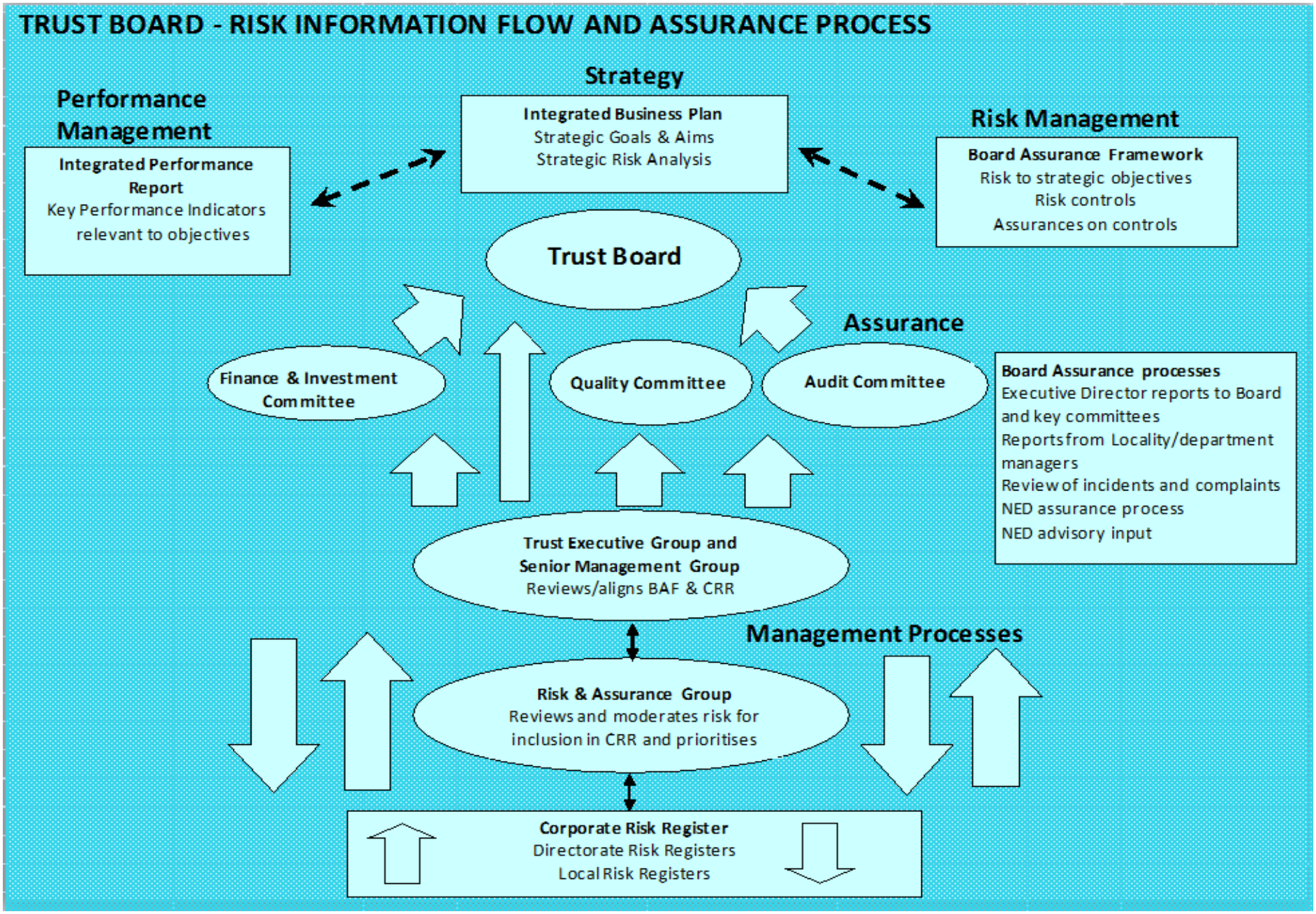
Yorkshire Ambulance Service NHS
NHS Trust

