Yorkshire Ambulance Service NHS
NHS Trust

An Aspirant Foundation Trust

MEETING TITLE Trust Board		**MEETING DATE** 23 July 2013	
TITLE of PAPER	Board Assurance Framework Quarter 1	**PAPER REF**	5.3
STRATEGIC OBJECTIVE	To develop a strategic framework for the management and monitoring of the agreed Trust Objectives for 2013/2014		
PURPOSE OF THE PAPER	The purpose of this paper is to update the Trust Board on the current position in regard to the Board Assurance Framework (BAF), and to provide assurance that these arrangements are being managed efficiently.		
For Approval	☐x	**For Assurance**	☐x
For Decision	☐	**Discussion/Information**	☐
AUTHOR / LEAD	Mark Hall (Associate Director for Risk & Safety)	**ACCOUNTABLE DIRECTOR**	Steve Page (Executive Director of Standards & Compliance)
PREVIOUSLY CONSIDERED BY	**Committee/Group:** Audit Committee	**Date:** 16 July 2013	
RECOMMENDATION	The Trust Board notes the current position and approves forward plans for the effective management of risks.		

RISK ASSESSMENT	**Yes**	**No**
Corporate Risk Register and/or Board Assurance Framework amended	☐	☐
Resource Implications (Financial, Workforce, other - specify)	☐	☐
Legal implications/Regulatory requirements	☐x	☐
Quality and Diversity Implications	☐	☐x

ASSURANCE/COMPLIANCE	
Care Quality Commission Registration Outcome(s)	4, 7, 8, 9, 10, 11, 12
NHSLA Risk Management Standards for Ambulance Trusts	1.4 1.5 2.2 2.5

1. PURPOSE/AIM

1.1 The purpose of this paper is to present the updated Quarter 1 Board Assurance Framework, demonstrating progress to date.

2. BACKGROUND/CONTEXT

2.1 The draft April 2013 iteration of the BAF was the subject of a comprehensive review at a Board Workshop on 23 April 2013. The content of the BAF was discussed in detail and a number of amendments made to the initial draft.

2.2 The July 2013 iteration of the Board Assurance Framework (BAF) contains the detail of 13 strategic objectives following peer reviews with Directors during June and July 2013.

2.3 The previous BAF was updated via Committees and lacked direct input from the Executive team that own the Objectives, this has now been addressed.

2.4 A key change is that for each gap in assurance or control there is now a corresponding action to address the gap with the action owner identified and the date by which the action is expected to be complete.

3. PROPOSALS/NEXT STEPS

Board Assurance Framework

3.1 The Associate Director for Risk & Safety will continue to meet with all Executive risk leads plus another Executive on a quarterly schedule to peer review the objective, risk, controls, assurances, gaps and actions to enable constructive discussion on progress toward the objective. The BAF will be updated based on the meeting with the Lead and reported to the Audit Committee and Trust Board.

3.2 The Associate Director for Risk & Safety will continue to make final amendments to the BAF before submission, and inform SMG of any forecast problems that may affect delivery of the Trust Objectives.

4. RECOMMENDATIONS

4.1 The Trust Board is asked to note the current position, support the proposed changes, and is assured in regard to the effective management of the BAF.

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BOARD ASSURANCE FRAMEWORK

Updated Quarter 1

June 2013

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 and Timeframe	Assurance
Exec Lead/Risk Area		Initial	Current	Target		Positive Assurance	Gaps in Assurance		Movement
1a. Adverse clinical outcomes due to failure of reusable medical devices and equipment. Exec Director of Finance & performance		5 x 2 = 10	5 x 2 = 10	5 x 1 = 5	1) Cleric Fleetman records management system 2) Maintenance schedules 3) Procedural documents (Strategy, Maintenance of Medical Devices Policy and associated procedures) 4) Physical audit of all medical equipment 5) SIP team meeting weekly to review progress including maintenance, staffing and assurance	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	1a) Enhance performance monitoring linked to IPR, Dir F&P, **Dec 2013** 1b) Establish audit of activity and adherence to maintenance schedules, Dir F&P, **Dec 2013** 2) Collate evidence of tracking and recording equipment maintenance processes, Dir F&P, **Feb 2014**	**AMBER GREEN** ⟷

