12 Executive Directors

Executive Directors have responsibility for ensuring that the Risk Management & Assurance Strategy is implemented and to encourage an open and honest culture, where mistakes and untoward incidents are identified quickly and dealt with in a positive and constructive way. All directors, executive and non-executive, have responsibility to constructively challenge the decisions of the Trust Board.

10.13 Non-Executive Directors

The Non-Executive Directors constructively challenge and assist in the development of strategy. They scrutinise the performance of management in meeting agreed goals, aims and objectives and they monitor reporting on performance. They seek assurance as to the integrity of financial, clinical and other information, that financial and clinical quality controls and systems of risk management and governance are robust and implemented.

10.14 Executive Director of Standards and Compliance

The Director of Standards and Compliance is responsible to the Trust Board and CEO in regard to risk management and assurance processes. The Director is obliged to provide the Trust Board and other executive groups with reports on risk management and assurance, as required. The Director is also responsible for providing expert advice to the Trust Board in relation to risk management and assurance and ensuring the Trust Board has access to regular and appropriate risk management information, advice, support and training when deemed necessary

10.15 Executive Director of Finance and Performance

The Director of Finance has lead responsibility for the management of financial risk, to implement systems to control fraud and corruption, and to ensure security of financial systems within the Trust. The Director advises the Trust Board, the Audit Committee, and other executive committees as appropriate, about risks associated with the Trust's financial procedures, and the financial elements (capital and revenue) of its activities. The Director also leads the development and implementation of the Trust's performance management arrangements and has delegated responsibility for preparing, implementing and updating the Performance Management Strategy.

10.16 Executive Medical Director

The Medical Director has lead responsibility for clinical governance and risk management, ensuring that all clinical procedural documents are maintained and updated appropriately. The Director advises the Trust Board, the Clinical Governance Group, and the other executive committees as appropriate, of risks associated with the Trust's clinical procedures and practices.

10.17 Associate Director of Risk and Safety

The Associate Director of Risk and Safety has lead responsibility for the development, maintenance and implementation of the Risk Management and Assurance Strategy, and to facilitate the delivery of effective risk management and assurance processes.

In consultation with education and development managers the Associate Director develops appropriate training sessions that will encourage staff to take responsibility for risk management within their area, and aim to minimise the impact of risk on the Trust.

10.18 Managers with specialist risk management responsibilities

The directors listed above are supported by a number of managers with specialist risk management responsibilities. Comprehensive detail on the responsibilities of these managers can be found in associated procedural documents listed in Section 12.

10.19 Directorate/Local Area Managers

Directorate/Local Area Managers will ensure effective dissemination of the Strategy and implementing all associated risk management procedural documents. The managers have responsibility for establishing and maintaining the directorate/local risk registers, implementing resultant risk treatment plans and ensuring that systems are in place to assess, treat and reduce risks within the directorate/local areas.

10.20 Staff

All staff within the Trust have a responsibility to familiarise themselves with the Strategy and comply with the contents of all associated procedural documents. Staff will be required to participate in activities which are commensurate with the Trust's Strategy and statutory requirements detailed in associated procedural documents.

11. EDUCATION AND DEVELOPMENT

The Trust has identified the risk management training requirements of all staff groups in order to promote the highest standards of risk management and clinical care. The training requirements are identified in the training needs analysis which can be found in the *Statutory and Mandatory Policy & Procedure.* Details of the training provided by the Trust can be found in the *Trust Annual Training Prospectus.*

Board members will receive specialist education and development updates throughout their service with Trust. The updates will occur, as a minimum, on an annual basis, as required, and be pertinent to the position of the Board members. Managers at all levels will receive bespoke risk management development programmes and other educational initiatives, on an annual basis.

12. ASSOCIATED PROCEDURAL DOCUMENTS

To support the Strategy, there are a number of related procedural documents that underpin the risk management arrangements for the Trust:

- Risk Escalation and Recording Procedure
- Quality Impact Assessment Procedure
- Quality Strategy
- Performance Management Strategy
- Policy for the Management of Incidents including the Management of Serious Incidents
- Policy for Investigation, Analysis and Learning from Adverse Events
- Health & Safety Policy
- Policy for the Consent to Examination or Treatment
- Information Governance Policy
- Standing Financial Instructions

Reference should also be made to all of the procedural documents required for assessment against the NHSLA Risk Management Standards for Ambulance Trusts 2012-13.

13. CONSULTATION

It is good practice to involve stakeholders as appropriate, in all areas of the Trust's activities, and this includes informing and consulting on the development of procedural documents. The stakeholders involved in the development of this Strategy include senior managers and all Board members.

14. COMMUNICATION AND DISSEMINATION

The Strategy is available on the Trust's intranet site. Details of the publication of the Strategy are provided in the weekly briefing document *Operational Update.* The Strategy and associated documents are also readily available in all departments and local work areas.

The Risk Manager sends out a global e-mail to all staff alerting them to the existence of the new strategy and advising that any locally held old (paper) copies of the strategy must be destroyed. The Bradford and Airedale PCT, as lead commissioner, is also made aware of this document's existence.

15. ARCHIVING

The review of this Strategy will be initiated by the Chief Executive Officer. The Strategy will be updated to reflect any changes to legislation or to Trust risk management processes. The previous version of the Strategy will be archived in line with the arrangements described in the *Policy for the Development, Monitoring and Management of Procedural Documents.*

16. MONITORING COMPLIANCE

To be assured that the process for managing risk is being implemented, as described within this Strategy, then key elements of the Strategy will be monitored for compliance. The areas chosen for monitoring reflect the minimum requirements of the NHSLA Risk Management Standards for Ambulance Trusts.

Minimum Requirement	Monitoring
organisational risk management structure detailing all those committees/sub-committees/groups which have some responsibility for risk	At the end of each fiscal year, the Risk Manager will complete an annual audit, to include committee reporting arrangements. The AD Risk & Safety will report the findings from the audit to the Trust Executive Group (TEG). Actions to address and deficiencies will be noted in the minutes of TEG and reviewed at subsequent meetings.
process for board or high level committee review of the organisation-wide risk register	The Audit Committee (AC) through its scrutiny and receipt of reports will monitor the CRR review. Actions to address and deficiencies will be noted in the minutes of the AC and reviewed at subsequent meetings.
process for the management of risk locally, which reflects the organisation-wide risk management strategy	The Risk & Assurance Group (R&AG) will monitor activity on a monthly basis and make quarterly reports to the TEG. Actions to address and deficiencies will be noted in the minutes of the TEG and reviewed at subsequent meetings.
duties of the key individual(s) for risk management activities	The duties of key members are monitored through KSF process. At the end of each fiscal year, the Risk Manager will complete an annual audit, to include committee attendance and reporting responsibilities. The AD Risk & Safety will report the findings from the audit to TEG. Actions to address and deficiencies will be noted in the minutes of the TEG and reviewed at subsequent meetings.
authority of all managers with regard to managing risk	The Risk & Assurance Group (R&AG) will monitor activity on a monthly basis and make quarterly reports to the TEG. Actions to address and deficiencies will be noted in the minutes of TEG and reviewed at subsequent meetings.

17. REFERENCES

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