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 Integrated Business Plan. 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 to 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 are managed efficiently and effectively.

1.4 The Trust has met with the NHS North of England and our lead commissioner for 2012/13, 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). The Trust has also engaged with the emerging clinical commissioning groups and Trust Development Authority.

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:

- A longer range agenda planning approach to ensure a focus on key decisions 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
  - Tendering for and mobilisation of the NHS 111/West Yorkshire Urgent Care Services contract
  - Financial Priorities
  - Quality governance
  - Board governance and committee arrangements
  - Risk management

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 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 (FT), the Trust completed the Board Governance Assurance Framework (BGAF), commissioned by the Department of Health. The BGAF 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 FT requirements. The process involved an initial self-assessment, followed by an in-depth review undertaken by external auditors. This included a significant desktop review of governance documentation, observation of Trust Board meetings, one to one Board member interviews, and stakeholder feedback. The findings from this review informed an action plan that the Trust executive developed and implemented to address areas of identified weakness. The report and subsequent action plan formed part of the submission to the SHA, which resulted in the Trust progressing to the next stage of the FT authorisation process.

2.7 During 2012/13 the Trust continued to commission external assessments in relation to its quality governance arrangements. These assessments have supported the Trust in strengthening its governance arrangements during the year, resulting in a governance rating score of 3.0 against a Monitor requirement of a score of < 4.0.

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

2.9 The Trust has successfully completed phase 2 of the Foundation Trust Historical Due Diligence exercise. The Trust executive developed and implemented an action plan to address areas of identified weakness, which formed part of the submission to the SHA and resulted in the Trust progressing to the next stage of the FT authorisation process.

2.10 In addition to the external scrutiny detailed above; members of the SHA FT applications team observed Trust Board and Non-Executive led committee meetings.

2.11 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.

2.12 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.

2.13 The Trust Board has been underpinned throughout 2012/13 by five key committees/management groups:

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

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 formal sub-committee of the Trust Board and is chaired by a Non-Executive Director. The Committee 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.

2.15 A comprehensive review of corporate governance arrangements was undertaken in 2011/12, leading to 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. 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. A key element of this work is scrutiny of the quality impact assessment of cost improvement plans and other service developments. The Committee also scrutinises and supports the Board in gaining assurance on risk management, workforce governance, health and safety and information governance issues.

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, embedded during 2012/13, have helped to reduce duplication and have increased the clarity of accountability and flow of information within the management groups.

2.17 The Trust Executive Group (TEG) meets fortnightly and is accountable for the operational delivery of objectives set by the Trust Board. The primary functions of TEG include; management of organisational governance, investment and disinvestment, performance delivery, including delivery of cost improvement programmes, horizon scanning, strategy and policy development, interpretation and implementation, and stakeholder and partner engagement. The Chief Executive Officer, as Accountable Officer, presents a progress report from the TEG to each meeting of the Trust Board.

2.18 The Senior Management Group (SMG) reports to TEG, consists of the Executive Directors and Associate Directors and is chaired by the Chief Executive. The SMG provides TEG with assurances on governance and compliance on areas of delegated responsibility, including; 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, and contributing to the development of strategy and policy.

Throughout 2012/13 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
- Information Governance Working Group
- Clinical Governance Group (including IP&C)

2.19 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 established a Transformation Programme Management Group. This Group commenced work in April 2012, with executive leadership and Non-Executive Director involvement. The Group provides regular reports on progress to the Trust Board.

2.20 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.

2.21 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.

2.22 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 on-going 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.

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

2.24 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.

2.25 The Standards and Compliance directorate has established 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.

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. Therefore Trust risk assessment is a dynamic 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 on-going 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 2012/13, were:

- Significant disruption to 999 service provision, leading to adverse impact on clinical outcomes due to the complexity and interface of different IT systems
- Adverse clinical outcomes due to failure of reusable medical devices and equipment Inability to improve the effectiveness of clinical care and patient outcome
- Harm to patients, staff and others due to deficiencies in the data flagging process leading to potential for data flags not being brought to the attention of interested parties
- Inability to deliver performance targets and clinical quality standards
- Lack of compliance with key regulatory requirements (CQC,HSE, IGT, NHSLA) due to inconsistent application across the Trust
- Loss of income due to inability to secure/retain PTS and other significant service contracts, adversely influencing future service commissioning intentions
- Inability to deliver service transformation and organisational change, including non-delivery of cost improvement programmes
- Failure to learn from patient experience and adverse events due to inadequate data management systems for reporting and to identifying learning opportunities
- Adverse impact on clinical outcomes due to failure to embed the clinical leadership framework

- Adverse impact on organisational performance and clinical outcomes due to significant events impacting on business continuity
- Adverse impact on developments in urgent/unscheduled care services in partnership with other providers due to failure to implement 111 service/WYUC provision

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.

During the year, the role of the Finance and Investment Committee and Quality Committee in gaining assurance on key risks was further developed, and both of these committees have provided significant assurances to the Audit Committee on risks relevant to their terms of reference.

3.8 Monthly iterations of the Board Assurance Framework are supported by separate risk movement and assurance movement reports. These reports provide detail on the actions taken to mitigate the strategic risks and any reports received that could provide the Trust Board with assurance.

3.9 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:

- In year, it was identified that a there was potential for a deficit against planned financial outturn due to significant overspending on the provision of Patient Transport Services. The risk was escalated to the Board for inclusion in the Board Assurance Framework and Corporate Risk Register in November and a mitigation plan established.