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 and Timeframe	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. NHSLA: 5: Ambulance Services CQC: 4: Care and welfare of people who use services 6: Cooperating with other providers 7: Safeguarding people who use services from abuse 12: Requirements relating to workers Exec Director of Operations	4 x 3 = 12	4 x 2 = 8	4 x 1 = 4	1) EOC procedures in place 2) Data flagging group is set up and functioning 3) Operational procedures which include the validation of existing lists	1) Incident reports to H&S Committee, bimonthly. 2) Incident reports to SMG, monthly. 3) Work is continuing with other agencies such as the Police 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.(CG) 2) Assurance reports to SMG and Quality Committee not yet in place. (AG)	1a) Monitor compliance with the Emergency Operations Centre procedures for management of data flags. **Aug 13** 1b) Continue pilot developments with police, probation and social services to support effective information sharing. **Dec 13** 2) Provide assurance reports on data flagging group activity to the Senior Management Group and Quality Committee. **July 13**	**AMBER GREEN** ↔

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 and Timeframe	Assurance
Exec Lead/Risk Area	Initial	Current	Target		Positive Assurance	Gaps in Assurance		Movement
2b. Reduced ability to evidence that patient care is of a sufficiently high standard, due to inadequate capacity to audit clinical practice NHSLA: 2: Learning from Experience 5: Ambulance Services CQC: 1: Respecting and involving people who use services 2: Consent to care and treatment 4: Care and welfare of people who use services 16: Assessing and monitoring the quality of service provision Exec Medical Director	4 x 3 = 12	4 x 3 = 12	4 x 3 = 4	1) Clinical audit procedural documents in place and assessed as Level 1 NHSLA compliant. 2) Established audit team in place under the leadership of Head of Clinical Effectiveness. 3) Processes for retrieval, scanning and verification of clinical data and records in place. 4) Established reporting procedures and mechanism for Clinical Performance Indicators, and Ambulance Quality Indicators.	1) Audit reports to NHS England (monthly) 2) Monitoring of audit activity by executive committees, SMG, TEG, Board via the IPR at each meeting, and a 6 monthly 'Deep Dive' by the Quality Committee. 1) Internal Audit annual plan includes monitoring and audit of processes relating to clinical audit 2) Positive external audit opinion on STEMI as part of the Quality Account	1) Time pressures on audit team to manage effectively 2) Functionality of scanning and verification software 3) Clinical audit is not embedded in everyday professional practice	1) Reconfiguration of the audit department and the implementation of ePRF. Head of Clinical Effectiveness, **Dec 13** 2) Development of functional scanning and verification solution, AD for ICT Mar 14 3a) Fully establish Clinical Leadership Framework, Dir of Ops, **Sep 13** 3b) support and encourage clinical audit as part of clinical education programmes, AD Education & Training, **Dec 13** 3c) reinforcing the importance of completing clinical audit within the operational environment, Head of Clinical Effectiveness, **Dec 13** 3d) Provision of information, training and support for clinical audit, Head of Clinical Effectiveness, **Mar 14** **NOTE:** ePRF is a long roll out project (3 year project 2016)	**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 and Timeframe	Assurance
Exec Lead/Risk Area	Initial	Current	Target		Positive Assurance	Gaps in Assurance		Movement
