Draft Annual Governance Statement (final version)

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Foundation Trust Accounting Officer Memorandum*.

The purpose of the 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 ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Bradford District Care NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Bradford District Care NHS Foundation Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

Leadership

The Chief Executive is the Trust's Accounting Officer responsible for ensuring that the principles of risk management are embedded throughout the organisation. Executive and Associate Directors have collective responsibility for the appropriate undertaking and operational application of the risk management process.

Oversight and assurance to the Board on the Trust's risk management arrangements (both clinical and non-clinical) are provided by the Audit Committee.

The Chief Executive has delegated responsibility for implementation of risk management as outlined below. The Medical Director has delegated responsibility for the overall coordination of risk management, whilst Directors have a lead for specific areas of risk:

- the Medical Director leads on quality, clinical governance and risk management, patient safety, medicines management, safe standards of medical practice and compliance with Care Quality Commission standards.

He was also responsible for informatics and information governance until 4 March 2018 (see below);

- the Director of Nursing and Operations ensures the effective application of risk management across clinical and operational services, including quality and leading on safeguarding and infection control;
- the Director of Finance, Contracting and Facilities leads on financial risk and manages risk in relation to the development, management and maintenance of the Trust estate and matters relating to fire safety;
- the Director of Human Resources and Organisational Development leads on risks associated with workforce capacity, retention of staff and absence management;
- the Associate Director of Corporate Affairs leads on the risks associated with corporate governance processes, communications, was the Trust's Senior Information Risk Owner (SIRO) during 2017/18 and oversees the Board Assurance Framework (BAF);
- the Associate Director of Informatics/Chief Information Officer leads on informatics and information governance risks (from 5 March 2018) and became the SIRO on 1 April 2018.

Directorate management teams review and managed related risks to their services.

Each member of staff employed by the Trust holds a responsibility for risk management which is integral to their role and is included as part of the job description. Staff are expected to identify and report issues of risks and incidents.

Training of risk management

Ultimately all who work at the Trust have a responsibility for the delivery of high quality, safe care and therefore we ensure there are excellent risk training packages in place to support staff in this responsibility. Experienced and qualified staff specialising in risk management develop, coordinate and deliver a variety of risk management training packages. All staff are required to attend a corporate induction on commencing work within the Trust and a refresher risk management course regularly. The refresher training includes 'Forward 2 Excellence' Trust Board days which includes Non-Executives, Executives and Senior Management. Specialist training is required where appropriate for specific roles such as risk guardians and incident managers. Clinical risk training is delivered through a combination of an e-learning package and a face to face session annually.

The risk and control framework

The Trust's Risk Management Strategy was approved by the Board in April 2016, which sets out the strategic direction of the Trust, including its risk management tolerance, which is moderate, and includes risk attitude statements. The Board set and review the tolerance levels of risk which are 'live' on the Corporate Risk Register (CRR) quarterly applying the use of heat maps to assist the process. The Trust uses

the 5 x 5 matrix (likelihood and consequence) to identify the risk rating for each individual risk. The Risk Management Strategy also introduced Charles Vincent's Measurement and Monitoring of Safety Framework which is being introduced as a useful concept and vehicle and being applied in services across the Trust and instigated the routine practice of safety huddles being implemented across all our in-patient services. A learning network was developed on the Trust's 'Connect' internal website. Learning is logged monthly and by subject matter as a result of the use of the framework. The network has learning leads in each directorate who have responsibility to share the learning from the network within their directorate and to capture and provide learning from their directorate logging it on the network for others to learn from.

The Trust's Risk Management Policy and Procedure was approved by the Board in August 2015. This sets out the structures and processes to systematically identify, assess, manage, monitor and review risk whether clinical or non-clinical and put in place robust plans for mitigation.