An Aspirant Foundation Trust

BOARD ASSURANCE FRAMEWORK

AUGUST 2012


TRUST BOARD - RISK INFORMATION FLOW AND ASSURANCE PROCESS
Strategy
Integrated Business Plan
Strategic Goals & Aims
Strategic Risk Analysis
Performance Management
Integrated Performance Report
Key Performance Indicators relevant to objectives
Risk Management
Board Assurance Framework
Risk to strategic objectives
Risk controls
Assurances on controls
Trust Board
Assurance
Finance & Investment Committee
Quality Committee
Audit Committee
Board Assurance processes
Executive Director reports to Board and key committees
Reports from Locality/department managers
Review of incidents and complaints
NED assurance process
NED advisory input
Trust Executive Group and Senior Management Group
Reviews/aligns BAF & CRR
Management Processes
Risk & Assurance Group
Reviews and moderates risk for inclusion in CRR and prioritises
Corporate Risk Register
Directorate Risk Registers
Local Risk Registers

STRATEGIC GOALS AND OBJECTIVES

The Yorkshire Ambulance Service NHS Trust Board have identified, agreed and published the following Strategic Goals and Objectives for 2012/2013. They form the basis of the Trust's Integrated Business Plan 2012-2017 and the Annual Business Plan for 2012-13.

Strategic Goal	Strategic Objective
Continuously Improving Patient Care	1. To improve clinical outcomes for key conditions
	2. To deliver timely emergency and urgent care in the most appropriate setting
High Performing	3. To provide clinically effective services which exceed regulatory and legislative standards
	4. To provide services which exceed patient and commissioner expectations
Always Learning	5. To develop culture, systems and processes to support continuous improvement and innovation
	6. 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	7. To be at the forefront of healthcare resilience and public health
	8. To provide cost-effective services that contribute to the objectives of the wider health economy

STRATEGIC GOAL:									
Ref No:	**Strategic Objective:** As detailed in the Integrated Business Plan 2012-2017 and the Annual Business Plan 2012-13					**Objective Owner:** Executive Director			
Principal Risk Reference No:	Risk Score			Key Controls	Assurances on Controls	Gaps in Controls	Action to Address Gaps	Action Lead	Assurance
Exec Lead/Risk Area	Initial	Current	Target		Positive Assurances	Gaps in Assurance			Movement
What could prevent the strategic objective from being achieved? CRR ref:	This will show the initial, the current (inc movement) and the target risk score. Risk is scored Consequence x Likelihood.			What controls/systems does the Trust have in place to assist in securing delivery of the strategic objective? Grade Strong (s), Moderate (m) to Weak (w)	Where can the Trust gain evidence that the controls/systems on which we are placing reliance are effective?	Where is the Trust failing to put controls/systems in place? Where is the Trust failing to make them effective?	What actions are required to address the gaps? What key actions have been taken? Cross reference should also be made to the Corporate Risk Register and the associated detailed risk treatment plan for mitigating the risk.	Who has Lead responsibility for actions identified	What is the level of assurance?
Who is the Executive Lead/Which area of the Trust does the risk relate to?					What evidence does the Trust have to show that it is managing its risks? Who has provided the assurance?	Where is the Trust failing to gain evidence that its controls/systems on which we place reliance are effective?			Direction of change in assurance level from previous month.

Key Controls	**Assurances on Controls**
The means by which the principal risk's consequence or likelihood may be reduced. Consideration should be given to the strength of the control in order to determine its effectiveness and impact on risk score. Risk controls are identified through a risk profiling process, as are any gaps in risk control. To assess the strength of controls the following scale is provided as a guide; **STRONG (s)** There is good supporting evidence to demonstrate that the key control is being monitored as effective/compliant with procedural documentation. **MODERATE (m)** There is limited supporting evidence to demonstrate that the key control is being monitored as effective/compliant with procedural documentation. **WEAK (w)** There is no supporting evidence to demonstrate that the key control is being monitored as effective/compliant with procedural documentation.	How the Board is informed that controls are in place and are effectively managing the principal risks to strategic objectives. There are two types of assurance on controls; • Assurance – (Internal), provided by executive governance committees, Quality Committee. • Positive Assurance – (Independent) provided by the Audit Committee, Internal and External Auditors, CQC, NHSLA, H&S Executive etc From assurance reports received the Trust Board supported by the relevant specialists agree the level of assurance on controls that it has received, and this is recorded on the Board Assurance Framework on the following scale; **GREEN** = Full Assurance/No Concerns; Multiple sources of assurance, with at least one item of positive assurance reports from an external regulator or auditor. **AMBER-GREEN** = Significant Assurance/Limited Concerns; including regulatory body concerns and other third party concerns with potential governance implications. Strong sources of independent assurance, including evidence of monitoring compliance with procedural documents. **AMBER-RED** = Negative Assurance/Material Concerns; including major service performance concerns and breaches in regulatory standards. Moderate sources of independent assurance, with limited evidence of monitoring compliance with procedural documents. **RED** = Limited Assurance/Significant Concerns; including significant breaches in service performance, major governance issues emerging from audit/assessment, breaches in regulatory standards and enforcement actions. Limited assurance due to the non-systematic or new nature of system/process, or lack of monitoring evidence base.