3a. Inability to deliver performance targets and clinical quality standards. NHSLA: 1: Governance CQC: 16: Assessing and monitoring the quality of service provision 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 2) On-going recruitment, education and training as part of the Workforce Strategy and Plan, 5 year Workforce Plan agreed. 3) AQIs and CPI's developed with national benchmarking 4) 2013/14 Training Programme agreed and established 5) Red1 delivery plan in place and monitored 6) Operational efficiency plan implemented as part of the Service Transformation Programme (STP)	1) Monthly IPR reports, including workforce KPI's to Trust Board, SMG and other executive groups. 2) Bi-monthly performance review group established. 3) STP dashboard reporting and monitoring in place 1) CQC Registration 2) Internal Audit review of training rated as substantial assurance. 3) NHSLA Level 1 assessment identified good workforce policy management. 4) NHS England positive benchmarking of AQI and CPI	1) Workforce skills and capacity not fully developed. 2) NHS 111 KPI's not fully adhered to. 3) Further work is needed to fully embed governance and performance management arrangements in all business units.	1) Implement Workforce Strategy and Training Plan, Dir Workforce & Strategy, **Mar 14** 2) Implement NHS 111 service optimisation and plan, and conclude NHS 111 pathway efficiency discussions with Commissioners, Dir S&C, **Oct 13** 3a) Implement Quality Governance action plan. Dir S&C, **Mar 14** 3b) Implement Risk and Safety Team work plans, Dir S&C, **Mar 14** 3c) Service Transformation Plan, Dir S&C, **Mar 14** 3d) Develop and monitor early warning indicators, Dir S&C, **Sep 13** 3e) Implement Clinical Leadership Framework, Dir of Ops **Dec 13** 3f) Implement service line management and reporting, Dir of Ops **Dec 13**	**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 and Timeframe	Assurance
Exec Lead/Risk Area	Initial	Current	Target		Positive Assurance	Gaps in Assurance		Movement
3b. Lack of compliance with key regulatory requirements (CQC, HSE, IGT, NHSLA) due to inconsistent application across the Trust. NHSLA: 1: Governance CQC: 16: Assessing and monitoring the quality of service provision Exec Director of Standards & Compliance	5 x 2 = 10	5 x 2 = 10	5 x 1 = 5	1) Procedural documentation in place 2) Inspections for Improvement process agreed 3) Project plan for NHSLA accreditation, including mock assessment developed 4) Clinical Quality Strategy and implementation plan in place 5) Quality Governance plan agreed including review of Francis recommendations	1) Compliance reports to Trust Board, SMG, and Quality 2) I4I Process positive findings from review 1) Internal audit report (SKL121111) re CQC compliance within CBU's. 2) CQC registration 2) IG Toolkit approved at Level 2 3) Deloitte Quality Governance Assessment. 4) HSE inspection reports. 5) NHSLA L1 achieved (9/10/12)	1) There has been a historical under-investment in management and leadership development, particularly in relation to NHS quality requirements. 2) 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. Implement Service Transformation Programme, Dir of S&C **Mar 14** 2a) Continue progress to NHSLA Level 1 risk management standards, Dir S&C **Mar 14** 2b) Implement Risk and Safety Team work plans, Dir S&C **Mar 14** 2c) Maintain and enhance the internal Inspections for improvement programme 2d) Maintain the focus on quality and compliance within performance management processes. Dir S&C **Mar 14** 2e) Implementation of Quality Governance action plan. Dir S&C **Mar 14** 2f) Development and implementation of performance and risk management processes within departments and CBUs. Dir of Finance & Performance, **Mar 14** 2g) Establish robust document management process, Dir S&C **Mar 14** 2h) Implement the Information Governance Work plan 2013/14, Dir S&C **Mar 14**	**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 and Timeframe	Assurance
Exec Lead/Risk Area	Initial	Current	Target		Positive Assurance	Gaps in Assurance		Movement
4a. Loss of income due to inability to secure/retain service contracts, adversely influencing future service commissioning intentions NHSLA: 1: Governance CQC: 16: Assessing and monitoring the quality of service provision 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) 3) PTS Transformation Programme (m) 4) Corporate Commercial team (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 3) The service has not met commissioner expectations. 4) There are inefficiencies in use of resources, leading to a historic inability to deliver performance and quality KPI's and desired patient experience	1a) Implementation of PTS Transformation Programme, Dir F&P, **Mar 14** 1b) Complete implement service line management and reporting in PTS, 111 and Private and Events, Dir F&P, **Mar 14**. 2a) Develop Trust Commercial and Business Development function, Dir F&P, **Dec 13**. 2b) Implement Stakeholder Engagement Plan. 3) Hold commissioner engagement event **Nov 13** 4) Contribute to regional and local improvement initiatives via Urgent Care Boards **Aug 13**.	**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 Standards & Compliance**	