Risk Management Process

The Trust uses a number of different risk assessment tools additional to the Trust 5 x 5 risk matrix, these are specific assessments applied to specific tasks for example clinical risk assessment, quality impact assessment, COSHH assessments and falls assessments. Risks are identified, assessed and logged on a risk register from wherever they present themselves and the Trust seeks to anticipate potential risks proactively putting controls and mitigation actions in place to prevent the risk materialising where possible.

Additional sources for identifying risks are varied and can include:

- Incident and Serious Incident reports
- Coroners reports
- Patient and Staff Surveys
- Multi-disciplinary reviews
- Safety Huddles
- Service Reviews
- Audits, clinical and non-clinical

- Freedom to Speak Up cases
- Health & Safety Assessments
- Fire Assessments
- National guidance and reports
- Trust 'Walkabouts'
- Activation of Business Continuity Plans
- Validation Exercise of Major Incident Plans

Each service in the Trust has a number of risk guardians with responsibility for maintaining their risk register. All risk registers are held on the Safeguard Risk Management System, maintained on 'Connect' the Trust's internal internet which all staff can access to 'read only' any risk logged. Each risk has a residual/target risk rating set and mitigating actions identified. Closed risks are reviewed to confirm they are still under control.

The Audit Committee monitor, review and report to the Board on the Trust's internal control and risk management processes ensuring they are efficient and effective. Individual Directors have responsibility for ensuring the Trust's services continue to deliver efficient and effective care and compassion in a safe environment. Directorates, services and local teams review their risk register quarterly in their quarterly quality and safety governance meetings.

Risk management processes are embedded and resilient within the Trust's services with risk registers available at team level to enable teams to better manage their risks at that level with an option to escalate them through the risk management levels up to corporate risk register when appropriate. The governance and quality framework provides an excellent conduit for risks to be identified, assessed, managed and mitigated at all levels. In our in-patient services daily multi – disciplinary safety huddles are undertaken which is a short sharp and SMART review of safety and risk issues presenting themselves and it is a forum in which preventative and anticipatory actions are identified to stop the risks actually occurring or coming to fruition where possible. This is an excellent process for all the staff that work on wards including housekeeping, pharmacists etc. to be aware of any pending risks and they are actively encouraged to raise issues of safety no matter how small or irrelevant they may think they are.

Board Assurance Framework and Corporate Risk Register

The Board Assurance Framework (BAF) and the CRR define and assess the principle strategic and operational risks against the Trust's strategic priorities. There is a robust quarterly reporting process of the BAF and CRR which is presented to Directors, the Executive Management Team (EMT) and the Board quarterly or escalated by exception if required. Any risk which scores a risk rating of 15 or above are routinely reviewed by the Board.

In July 2017, in response to the Board's task and finish group approach to reviewing its own effectiveness, the wording of the strategic objectives was revised to more accurately reflect the priorities of the Trust and the BAF risks were refreshed. Each objective was also summarised into a key phrase to help simplify communication with staff.

- Strategic objective 1: Quality and Workforce – to provide high quality, evidence-based services delivered by a diverse, motivated and engaged workforce;
- Strategic objective 2: Integration and Partnerships – to be influential in the development of new models of care locally and more widely across the West Yorkshire and Harrogate STP; and
- Strategic objective 3: Sustainability and Growth – to maintain our financial viability whilst actively seeking appropriate new business opportunities.

The key risks to delivery of the Trust's strategic objectives identified in the BAF have remained relatively constant during the financial year. A review of the workforce-

related risks resulted in one risk relating to developing an engaged and motivated workforce increased from a score of 12 to 16. For 2018/19, both the BAF and CRR will be discussed monthly by the Executive Management team to further strengthen oversight and assurance.