STRATEGIC GOAL: CONTINUALLY IMPROVING PATIENT CARE									
Ref No:	**Strategic Objective 1: To improve clinical outcomes for key conditions**					**Objective Owner: Medical Director**			
Principal Risk Ref No:	Risk Score			Key Controls	Assurances on Controls	Gaps in Controls	Action to Address Gaps	Action Lead	Assurance
Exec Lead/Risk Area	Initial	Current	Target		Positive Assurance	Gaps in Assurance			Movement
1a. Significant disruption to 999 service provision, leading to adverse impact on clinical outcomes due to the complexity and interface of different IT systems CRR ref: 22 Exec Director of Finance & performance	4 x 2 = 8	4 x 2 = 8	4 x 1 = 4	1) Work is ongoing to fully test all business continuity plans (m) 2) Hardware capacity reviews (m) 3) Proc-active network and server monitoring (s) 4) Change control process.(m) Overall Strength of Controls = (m)	1) SUI follow up reports 2) External review of change control processes. 1) Internal audit report: Command and Control System (CW121103). Significant assurance. 2) Internal audit report: Network Controls (CW/11116). Significant assurance.	1) Business continuity plans not fully tested. 2) Regular review of hardware capacity is required in the light of changing service requirements (m)	1) Joint meeting with CAD supplier between YAS, EMAS, SWAS and NWAS to address CAD performance issues. 2) C3 release upgrade. 3) Test all business continuity plans 4) Continue to ensure regular hardware capacity reviews and escalation of emerging risks. 5) Develop and monitor early warning indicators.	EDFP	**AMBER GREEN** ⟷
1b. Adverse clinical outcomes due to failure of reusable medical devices and equipment.. CRR ref: 84 Exec Director of Finance & performance	5 x 2 = 10	5 x 2 = 10	5 x 1 = 5	1) Cleric Fleetman records management system (m). 2) Maintenance schedules (m). 3) Procedural documents (Strategy, Maintenance of Medical Devices Policy and associated procedures) (w). 4) Physical audit of all medical equipment. (m) 5) SIP team meeting weekly to review progress including maintenance, staffing and assurance (m) Overall Strength of Controls = (m)	1) Monitoring of incidents at H&S Committee. 2) Monthly reports to SMG 3) Tracking of KPIs in the IPR 1) CQC registered without conditions.	1) Policy and associated procedural documents require update. 2) Further work is needed to strengthen the tracking and recording of equipment maintenance processes.	1) Review and update Maintenance of Medical Devices Policy and individual maintenance schedules. 2) Review and develop records management system. 3) Enhance performance monitoring linked to IPR. 4) Improve incident reporting, in particular near miss reporting.	EDFP	**AMBER RED** ⟷

STRATEGIC GOAL: CONTINUALLY IMPROVING PATIENT CARE									
Ref No:	**Strategic Objective 2: To deliver timely emergency and urgent care in the most appropriate setting**					**Objective Owner: Director of Operations**			
Principal Risk Ref No:	Risk Score			Key Controls	Assurances on Controls	Gaps in Controls	Action to Address Gaps	Action Lead	Assurance
Exec Lead/Risk Area	Initial	Current	Target		Positive Assurance	Gaps in Assurance			Movement
2a. 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. CRR ref: 66 Exec Director of Operations	4 x 3 = 12	4 x 3 = 12	4 x 1 = 4	1) EOC procedures (m) 2) Data flagging group (w) 3) Operational procedures which include the validation of existing lists (w) 4) Incident reporting policy (m) Overall Strength of Controls = (w)	1) Incident reports to H&S Committee. 2) Incident reports to SMG. 3) Work is continuing with other agencies to ensure effective sharing of information within a sound governance framework.	1) Further work is needed to update and systematise the processes for initiating, reviewing and communicating data flags.	1) Complete the review of Emergency Operations Centre procedures for management of data flags. 2) Develop the role and membership of the Data Flagging Group. 3) Continue pilot developments with police, probation and social services to support effective information sharing.	EDoO	**AMBER RED** ⟷