Principal Risk Ref No:	Risk Score			Key Controls	Assurances on Controls	Gaps in Controls	Action to Address Gaps and Timeframe	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 NHSLA: 1: Governance CQC: 16: Assessing and monitoring the quality of service provision Executive Director of Standards & Compliance	5 x 4 = 20	5 x 4 = 20	5 x 2 = 10	1) TEG approved approach to staff engagement 2) Clinical Leadership programme agreed 3) Programme management of Service Transformation Programme (STP) 4) Quality Impact Assessment process in place 5) CIP Monitoring Group and progress tracker in place 6) CQUINS tracking through STP and IPR reports	1) Monthly IPR monitoring reports to TEG, Quality Committee (STP, dashboards)	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 4) Service line management is not yet fully embedded	1) Implement leadership development and service improvement skills programme as part of the STP, Dir Workforce Strategy, **Mar 14** 2a) Implement Service Transformation Programme, Dir of S&C **Mar 14** 2b) Implement Cost Improvement Programme management as a key part of overall programme management, Dir of Finance & Performance, **Mar 14** 3) Implement Staff Engagement and Communication Plan, and ICT strategy, Dir of Finance & Performance, **Mar 14** 4) Implement service line management and agreed process for Quality Impact Assessment of CIP Programmes, Dir of Finance & Performance, **Mar 14**	**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 Standards & Compliance**		
Principal Risk Ref No:	Risk Score			Key Controls	Assurances on Controls	Gaps in Controls	Action to Address Gaps and Timeframe	Assurance
Exec Lead/Risk Area	Initial	Current	Target		Positive Assurance	Gaps in Assurance		Movement
5b. Failure to learn from patient and staff experience and adverse events within the Trust or externally. NHSLA: 1: Governance 2: Learning from Experience CQC: 1: Respecting and involving people who use services 4: Care and welfare of people who use services 16: Assessing and monitoring the quality of service provision Exec Director of Standards & Compliance	4 x 2 = 8	4 x 2 = 8	4 x 1 = 4	1) Involvement in Health Watch and other patient groups) 2) Incident, Complaints and claims reporting policies and lessons learned processes in place. 3) Incident review group disseminates learning around lessons learned via clinical updates 4) Clinical case review process in place 5) Trust has support from an expert patient In place attending key Committees such as Quality Committee 6) Process for review of external inquiries and reports in place 7) Process for learning from Healthcare professional feedback in place (e.g. 111 online feedback form) 8) Risk management software systems are in place in support of the learning process	1) Significant events and lessons learned reports to Trust Board, SMG, Quality Committee and other executive groups. 2) Bi-weekly reports to incident review group 1) CQC assessment January 2013 2) Internal Audit report on Lessons Learned showed significant assurance, July 11 3) Audit Committee and Board review of Francis report, April/May 13 4) Board reports on learning from Hillsborough Independent Panel 5) Deloitte quality governance review	1) Further work is needed to embed learning processes aligned to corporate systems, at departmental level throughout the Trust. 2) Need to develop clinical audit capability 3) Need to enhance investigation process 4) Further work needed to support development of a professional caring culture.	1) Develop patient feedback and engagement in line with the Clinical Quality Strategy, and continue to develop review processes at department level, aligned to existing Trust systems, Dir S&C **Mar 14** 2) Implement the clinical audit plan, Medical Dir, **Mar 14** 3) Develop the investigation process, to include policy management, Dir S&C, **Dec 13** 4) Implement quality governance plan including relevant Francis report recommendations, Dir S&C, **Dec 13**	**AMBER GREEN** ↔