The strategic risks in the BAF were as follows:

Board Assurance Framework	
Strategic Objective	Strategic Risks
Quality and Workforce	- If demand exceeds capacity then service quality, safety and performance could deteriorate - If regulatory standards are not met then we may experience intervention from regulators or damage to our reputation - If we do not provide a positive service user/carer experience then we may not be responsive to local communities or commissioners' needs - If we fail to recruit and retain a diverse workforce then the quality of our services may deteriorate and our agency costs increase - If we do not develop an engaged and motivated workforce then the quality of our services may deteriorate - If we fail to develop an innovative learning culture with staff then we may not exploit new opportunities that emerge.
Integration and Partnerships	- If partners (including BDCFT) fail to deliver a robust West Yorkshire and Harrogate STP then there could be financial and quality implications for the wider health economy - If partners (including BDCFT) fail to deliver a robust Bradford and Craven STP then there could be financial and quality implications for the local health economy - If partners (including BDCFT) fail to develop a robust and sustainable ACS across AWC then there will not be the system-wide change needed to manage resources vs demand - If partners (including BDCFT) fail to develop a robust and sustainable ACS in Bradford then there will not be the system-wide change needed to manage resources vs demand
Sustainability and Growth	If we are unable to facilitate a dynamic culture of innovation then we are unlikely to meet future quality and financial challenges which threaten our performance and sustainability in the market place

	• If we do not have a clear and viable vision for business growth we will not be able to respond confidently and creatively to opportunities
	• If we do not create resilience and invest capacity within the organisation to support transformation and transition we will stifle innovation, create disengagement and not achieve our vision for sustainability and growth
	• If public sector finances tighten then our financial position could deteriorate
	• If productivity and value for money are not improved then we may gradually lose contracts to more competitive providers and become unviable
	• If commissioners reduce the value of contracts then we may not be able to cover fixed costs with adverse consequences to our financial viability

The Trust Board reviewed the CRR and all significant risks on a quarterly basis during 2017/18. There have been between 13 and 15 corporate risks on the CRR during the year. Following discussion by the Board, two risks were removed, two escalated from local risk registers and two new risks were added as summarised below:

- Waiting time standards (closed in October)
- Convincing commissioners we are capable of improving accessibility to local services (remained the same all year)
- Failure to forecast and mitigate 2016/17 pressures (increased from 15 to 20, and subsequently decreased to 15 again in-year)
- Financial efficiencies (decreased from 20 to 16 in year)
- Failure to develop best practice services (remained the same all year)
- Failure to set organisational self-interest aside (decreased from 16 to 12 in-year)
- Demands on the Trust's community services (remained the same all year)
- Case for investment in mental health (decreased from12 to 9 in year)
- Expansion of existing services and securing new services (remained the same all year)
- Successful marketing of the Trusts reputation (closed in January)
- Transformation of the Trusts informatics function (remained the same all year)
- Training of the workforce to utilise the power of new technologies (archived in August)
- Recruitment, retention and engagement of a diverse workforce (remained the same all year)
- Cladding at Airedale Centre for Mental Health (escalated in November)
- Risk of fire at Cemetery Road (escalated in November)
- Future cyber-attacks (archived in April 2018)
- Major delays or complications in the implementation of SystmOne for Mental Health (remained the same since added in-year)

- Failure to fully and correctly implement the requirements of the General Data Protection Regulation (remained the same since added in-year)

A quality report for all logged risks is presented to Directors every quarter and the CRR and all significant risks are reported every month for review and discussion, with appropriate further action being identified as appropriate.

Compliance with NHS foundation trust condition 4 – NHS Foundation Trust governance arrangements

The Board confirms that it has prepared a 'comply or explain' document against the Code of Governance to record where the Trust has not followed the guidance or where an action plan is required to ensure compliance.

Potential and identified risks, which may impact on external stakeholders and key partners such as local authorities, other NHS trusts, voluntary organisations and service users are managed through structured mechanisms and forums such as the Overview and Scrutiny Committees, contract negotiation meetings, Council of Governors meetings and service user forums.

Other controls

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 into 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.

