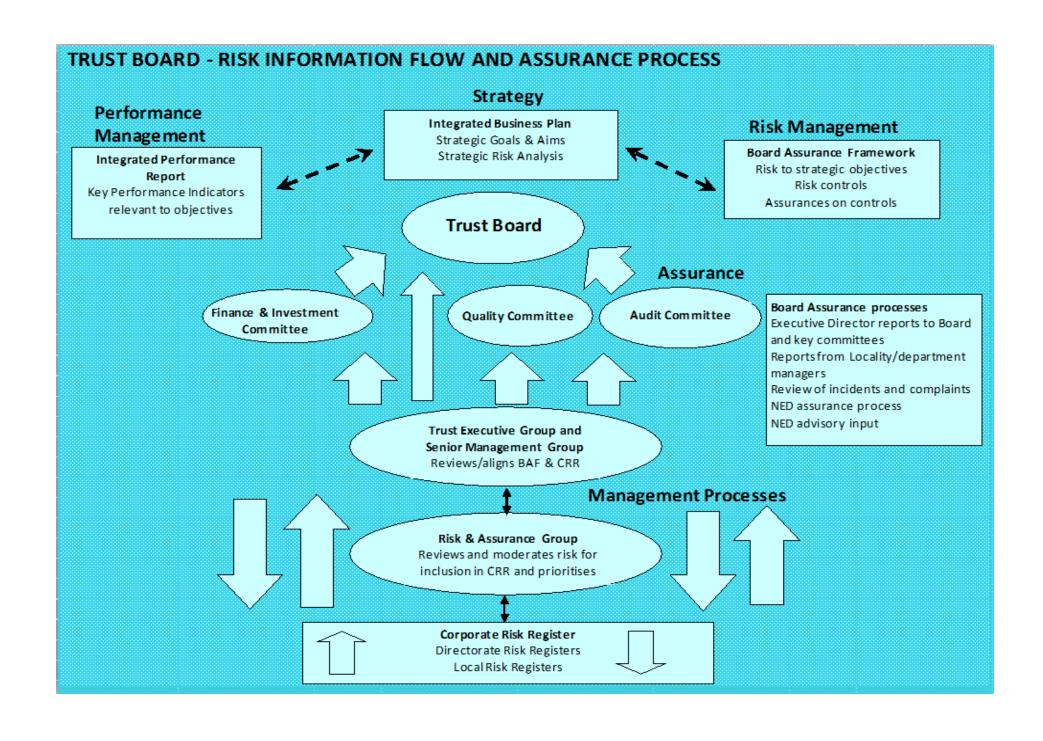




An Aspirant Foundation Trust

BOARD ASSURANCE FRAMEWORK

MARCH 2013



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	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:		trategic Objective: As detailed in the Integrated Business Plan 2012-2017 and the noual Business Plan 2012-13 Objective Owner: Executive Director										
Principal Risi Reference No		Ris	sk Sc	ore		Assurances on Controls	Gaps in	Controls	Action to Address Cons	Action	Assurance	
Exec Lead/Risk	Area	Initial Current Target		Target	Key Controls	Positive Assurances	Gaps in Assurance		Action to Address Gaps	Action Lead	Movement	
What could prevent the straffrom being achieved? CRR ref: Who is the Executive Lead/the Trust does the risk relations.	the curr mov and risk Risk	s will s initial, ent (in vemen the ta score c is score seques telihoo	the nc it) irget ored ence	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? What evidence does the Trust have to show	Where is the failing to purcontrols/system place? When Trust failing them effection. Where is the failing to ga	t tems in tree is the g to make ve?	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.	has Lead responsibility for actions identified	What is the level of assurance? Direction of change in		
					(-)	that it is managing its risks? Who has provided the assurance? that its controls/sys which we play reliance are		ace		Who h	assurance level from previous month.	

Key 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.

Assurances on Controls

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.

Ref Strated				UALLY IMPROVING 1: To improve clinical		conditions	Objective Owner: Medical Director		
Principal Risk Ref No:	Ris	sk Sc	ore		Assurances on Controls	Gaps in Controls			Assurance
Exec Lead/Risk Area	Initial	Current	Target	Key Controls	Positive Assurance	Gaps in Assurance	Action to Address Gaps	Action Lead	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 1 = 4	1) Work is on-going to fully test all business continuity plans (s) 2) Hardware capacity reviews (s) 3) Pro-active network and server monitoring (s) 4) Change control process.(m) Overall Strength of Controls = (s)	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. 3) 20 BC Plans live tested and deemed efficient		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	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 1 = 5	1) Cleric Fleetman records management system (s). 2) Maintenance schedules (m). 3) Procedural documents (Strategy, Maintenance of Medical Devices Policy and associated procedures) (m). 4) Physical audit of all medical equipment. (m) 5) SIP team meeting weekly to review progress including maintenance, staffing and assurance (s) 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 assessment January 2013, registered without conditions. 2) Internal Audit Report 3) NHSLA L1 Report	1) Further work is needed to strengthen the tracking and recording of equipment maintenance processes. 2) Robust audit of activity and adherence to maintenance schedules	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 GREEN

STRATEGIC GOA	L: C	CON	TIN	UALLY IMPROVING	PATIENT CARE				
Ref Strateg No: most ap				2: To deliver timely e	mergency and urge	nt care in the	Objective Owner: Director of Operation	ıs	
Principal Risk Ref No:	Ris	sk Sc	ore		Assurances on Controls	Gaps in Controls	Action to Address Gaps		Assurance
Exec Lead/Risk Area	Initial	Current	Target	Key Controls	Positive Assurance	Gaps in Assurance	Action to Address Gaps	Action Lead	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	4 x 3 = 12		4 x 1 = 4	1) EOC procedures (m) 2) Data flagging group (m) 3) Operational procedures which include the validation of existing lists (m) 4) Incident reporting policy (s)	Incident reports to H&S Committee. Incident reports to SMG. 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) Further work is needed to update and systematise the processes for initiating, reviewing and communicating data flags.	Complete the review of Emergency Operations Centre procedures for management of data flags. Develop the role and membership of the Data Flagging Group. Continue pilot developments with police, probation and social services to support effective information sharing.	EDoO	AMBER GREEN
Exec Director of Operations				Overall Strength of Controls = (m)					

STRATEGIC GOA	۱: ا	HIG	H PE	ERFORMING					
				3: To provide clinical slative standards	ly effective services	s which exceed	Objective Owner: Director of Standards	s & Con	npliance
Principal Risk Ref No:		isk So			Assurances on Controls	Gaps in Controls	Astion to Address Ones		Assurance
Exec Lead/Risk Area	Initial	Current	Target	Key Controls	Positive Assurance	Gaps in Assurance	Action to Address Gaps	Action Lead	Movement
3a. Inability to deliver performance targets and clinical quality standards. CRR Ref: 103	3 = 15		2 = 10	1) Major trauma project action log in place which includes training requirements. (s) 2) On-going paramedic recruitment as part of Workforce Strategy and Plan. (s) 3) HEI programmes for paramedic conversion (m) 4) AQIs developed (m)	1) IPR reports, including workforce KPI's to Trust Board, SMG and other executive groups. 2) Quarterly performance review group established. 3) Board approved performance management strategy and Workforce Plan.	1) Workforce skills and capacity not fully developed. 2) Ability to deliver the training plan due to conflicting operational pressures.	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. 8) Implement Risk and Safety Team work plan	ED WS	AMBER RED
Exec Director of Standards & Compliance	5 x		5 X	5) CPIs developed (m) 6) 2012/13 Training Programme (m) 7) 5 year Workforce Plan agreed. (s) 8) YAS Turnaround Group with Non- Executive Director membership (s) Overall Strength of Controls = (m)	CQC Registration without conditions Internal Audit review of S&M training rated as substantial assurance. NHSLA Mock assessment identified good workforce policy management.	1) Further work is needed to fully embed governance and performance management arrangements in all business units.			
3b. Lack of compliance with key regulatory requirements (CQC,HSE, IGT, NHSLA) due to inconsistent application across the Trust. CRR Ref: 94	2 = 10		x 1 = 5	1) Procedural documentation (w) 2) Inspections for Improvement process (s) 3) Project plan for NHSLA accreditation, including mock assessment (s) 4) Clinical Quality Strategy and	1) Compliance reports to Trust Board, SMG and other executive committees 2)Internal audit report (SKL121111) re CQC compliance within CBU's. 3) I4I Process positive findings from review	1) There has been a historical under-investment in management and leadership development, particularly in relation to NHS quality requirements. 1) Fastlanded in American in the state of	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.	EDSC	AMBER GREEN
Exec Director of Standards & Compliance	5 × 5		5 x	implementation plan (m) Overall Strength of Controls = (m)	1) CQC assessment January 2013, without conditions. 2) IG Toolkit Level 2 3) Deloitte Quality Governance Assessment. 4) HSE inspections reports. 5) NHSLA L1 achieved (9/10/12)	Further work is continuing to embed quality and compliance monitoring and action at departmental level throughout the Trust.	7) Implementation of Quality Committee work programme. 8) Development and implementation of performance management processes within departments and CBUs.		←

				e 4: To provide service ectations	es which exceed par	tient and	Objective Owner: Director of Finance 8	R Perfor	mance
Principal Risk Ref No:		Risk S	Score		Assurances on Controls	Gaps in Controls			Assurance
Exec Lead/Risk Area	1	Current	Tardet	Key Controls	Positive Assurance	Gaps in Assurance	Action to Address Gaps	Action Lead	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		4 x 4 = 10	x - C > 4	Overall Strength of	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.	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
Finance & Performance				Controls = (m)					

STRATEGIC GOA	L: A	LW	AY	S LEARNING					
				5: To develop culture ement and innovation		esses to support	Objective Owner: Director of Finance 8	Perfor	mance
Principal Risk Ref No:	1	sk Sc			Assurances on Controls	Gaps in Controls			Assurance
Exec Lead/Risk Area	Initial	Current	Target	Key Controls	Positive Assurance	Gaps in Assurance	Action to Address Gaps	Action Lead	Movement
5a. Inability to deliver service transformation and organisational change, including non-delivery of cost improvement programmes CRR Ref: 105	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	Monitoring reports to TEG. 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) Service line management is not yet fully embedded	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
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	4 × 2 = 8		4×1=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)	1) Significant events and lessons learned reports to Trust Board, SMG, Quality Committee and other executive groups. 2) Reports to incident review group. 1) 1) CQC assessment January 2013, registered without conditions. 2) Internal Audit report on Lessons Learned	1) Further work is needed to embed learning processes aligned to corporate systems, at departmental level throughout the Trust. 2) Need to develop audit capability 3) Need to enhance investigation process 1) Risk management software systems are inefficient and do not support the learning process. 2) Further work is	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 GREEN
Exec Director of Standards & Compliance				Overall Strength of Controls = (m)	on Lessons Learned showed significant assurance, July 11	required to develop the learning and reporting processes within the 111 service			

STRATEGIC GOA									
				6: To create, attract a service needs now an		ced and skilled	Objective Owner: Director of Workforce	e & Stra	itegy
Principal Risk Ref No:	1	sk Sc			Assurances on Controls	Gaps in Controls			Assurance
Exec Lead/Risk Area	Initial	Current	Target	Key Controls	Positive Assurance	Gaps in Assurance	Action to Address Gaps		Movement
6a. Adverse impact on clinical outcomes due to failure to embed the clinical leadership framework. CRR Ref: 39	4 x 3 = 12		4×1=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) 5) Clinical leadership dashboard (m) 6) Clinical leadership project group (m)	Performance reports to Quality Committee. CQUINS reporting. CL Dashboard CL project group Bradford University CL programme evaluation.	1) There remains under-investment in management and leadership development. To be addressed by the STP 2) Clinical leadership dashboard activity 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 a specific dashboard for Clinical Leadership. 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. 8) Appoint developmental Clinical Supervisors for succession planning.	EDO	AMBER GREEN
Exec Director of Operations				Overall Strength of Controls = (m)					

STRATEGIC GOA	\L: \	/AL	UE	FOR MONEY AND	PROVIDER OF	CHOICE			
Ref Strateg			tive	7: To be at the forefro	ont of healthcare re	silience and	Objective Owner: Director of Operation	s	
Principal Risk Ref No:	Ris	sk Sc	ore		Assurances on Controls	Gaps in Controls			Assurance
Exec Lead/Risk Area	Initial	Current	Target	Key Controls	Positive Assurance	Gaps in Assurance	Action to Address Gaps	Action Lead	Movement
7a. Adverse impact on organisational performance and clinical outcomes due to significant events impacting on business continuity. CRR Ref: 74	3 = 15		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	Monitoring of business continuity plans in Executive groups. Monthly IPR to Board	Further limited work is need to fully test all departmental business continuity plans and to ensure that all staff receive appropriate training	Implement training programme for business continuity leads and key staff. Test all business continuity plans. Establish new Gold Command facility. Relocate HART to new premises.	EDO	AMBER GREEN
Exec Director of Operations	5 ×		5 ×	schedule and monitoring of effectiveness (m) 5) BC Resilience Board (m) Overall Strength of Controls = (m)	20 Business Continuity Plans live tested, and deemed efficient.	The Trust faces a broad range of business continuity threats, from both natural and man-made causes.			

STRATEGIC GOA	L: V	/AL	UE	FOR MONEY AND	PROVIDER OF	CHOICE																							
No: objective				8: To provide cost-ef der health economy.	fective services tha	t contribute to the	Objective Owner: Director of Finance 8	Perfor	mance																				
Principal Risk Ref No:	Ris	sk Sc	ore		Assurances on Controls	Gaps in Controls			Assurance																				
Exec Lead/Risk Area	Initial	Current	Target	Key Controls	Positive Assurance	Gaps in Assurance	Action to Address Gaps	Action Lead	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	.15		= 5	1) Established experienced project management team(s) 2) Support provided by successful bidder (NEAS) (s) 3) Consultancy support provided by BAE Detica (s)	The Trust has experience of the commercial process of bidding for contracts on this scale.		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.		GREEN																				
CRR ref: 93 Exec Director of Standards & Compliance	5 x 3 =		5 x 1 =	×	5 X 1	5×1	5×1	5×1	5×7	×c	2×	5×1	5×7	5 × 5	2×	2×	, co	5 x 1	5×1	5 × 3	5 x	5 x	5×	Overall Strength of Controls = (s)	1) The 111 Project Board is comprehensively monitoring activity and providing assurance. 2) Positive feedback from Board presentation – Jan13		All above actions completed. Going forward the risk will be refocused on delivery of contract and remain on the BAF.	EDFP	→
8b. Deficit against planned financial outturn due to significant overspending on the provision of Patient Transport Services CRR ref: 106	5 x 4 = 20		5 x 2 = 10	1) Procedures regarding levels of sign of and expenditure - organisational cost control (m). 2) Monthly budget monitoring between finance, senior and operational managers in PTS (m). 3 Authorisation procedures for contractor spend. (w).	Review monthly by the Board through Integrated Performance Report	The authorisation procedure for contractor spend, although developed needs to be applied consistently across all areas	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 sub-contractors 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.	EDO	AMBER RED																				
Executive Director of Operations																													