STRATEGIC GOAL: HIGH PERFORMING									
Ref No:	**Strategic Objective 3: To provide clinically effective services which exceed regulatory and legislative standards**					**Objective Owner: Director of Standards & Compliance**			
Principal Risk Ref No:	Risk Score			Key Controls	Assurances on Controls	Gaps in Controls	Action to Address Gaps	Action Lead	Assurance
Exec Lead/Risk Area	Initial	Current	Target		Positive Assurance	Gaps in Assurance			Movement
3a. Inability to deliver performance targets and clinical quality standards. CRR Ref: 103 Exec Director of Standards & Compliance	5 x 3 = 15	5 x 3 = 15	5 x 2 = 10	1) Major trauma project action log in place which includes training requirements. (m) 2) Ongoing paramedic recruitment as part of Workforce Strategy and Plan. (m) 3) HEI programmes for paramedic conversion (m) 4) AQIs developed (m) 5) CPIs developed (m) Overall Strength of Controls = (m)	1) IPR reports, including workforce KPI's to Trust Board, SMG and other executive groups. (m) 1) CQC Registration without conditions	1) Workforce skills and capacity need significant development to ensure alignment with future needs. 2) Training requirements are not yet finalised in the 2012/2013 training programme. 1) Further work is needed to fully embed governance and performance management arrangements in all business units.	1) Implement Workforce Strategy and Plan. 2) Implement Training Plan. 3) Implement Quality Governance action plan. 4) Develop and monitor early warning indicators. 5) Implement Clinical Leadership Framework. 6) Implement service line management and reporting. 7) Implement processes around notification of staff being released for training.	ED WS	**AMBER RED** ⟷
3b. Lack of compliance with key regulatory requirements (CQC,HSE, IGT, NHSLA) due to inconsistent application across the Trust. CRR Ref: 94 Exec Director of Standards & Compliance	5 x 2 = 10	5 x 2 = 10	5 x 1 = 5	1) Procedural documentation (m) 2) Inspections for Improvement process (s) 3) Project plan for NHSLA accreditation, including mock assessment (m) 4) Clinical Quality Strategy and implementation plan (m) Overall Strength of Controls = (m)	1) Compliance reports to Trust Board, SMG and other executive committees 2)Internal audit report (SKL121111) re CQC compliance within CBU's. 1) CQC registration without conditions. 2) IG Toolkit approved at Level 2 3) Deloitte Quality Governance Assessment. 4) HSE inspections reports.	1) There has been a historical under-investment in management and leadership development, particularly in relation to NHS quality requirements. 1) Further work is continuing to embed quality and compliance monitoring and action at departmental level throughout the Trust.	1) Implement Clinical Quality Strategy and implementation plan. 2) Continue progress to NHSLA Level 2 risk management standards. 3) Implement Risk and Safety Team work plans 4) Maintain and enhance the internal Inspections for improvement programme 5) Maintain the focus on quality and compliance within performance management processes. 6) Implementation of Covalent performance management system. 7) Implementation of Quality Committee work programme. 8) Development and implementation of performance management processes within departments and CBUs.	EDSC	**AMBER GREEN** ⟷

STRATEGIC GOAL: HIGH PERFORMING									
Ref No:	**Strategic Objective 4: To provide services which exceed patient and commissioner expectations**					**Objective Owner: Director of Finance & Performance**			
Principal Risk Ref No:	Risk Score			Key Controls	Assurances on Controls	Gaps in Controls	Action to Address Gaps	Action Lead	Assurance
Exec Lead/Risk Area	Initial	Current	Target		Positive Assurance	Gaps in Assurance			Movement
4a. Loss of income due to inability to secure/retain PTS and other significant service contracts, adversely influencing future service commissioning intentions CRR Ref: 104 Executive Director of Finance & Performance	4 x 4 = 16	4 x 4 = 16	4 x 2 = 8	1) Major tender assurance process (s) 2) Weekly Contracting and Commissioning Team meetings (s) Overall Strength of Controls = (m)	1) Executive review at TEG and Finance and Investment Committee. 2) Contractual KPI's in IPR - reported to TEG and Board. 1) Feedback from Commissioner meetings	1) Further work is needed to develop managerial and leadership capability and capacity. 2) The commissioning landscape is undergoing significant change and the Trust needs to ensure active engagement with new commissioners and other stakeholders 1) The service has not met commissioner expectations. 2) There are inefficiencies in use of resources, leading to a historic inability to deliver performance and quality KPI's and desired patient experience	1) Implement PTS Transformation Programme . 2) Implement service line management and reporting. 3) Develop Trust commercial unit. 4) Implement Stakeholder Engagement Plan. 5) Contribute to regional and local improvement initiatives. 6) Appointment of Associate Commercial Director and development of key procedures.	EDFP	**AMBER RED** ⟷

STRATEGIC GOAL: ALWAYS LEARNING									
Ref No:	**Strategic Objective 5: To develop culture, systems and processes to support continuous improvement and innovation.**					**Objective Owner: Director of Finance & Performance**			
Principal Risk Ref No:	Risk Score			Key Controls	Assurances on Controls	Gaps in Controls	Action to Address Gaps	Action Lead	Assurance
Exec Lead/Risk Area	Initial	Current	Target		Positive Assurance	Gaps in Assurance			Movement
5a. Inability to deliver service transformation and organisational change, including non-delivery of cost improvement programmes CRR Ref: 105 Executive Director of Finance & Performance	5 x 4 = 20	5 x 4 = 20	5 x 2 = 10	1) TEG approved approach to staff engagement (s) 2) Clinical Leadership programme (m) 3) Programme management (m) 4) Quality Impact Assessments. (m) 5) CIP Monitoring Group. (m) 6) Clinical Review Group.(m) 7) CQUINS (s) Overall Strength of Controls = (m)	1) Monitoring reports to TEG. 2) Performance reports to Quality Committee	1) Further work is needed to develop managerial and leadership capability and capacity. 2) Programme management arrangements are at an early stage and need to be refined and fully embedded 3) There is a need to develop management and staff engagement and accountability	1) Implement Service Transformation Programme. 2) Implement Cost Improvement Programme management as a key part of overall programme management. 3) Implement Staff Engagement and Communication Plan. 4) Implement service line management. Implement agreed process for Quality Impact Assessment of CIP Programmes. 5) Achieve actions on FT implementation plan within specified timeframes 6) Implement Workforce Strategy and Plan. 7) Implement Training Plan.	EDFP	**AMBER RED** ⟷
						1) Service line management is not yet fully embedded			
5b. Failure to learn from patient experience and adverse events due to inadequate data management systems for reporting and to identifying learning opportunities. CRR Ref: 69 Exec Director of Standards & Compliance	4 x 2 = 8	4 x 2 = 8	4 x 1 = 4	1) Involvement in patient groups and LINKs(s) 2) Incident reporting policy. (m) 3) Complaints and claims policy. (m) 4) Incident review group disseminates learning around lessons learned via clinical updates. (m) 5) Clinical audit reviews. (m) 6) Trust has an expert patient. (s) Overall Strength of Controls = (m)	1) Significant events and lessons learned reports to Trust Board, SMG, Quality Committee and other executive groups. 2) Reports to incident review group.	1) Further work is needed to embed learning processes aligned to corporate systems, at departmental level throughout the Trust.	1) Develop patient feedback and engagement in line with the Clinical Quality Strategy. 2) Implement the clinical audit plan. 3) Continue to develop review processes at department level, aligned to existing Trust systems. 4) Implement the risk management data systems project	EDSC	**AMBER RED** ⟷
					1) CQC Assessment in January 2012. 2) Internal Audit report on Lessons Learned showed significant assurance, July 11	1) Risk management software systems are inefficient and do not support the learning. process.			