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

Sustainability

The foundation trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Review of economy, efficiency and effectiveness of the use of resources

The Trust's Operational Plan is approved and monitored in detail by the Board of Directors on a monthly basis through key performance indicators (including those required by NHS Improvement) within the Integrated Performance Report (IPR) and a wider 6-month review of the Plan in October. Board Committees review performance in further detail through the use of individual Committee performance dashboards. The Trust's resources are managed within an approved framework set

by the Board, which includes Standing Financial Instructions (SFIs), were reviewed by the Audit Committee in November 2017. Financial governance arrangements are supported by internal and external audit to ensure economic, efficient and effective use of resources.

The EMT meets weekly, and Executive Directors and Deputy Directors meet monthly (known as 'the Directors meeting') to oversee strategy, business delivery and quality and performance issues. In addition, Business Units and Corporate Departments are responsible for the delivery of their own financial and other performance targets, which is monitored through Business Unit performance meetings, chaired by Executive Directors. The Trust's Performance Management Framework for 2016-18 was approved by the Audit Committee in May 2016.

Internal Audit undertakes a review and reports on the risk management processes annually, reporting to the Audit Committee. This Committee has a timely reporting process in place to ensure that identified actions from audit reports are progressed to satisfactory conclusion through the implementation of the agreed recommendations. Internal Audit's opinion for 2017/18 (based upon and limited to the work performed) was 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.

In terms of deterrents against fraud, the Trust has a very proactive nominated Local Counter Fraud Specialist provided via the Audit Yorkshire, who is fully accredited by the NHS Counter Fraud and Security Management Service. The Audit Committee approved the Annual Counter Fraud Plan for 2017/18 in April 2017 and received regular updates on progress of counter fraud work during the year. Areas of work during the year have included: proactive counter fraud activity to raise awareness of policies, systems and controls, reactive investigations where potential fraud areas have been identified and wider intelligence gathering through NHS protect bulletins and alerts.

Data security

Information governance and data security risks are monitored through the Information Governance Group (IGG) and assessed using the Information Governance Toolkit. The IGG membership comprises the SIRO* (Chair), Caldicott Guardian**, and lead information governance officers. The IGG meets every 2 months and reports quarterly on any information governance issues to the Informatics Board. The Informatics Board oversees the strategic aspects of the Trust's digital, technology and information agenda. During the year, the IGG has apprised itself of changes to IG policies, data quality issues, cyber security and preparations for the introduction of General Data Protection Regulations (GDPR).

Information governance

Any incidents and near misses are reported internally through the web based incident reporting system (IR-e) and notified immediately to the Information Governance (IG) & Records Manager. They are logged on the 'Serious Incidents Requiring Investigation' section of the Information Governance Toolkit and if appropriate with the Trust's Serious Incident Lead. Incident data is regularly reported to, and monitored by, the IG Group, investigated and lessons learnt shared.

There was one case at Level 2 that was reported to the Information Commissioner's Office (ICO) and Department of Health (DH) in the year 2017/18. This related to child measurement data of 500 + children (height, weight etc.) in paper format that was lost whilst being delivered to an Admin Hub.

Level 1 (Confirmed IG SIRI but no need to report to the ICO and DH)   94

Level 0 (Near miss/non-event)   245

Summary of personal data related incidents (Level 1 and 2)

Category	Breach type (IG Toolkit headings)	Total (Level 1)	Total (Level 2)
A	Corruption or inability to recover electronic data	0	0
B	Disclosed in error	55	0
C	Lost in transit	5	1
D	Lost or stolen hardware	3	0
E	Lost or stolen paperwork	10	0
F	Non-secure disposal – hardware	1	0
G	Non-secure disposal – paperwork	1	0
H	Uploaded to website in error	1	0
I	Technical security failing (including hacking)	3	0
J	Unauthorised access/disclosure	14	0
K	Other	1	0
Total		94	1

Annual Quality Report

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. NHS Improvement (in exercise of the powers conferred on Monitor) has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

The annual Quality Report is produced following mandated guidance and processes. The Trust's process incorporates:

- significant clinical engagement in year;
- joint working with the Communications team;
- joint working with the Director of Corporate Affairs to ensure the Quality Report is consistent with the information also included in the Trust's Annual Report;
- scrutiny by external auditors;
- review by Board Committees;
- oversight by a Task and Finish Group made up of members of our Council of Governors, who review content and support the scrutiny of our Quality Goals and Quality Indictors and who recommend a Quality Goal to be reviewed by the external auditors;
- input from Governors and members in relation to our Quality Goals; and
- review and comment from our key commissioners and stakeholders.