- Analysis of incident and other adverse event reporting data identified the risk of harm to staff due to moving and handling as a significant area of concern. Risk mitigation required the implementation of a number of bespoke projects, including most notably;
  - *Review of carry chairs*
    Following extensive trials, the Trust Vehicle and Equipment Group recommended the purchase of a new carry chair with detachable track. Funding has been secured for procurement of the new chairs from April 2013, which should reduce the number of moving and handling injuries and positively influence staff welfare.
  - *Review of Emergency Response Bag*
    Incident data indicated that moving and handling incidents relating to

the current emergency response bag are the third biggest cause of injury to staff and that the majority occur amongst RRV drivers. The Trust has worked with Loughborough University to determine a specification for a new emergency response bag. The work to procure and implement a suitable response bag has now been completed, for implementation in quarter 1 2013/14.

- Actions taken to mitigate the risk of an adverse impact on clinical outcomes due to failure to embed the clinical leadership framework had not progressed as anticipated. Albeit some good progress has been made to implement the Clinical Leadership Framework, the risk score has been returned to its start of year position, primarily due to issues relating to operational demand impacting on the implementation of a number of key actions. The risk treatment plan has been refocused to address the emerging issues and gaps identified.

- There was positive movement in year on the delivery of performance targets and clinical quality standards, however; achievement of the response time targets remained challenging. Delivery of the Red 1 target has been specifically highlighted for the year ahead. To effectively manage this risk in 2013/14, a comprehensive, Board approved risk mitigation plan has been developed and submitted to the Trust Development Authority.

In addition to monitoring by the Trust Board and Audit Committee, progress against risk treatment plans have been routinely discussed in each meeting of the Quality Committee.

3.10 All corporate risks subject to on-going risk management plans will be recorded on the 2013/14 iteration of the Board Assurance Framework and will continue to be managed through the Corporate Risk Register.

3.11 The Trust achieved its operational targets for immediately life threatening calls in 2012/13. 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.

3.12 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.
- on-going 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, Finance and Investment Committee and Quality Committee. 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 six monthly 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 executive committees/management groups as appropriate.

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 other Board Committees, 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 2012/13 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 and External 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 2012/13 iteration of the Board Assurance Framework, two significant control issues were identified relating to inadequate capacity to audit clinical practice and significant overspending on the provision of Patient Transport Services (see Section 6).

5.11 **Head of Internal Audit Opinion**

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 clinical audit arrangements, the management of fuel cards, the management of medical devices and the accounts payable system.

The audits for 2012/13 were drawn from the Operational Internal Audit plan approved by the Audit Committee in April 2012. This was a risk based plan and regular reports have been presented to the Audit Committee concerning achievement of the plans and any in-year changes.

During the year audits deemed mandatory by the Trust have been completed, including; Board Assurance Framework, Information Governance Toolkit and core financial systems work, i.e. Main Accounting System, Accounts Payable, Budgetary Control and Fixed Assets. In addition, areas the Trust considered to be of significant risk have been completed, including; clinical audit, statutory and mandatory training, staff recruitment, lessons learned from SUIs, clinical record management, CQC requirements, capital management, facilities management, management of medical devices and business continuity/disaster recovery arrangements.

Of the 20 reviews completed; 13 provided significant assurance, 6 provided limited assurances (Clinical Audit, Fuel Cards, Adastra System General Controls, Management of Medical Devices, Asset Register and Accounts Payable) and one review (Business Continuity Gap Analysis) did not require an overall assurance level.

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 2013/14 will be reviewed through the risk management and committee arrangements outlined in section 2 of this statement.

6. Significant Issues

6.1 The 2012/13 review of the Trust's system of internal control has identified three significant control issues relating to: full mobilisation of the NHS 111

service, inadequate capacity to audit clinical practice and significant overspending on the provision of Patient Transport Services.

6.2 The risk relating to clinical audit arises from in-year problems with clinical record scanning systems and the impact this has on clinical audit capacity. Immediate risk mitigation was put in place in the form of additional temporary staffing to ensure the delivery of core national clinical audit requirements. To improve its ability to evidence that patient care is of a sufficiently high standard, the Trust has developed a multi-faceted risk treatment plan which will focus on; the further development of procedural documents, the implementation of a functional scanning and verification solution and to fully establish the Clinical Leadership Framework.

6.3 A comprehensive risk treatment plan was developed to manage the potential for a deficit against planned financial outturn due to significant overspending on the provision of Patient Transport Services. Key elements include; managerial sign off required for all sub -contractor spend, recruitment review, review of sub-contractors support, revised financial forecast and identified cost savings underpinned by a PTS transformation programme, and consistent application of authorisation procedures.

6.4 The NHS 111 service was scheduled to go live across the whole of the contracted area in March 2013. The initial implementation was limited to West Yorkshire and early operation highlighted a number of challenges both for the Trust and wider health system, which have required additional Trust resources to be targeted to support delivery. Following review involving commissioners, the Department of Health and the Trust, it was agreed that further roll out should be phased, with full roll out completed in early 2013/14. The Trust is continuing to work with commissioners to deliver, and to manage the risks associated with the final stages of mobilisation.

6.5 Management of these risks will be monitored during 2013/14 through the Trust Executive Group, Finance and Investment Committee, Quality Committee and Board. Additional monitoring and assurance will be provided through the Trust Transformation Programme Management Group, 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: