Yorkshire Ambulance Service NHS Trust
Corporate Risk Register (March 2013)

Risk ID	Risk Source Date	Directorate/ Committee	Dept / Team/ Workstream	Risk Description	Risk Controls in Place	C	L	Risk Score	Risk Treatment Plan	Risk Owner	Comp date	C	L	Residual Risk Score	Review Date	Progress Notes
CRR22 (BAF1a)	Internal Review (IM&T Prism 715)	F&P	ICT (ICT 28)	Significant disruption to 999 service provision, leading to adverse impact on clinical outcomes due to the complexity and interface of different IT systems	1) Work is on-going to fully test all business continuity plans (m) 2) Hardware capacity reviews (m) 3) Pro-active network and server monitoring (s) 4) Change control process.(m) 5) Clinical leadership dashboard (m) 6) Clinical leadership project group (m)	4	2	8 AMBER	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. The Risk Treatment Plan Provides specific details on actions, ownership and timeframes.	DJ	Mar-13	4	1	4 YELLOW	Monthly	Actions on original risk treatment plan completed. Reviewed by R&AG on 29 Aug. Revised risk description is more strategic and broadened. Risk treatment plan to be rewritten to reflect this. Eight business continuity plans have been live tested. 16 Nov - SP/RB have discussed progress with risk lead and agreed requirements for risk treatment plan. To be finalised on 23/11 in meeting with AL. KDW risk review meeting with Exec Director 18/12. Additional controls and assurances on controls identified. 15/1 R&AG and 25/1 TEG discussed and agreed at TEG on 25/1 to archive this risk. Executive review in Feb/March agreed to archive the risk and to monitor and review at Directorate level.

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CRR39 (BAF6a)	Internal review (ET) Sept 2010	W&S	Leadership & Management Development	Adverse impact on clinical outcomes due to failure to embed a clinical leadership framework	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)	4	3	12 **AMBER**	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. 7) Scope work for service transformation programme, including specific investment in leadership development. The Risk Treatment Plan Provides specific details on actions, ownership and timeframes.	DW	Mar-13	4	1	4 **YELLOW**	Monthly	SM Update 27-9-12. Key actions include progress on implementation of Training Plan and Workforce Strategy and Plan. A monitoring dashboard is now in place. Clinical Supervisors and CDMs appointed and operational. Additional action identified relating to scoping work for service transformation programme, including specific investment in leadership development. 29-10-12 R&AG concerns identified regarding training as not all CS staff appointed, trained so therefore gap in functionality. Risk treatment plan to be updated to reflect this. Good progress being made against other actions in risk treatment plan. KDW risk review meeting with Exec Director 18/12. Additional controls and assurances on controls identified. An extra action placed on risk treatment plan relating to succession planning. A monitoring dashboard is now in place. 15/1 RAG general progress being made against actions on risk treatment plan. Executive review in Feb/March agreed to retain the risk on CRR/BAF but with a refocused RTP with additional actions relating to the gaps identified above.

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CRR66 (BAF2a)	Safeguarding Team April 2011	Ops	EOC	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.	1) EOC procedures (m) 2) Data flagging group (m) 3) Operational procedures which include the validation of existing lists (w) 4) Incident reporting policy (m)	4	3	12 AMBER	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. The Risk Treatment Plan Provides specific details on actions, ownership and timeframes.	SB	Mar-13	4	1	4 **YELLOW**	Monthly	Discussed at R&AG 29 Aug. Risk treatment plan developed, but has yet to commence implementation. EOC Locality Director has developed a new data flagging process and will present this to TEG for approval. Actions still to be completed. KDW to liaise with risk lead to progress findings from TEG. KDW risk review meeting with Exec Director 17/12. Controls strengthened and positive movement on risk treatment plan.15/1 R&AG and 25/1 TEG proposed archiving of this risk. Data flagging group in it's infancy but is meeting regularly. .Executive review in Feb/March agreed to retain the risk on CRR/BAF but with a refocused RTP on monitoring compliance.
CRR69 (BAF5b)	Review of BAF Gaps in Control (July 2011)	S&C	Risk & Safety / Quality	Failure to learn from patient experience and adverse events due to inadequate data management systems for reporting and to identifying learning opportunities.	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)	4	2	8 AMBER	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 The Risk Treatment Plan Provides specific details on actions, ownership and timeframes.	KW KDW	Mar-13	4	1	4 **YELLOW**	Monthly	Implementation of Datix which will replace Prism in March 2013 for the management of incidents, complaints and claims. Lessons learned report now submitted to Board and Quality Committee bi-monthly. Good progress being made against actions on risk treatment plan. 20/11/12 Investigation skills training roll out to managers will not commence until April 2013 due to competing operational pressures. 15/1 R&AG Datix implementation plan on target with exception of Ops management training. This remains a concern. Executive review in Feb/March agreed to retain the risk on CRR/BAF but with a refocused RTP with additional actions relating to the gaps identified above.

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CRR74 (BAF7a)	Review of BAF Gaps in Control (July 2011)	Ops	Resilience & Specialist Services	Adverse impact on organisational performance and clinical outcomes due to significant events impacting on business continuity.	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)	5	3	15 **RED**	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. The Risk Treatment Plan Provides specific details on actions, ownership and timeframes.	IW	Mar-13	5	2	**10** **AMBER**	Monthly	Business Continuity plans in place across the Trust. Now routinely monitored via BC Resilience Group. Gold Command Centre fully operational, training programme completed. 8 department BC plans live tested. HART still experiencing difficulties in relocation and some concerns regarding training of business continuity leads.. IKDW risk review meeting with Exec Director 17/12.20 BC plans now live tested and general positive movement on risk treatment plan. 15/1 RAG and TEG; general progress being made. Executive review in Feb/March agreed to retain the risk on CRR/BAF but with a refocused RTP with additional actions relating to the gaps identified above.
CRR84 (BAF1b)	SMG January 2012	Capital Fleet & Equipment Group		Adverse clinical outcomes due to failure of reusable medical devices and equipment.	Cleric Fleetman records management system (m). Maintenance schedules (m). Procedural documents (Strategy, Maintenance of Medical Devices Policy and associated procedures) (w). Physical audit of all medical equipment. (m)	5	2	10 **AMBER**	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. The Risk Treatment Plan Provides specific details on actions, ownership and timeframes.	MS	Mar-13	5	1	**5** **YELLOW**	Monthly	Positive developments in equipment maintenance scheduling systems. Weekly monitoring arrangements established within Directorate. Positive assurance received from July, NHSLA Mock L2 assessment. Risk treatment plan requires updating into correct format and to include detail on performance monitoring. 15/1 RAG general progress being made against actions on risk treatment plan. Positive assurance from internal audit report. Executive review in Feb/March agreed to retain the risk on CRR/BAF but with a refocused RTP on developing the process and monitoring compliance.

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CRR93 (BAF8a)	BAF review April 12	S&C	Projects	Adverse impact on developments in urgent/unscheduled care services in partnership with other providers due to failure to implement 111 service/WYUC provision	111 Project Team developing 111 ITT response (s)	5	3	15 **RED**	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. The project plan and risk register provides specific details on actions, ownership and timeframes.	KT	Mar-13	5	1	5 **YELLOW**	Monthly	111 service/WYUC provision secured July 2012. Implementation plan under development with contributions from identified workstream leads. Some positive developments regarding securing premises, IT solutions and hardware. There are a number of risks emerging relating to training and recruitment. Risks effectively managed by 111 Project Management Board. 15/1 RAG general progress being made. There are concerns relating to training and recruitment. Risks are effectively managed by 111 Project Management Board. Project risk register monitored monthly by project team. Executive review in Feb/March agreed to close this risk and to create a new risk for the 2013/14 iterations of the BAF.

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CRR94 (BAF3b)	BAF review June 12	S&C	Risk & Safety	Lack of compliance with key regulatory requirements (CQC,HSE,IGT, NHSLA) due to inconsistent application across the Trust.	Procedural documentation (m) Clinical audit process (m) Inspections for improvement programme. (s) KPI indicators. (m) Project plan re NHSLA accreditation, including mock assessments. (m) Clinical Quality Strategy and implementation plan. (m) Quality accounts.(s)	5	2	10 **AMBER**	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. The Risk Treatment Plan Provides specific details on actions, ownership and timeframes.	ED S&C	Mar-13	5	1	5 **YELLOW**	Monthly	NHSLA mock L2 assessment in July 2012 highlighted key areas for improvement. Further work is required to enable the Trust to succeed at L2. The Inspection for Improvement programme is still underway to identify any CQC related issues. 9 October 2012 Trust achieved NHSLA L1 compliance with a score of 50/50. New CQC inspector allocated to Trust. Two items on QRP rated as red; AQI's for MI and staff flu immunisation. HSE satisfied with a number of previous concerns relating to stress management, occupational health, HAV's. Further work required to alleviate concerns relating to M&H. Risk treatment plan updated to reflect this. 15/1 RA&G and 25/1 TEG; positive movement relating to work of CAG, IG Toolkit and implementation of Quality Strategy. Some concerns remain regarding preparation for NHSLA L2, moving and handling and IG training. Executive review in Feb/March agreed to retain the risk on CRR/BAF but with a refocused RTP with additional actions relating to the gaps identified above.

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CRR103 (BAF3a)	TEG review June 12	S&C W&S	Compliance Education	Inability to deliver performance targets and clinical quality standards.	1) Major trauma project action log in place which includes training requirements. (m) 2) On-going 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)	5	3	15 **RED**	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. The Risk Treatment Plan Provides specific details on actions, ownership and timeframes.	KW SP	Mar-13	5	2	10 **AMBER**	Monthly	SM Update 27-9-12 Positive movement with additional control (previous gap) and assurances. Key actions include progress on implementation of Training Plan and Workforce Strategy and Plan. Board approved Workforce plan in place. November update - A quarterly performance review group has been established. Board approved performance management strategy implemented. 15/1 RAG and 25/1 TEG; General progress being made against actions on risk treatment plan. Achievement of the Red 1 response time targets remains challenging, and elements of training have been re-scheduled to support this. A Turnaround Group with Non-Executive Director membership has ben established. Executive review in Feb/March agreed to retain the risk on CRR/BAF but with a refocused RTP with additional actions relating to the gaps identified above.

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CRR104 (BAF4a)	TEG review June 12	F&P	Finance	Loss of income due to inability to secure/retain PTS and other service contracts, adversely influencing future service commissioning	1) Major tender assurance process (s) 2) Weekly Contracting and Commissioning Team meetings (s)	4	4	16 **RED**	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. The Risk Treatment Plan Provides specific details on actions, ownership and timeframes.	AR	Mar-13	4	2	8 AMBER	Monthly	New risk following TEG review in June 2012. November update - Risk treatment plan under development by newly appointed Associate Director of PTS. The Transformation programme is still under development. Action has been taken to mitigate the risk via the PTS transformation programme and appointment of a new manager. Work is also progressing to strengthen the corporate commercial team. The financial performance in PTS remains a key risk. The risk treatment plan is being strengthened. AL/KDW to liaise with JH to provide support in finalising the risk treatment plan. AL liaise with CBalazs to provide update and support. 15/1 R&AG and 25/1 TEG; some positive movements on RTP.Executive review in Feb/March agreed to retain the risk on CRR/BAF.

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CRR105 (BAF5a)	TEG review June 12	F&P S&C	FT TCP	Inability to deliver service transformation and organisational change, including non-delivery of cost improvement programmes.	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)	5	4	20 **RED**	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. The Risk Treatment Plan Provides specific details on actions, ownership and timeframes.	AR KW	Mar-13	5	2	10 AMBER	Monthly	CIP Plans finalised and quality impact assessed. Q2 CQUIN report finalised October 2012 with actions in place to progress. 29-10-12 R&AG 5 year CIP now in place. Downside financial risk assessment completed. IBP programme management in place for majority of CIP's. Further engagement with workforce required. Transformation programme group established. Portfolio Manager (Transformation) appointed. Progress being made towards appointment of Commercial Director. 15/1 R&AG and 25/1 TEG; some positive movement in regard to CQUIN performance and CIP process. Long Term Financial Model approved. Progress being made towards appointment of Commercial Director. Executive review in Feb/March agreed to retain the risk on CRR/BAF.

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CRR106 (BAF8b)	TEG Nov 2012	Ops	PTS	Deficit against planned financial outturn due to significant overspending on the provision of Patient Transport Services	Procedures regarding levels of sign of and expenditure - organisational cost control (m). Monthly budget monitoring between finance, senior and operational managers in PTS (m).	5	4	20 **RED**	1) Managerial sign off required for all sub contractor spend 2) Hold on all unfilled vacancies in PTS with revised vacancy approval process implemented in PTS - all requests for vacancy recruitment signed off by Associate Director and based on service delivery priority and avoidance of sub contractor spend only 3) Removal of highest cost subcontractors from operational deployment 4) Revised financial forecast and identified cost savings agreed with monthly monitoring against compliance 5) Achieve consistent application of the authorisation procedure across all areas.	JH	Mar-13	5	2	10 AMBER	Monthly	Associate Director of Operations (PTS) commenced in post 5.11.12. Priority to reduce overspend as much as possible without compromising patient safety. Sub-contractors removed during November/December 12. 15/1 R&AG RTP in early in early stages of implementation but with some evidence of positive movement in terms of reducing potential overspend. Executive review in Feb/March agreed to retain the risk on CRR/BAF.