The Medical Director is accountable for the Quality Report and the final version is considered and approved at Trust Board each May.

Care Quality Commission (CQC) Registration and quality governance

Quality Governance in the Trust is overseen by the Quality and Safety Committee which meets every 6 weeks. It receives assurances from a variety of sources, including a quarterly dashboard, regular and ad hoc reports as detailed in the committee annual workplan and specifically requested papers where additional assurance is required. The Quality and Safety Committee is the lead Committee to receive assurances in relation to CQC related workstreams.

CQC registration is overseen by the Deputy Director of Quality Improvement. The foundation trust is fully compliant with the registration requirements of the CQC, following its recent report published in February 2018, when the Trust was rated overall as 'Requires Improvement'. The Trust was rated as good for the caring and responsive domains and community health services for adults was rated as outstanding in the caring domain and the community end of life care was rated as outstanding in the responsive domain.

The CQC inspection report contained 51 'must do's' which have been collated into a CQC inspection report action plan, which has already been shared with the CQC, local commissioners and the Council Overview and Scrutiny Committee.

The CQC inspection report action plan was approved by the Trust Board in March 2018 and is being monitored at each meeting of the Quality and Safety Committee/Mental Health Legislation Committee with quarterly submission to Trust Board in 2018/19. An Improving Quality Programme Board will oversee delivery of the action plan, reporting formally to the Quality and Safety Committee. Further information is provided in the Quality Report section.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this Annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. 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, the Audit Committee Quality and Safety Committee, Finance, Business and Investment Committee, Mental Health Legislation Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

My review is informed in a number of other ways. The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the BAF and on the controls reviewed as part of the internal audit work. A significant opinion has been given for 2017/18. There was one limited/improvement required rated assurance report (Learning from Deaths report, BDCT13/2018) and no low/weak rated assurance reports received from the internal auditors. Robust procedures are in place for following up all internal audit recommendations. Internal audits are undertaken to report on effectiveness throughout the year; all internal audit reports are presented at Audit Committee.

Executive and Associate Directors who have responsibility for the development and maintenance of the system of internal control, also provide me with assurance, through individual letters of representation.

The Trust's BAF provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its strategic intents have been reviewed.

Finally, my review is informed by external assessments carried out by:

- CQC reports (covered in the Quality Report section);
- KPMG (our external auditors – at a cost of £60,500 for 2017/18);
- National patient and staff surveys;
- Local Healthwatch reports; and
- Bradford & Airedale and North Yorkshire Overview and Scrutiny Committees.

Statement as to disclosure to auditors

In the case of each of the persons who are Directors at the time the report is approved:

- so far as each Director is aware, there is no relevant audit information of which the company's auditor is unaware; and
- each Director has taken all the steps that he/she ought to have taken as a Director in order to make themselves aware of any relevant audit information and to establish that the company's auditor is aware of that information.

Conclusion

My review confirms that the Trust has generally sound systems of internal control that supports the achievement of its policies, aims and objectives and that those control issues have been, or are being, addressed. The CQC report published on 12 February 2018 placed a series of requirements upon the Trust which are in the process of being addressed and monitored by the Board and its Committees. I am satisfied that no other significant control issues have been identified for the period 2017/18.

Signed………………..

Liz Romaniak
Interim Chief Executive
Date: xx May 2018

*Senior Information Risk Owner is a Director-level position who advises the Board on the effectiveness of information risk management across the Trust.

**Caldicott Guardian is a Director-level position who ensures that the Trust satisfies the highest practical standards for handling patient identifiable information.