STRATEGIC GOAL: ALWAYS LEARNING									
Ref No:	**Strategic Objective 6: To create, attract and retain an enhanced and skilled workforce to meet service needs now and in the future.**					**Objective Owner: Director of Workforce & Strategy**			
Principal Risk Ref No:	Risk Score			Key Controls	Assurances on Controls	Gaps in Controls	Action to Address Gaps	Action Lead	Assurance
Exec Lead/Risk Area	Initial	Current	Target		Positive Assurance	Gaps in Assurance			Movement
6a. Adverse impact on clinical outcomes due to failure to embed the clinical leadership framework. CRR Ref: 39 Exec Director of Operations	4 x 3 = 12	4 x 3 = 12	4 x 1 = 4	1) Clinical Quality Strategy and associated implementation plans (m) 2) CQUIN programme management (s) 3) Appointment of clinical supervisors by robust process of recruitment and selection. (s) 4) Bradford University CL programme. (w) Overall Strength of Controls = (m)	1) Performance reports to Quality Committee. 2) CQUINS reporting. 1) Independent report on governance of quality, July 11.	1) There has been a historical under-investment in management and leadership development. 2) Until recently the clinical leadership framework was poorly defined and supported, and inconsistently implemented across the Trust. 1) Further work is needed to ensure that the new framework is fully embedded and effective in practice.	1) Implement Clinical Leadership Framework 2) Provide leadership and management development for all new Clinical Supervisors. 3) Establish effective monitoring of relevant KPIs as part of the wider workforce dashboard. 4) Review wider operational management structures and systems to ensure alignment with new clinical leadership model. 5) Implementation of CPD programme. 6) Development of clinical progression framework.	EDO	**AMBER GREEN** ⟷

STRATEGIC GOAL: VALUE FOR MONEY AND PROVIDER OF CHOICE									
Ref No:	**Strategic Objective 7: To be at the forefront of healthcare resilience and public health.**					**Objective Owner: Director of Operations**			
Principal Risk Ref No:	Risk Score			Key Controls	Assurances on Controls	Gaps in Controls	Action to Address Gaps	Action Lead	Assurance
Exec Lead/Risk Area	Initial	Current	Target		Positive Assurance	Gaps in Assurance			Movement
7a. Adverse impact on organisational performance and clinical outcomes due to significant events impacting on business continuity. CRR Ref: 74 Exec Director of Operations	5 x 3 = 15	5 x 3 = 15	5 x 2 = 10	1) Range of risk assessments (s) 2) Resilience plans (m) 3) Business Continuity Plans monitored and reviewed annually and exercised periodically (m) 4) All MAJAX/Specific resilience plans testing schedule and monitoring of effectiveness (m) 5) BC Resilience Board (m) Overall Strength of Controls = (m)	1) Monitoring of business continuity plans in Executive groups. 2) Monthly IPR to Board	2) Further work is need to fully test all departmental business continuity plans and to ensure that all staff receive appropriate training 1) The Trust faces a broad range of business continuity threats, from both natural and man-made causes.	1) Implement training programme for business continuity leads and key staff. 2) Test all business continuity plans. 3) Establish new Gold Command facility. 4) Relocate HART to new premises.	EDO	**AMBER GREEN** ⟷

STRATEGIC GOAL: VALUE FOR MONEY AND PROVIDER OF CHOICE									
Ref No:	**Strategic Objective 8: To provide cost-effective services that contribute to the objectives of the wider health economy.**					**Objective Owner: Director of Finance & Performance**			
Principal Risk Ref No:	Risk Score			Key Controls	Assurances on Controls	Gaps in Controls	Action to Address Gaps	Action Lead	Assurance
Exec Lead/Risk Area	Initial	Current	Target		Positive Assurance	Gaps in Assurance			Movement
8a. Adverse impact on developments in urgent/unscheduled care services in partnership with other providers due to failure to implement 111 service/WYUC provision CRR ref: 93 Exec Director of Standards & Compliance	5 x 3 = 15	5 x 3 = 15	5 x 1 = 5	1) Established experienced project management team 2) Support provided by successful bidder (NEAS) 3) Consultancy support provided by BAE Detica Overall Strength of Controls = (s)	1) The Trust has experience of the commercial process of bidding for contracts on this scale.	2) The service will need to be delivered to a high specification within very tight budgetary constraints. 1) The 111 service development is a major component of Trust strategy and key to wider urgent care developments. 2) The timescale for mobilisation is short	1) Put in place project management arrangements and targeted resources to support the mobilisation process. 2) Establish defined partnership and Trust governance and management arrangements as outlined in the service bid. 3) Ensure project management to support development and delivery of other service developments if the 111 bid is unsuccessful.	EDFP	**AMBER GREEN** ⟷