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 and Timeframe	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. NHSLA: 3: Competent & Capable Workforce CQC 14: Supporting workers 16: Assessing and monitoring the quality of service provision Exec Director of Operations	4 x 3 = 12	4 x 2 = 8	4 x 1 = 4	1) Clinical Quality Strategy and associated implementation plans signed off by Trust Board 2) Appointment of clinical supervisors by robust process of recruitment and selection. 3) Bradford University CL programme in place and staff are attending. 4) Clinical leadership dashboard being monitored by the Clinical Leadership Project Group 5) Clinical leadership project group in place 6) Action plan developed and monitored via OMG	1) Performance reports to Quality Committee bimonthly. 2) CL Dashboard monitoring at CL project group 1) Bradford University CL programme evaluation. (Ext)	1) There remains under-investment in management and leadership development. To be addressed by the STP 2) Recruitment to vacancies not taking place as they arise.	1) Monitor and ensure completion of the CL Framework action plan by the OMG, to be monitored by TEG and Quality Committee until completion. **Dec 13** 2) TEG approved recruitment mitigation actions in respect of recruitment and training resource requirements. **July 13** (see 6b)	**AMBER GREEN** ↔

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 and Timeframe	Assurance
Exec Lead/Risk Area	Initial	Current	Target		Positive Assurance	Gaps in Assurance		Movement
6b. Adverse impact on clinical outcomes and operational performance due to inability to deliver the A&E workforce plan and associated recruitment and training requirements. NHSLA: 3 Competent & Capable Workforce CQC: 13 Staffing 14 Supporting workers 16 Assessing and monitoring the quality of service provision Deputy Chief Executive and Executive Director of Workforce & Strategy	5 x 3 = 15	5 x 3 = 15	5 x 1 = 5	1) Clear and prioritised business plan for Workforce & Strategy Directorate to ensure staff focus on the key areas has been agreed. 2) Agreed Workforce plan is agreed and in place. 3) Continued focus and monitoring of the workforce plan requirements and delivery with UNISON through the Joint Steering Group meetings. 4) Approved and costed Annual Education & Training Plan is agreed and in place.	1) Board level monitoring of progress via Integrated Performance Report and Quality Committee. PA 2) Workforce Governance Group Monitoring delivery of Workforce Plan, including both recruitment and training elements. 3) STP/TEG monitoring of key post recruitment activity.	1) Potential for inadequate resource levels within Workforce & Strategy to deliver necessary recruitment and training activity. 2) Potential for inadequate candidates of sufficient quality to deliver the required numbers to achieve 100% establishment levels within A&E. 3) Local industrial action affects the reputation of the Trust as an employer. 4) Abstraction levels for training not delivered by the Operations Directorate.	1) TEG approved recruitment mitigation actions in respect of recruitment and training resource requirements. **July 13** 2) Implementation of Values Based Recruitment Assessment Centre approach to improve efficiency and effectiveness of high volume recruitment. Positive work to increase candidate attraction being undertaken via regional jobs fairs. **Sep 13** 3) Local industrial action effectively managed via a collaborative approach between Operations, HR and Corporate Communications, with well-developed business continuity and resilience plans in place. **July 13** 4) Abstraction management and recruitment and training issues controlled on a weekly basis via HR and OE&E attendance at Operations Management Group meeting. **Sep 13**	**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 and Timeframe	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. NHSLA: 5: Ambulance Services CQC: 16: Assessing and monitoring the quality of service provision Exec Director of Operations	5 x 3 = 15	5 x 2 = 10	5 x 1 = 5	1) Range of risk assessments in support of Resilience plans 2) Business Continuity Plans monitored and reviewed annually and exercised periodically 3) All MAJAX/Specific resilience plans undergo a testing schedule and effectiveness is monitored 4) BC Resilience Board meets regularly to review BC planning	1) Monitoring of business continuity plans in Executive groups. 2) Monthly IPR to Board 3) BC sessions delivered to Board Development meetings and reported monthly in IPR 1) 20 Business Continuity Plans live tested, and deemed efficient. (Ext)	1) All departmental business continuity plans need to be live tested 2) Appropriate training programmes not completed	1) Test all business continuity plans**. Dec 13** 2) Implement training programme for business continuity leads and key staff. **Dec 13**	**AMBER RED** ↔

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 and Timeframe	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 meet the requirements of the 111 service contract NHSLA: 1: Governance 5: Ambulance Services CQC: 16: Assessing and monitoring the quality of service provision Exec Director of Standards & Compliance	5 x 3 = 15	5 x 3 = 15	5 x 1 = 5	1) Established service delivery team in place 2) Appropriately educated workforce recruited and trained in support of objectives 3) Procedural documentation in place including SOP's 4) Support from the Corporate contract management team is in place	1) Established contract monitoring arrangements 2) Bi-monthly monitoring by Quality Committee and Finance & Investment Committee 3) Daily Sit Rep report monitored by 111 project board	1) Resources required to support contract specification excess to budgeted establishment 2) Complexities in the wider health system impacting negatively on KPI delivery	1a) Implement service optimization plan Dir S&C **Oct 13** 1b) Review service expenditure and identify in year opportunities for cost savings/secure 111 income, Dir S&C **Sep 13** 1c) Complete West Yorkshire Urgent Care Capacity review with Commissioners, Dir S&C, **Sep 13** 2) Continue to work with Commissioners to address known wider system challenges, Dir S&C, **Mar 14**	**AMBER RED** ⟷

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 and Timeframe	Assurance	
Exec Lead/Risk Area	Initial	Current	Target		Positive Assurance	Gaps in Assurance		Movement	
8b. Deficit against planned financial outturn e.g. due to significant overspending on the provision of Patient Transport Services, 111 service and A&E service. NHSLA: 1: Governance CQC: 16: Assessing and monitoring the quality of service provision Executive Director of Operations	5 x 4 = 20	5 x 4 = 20	5 x 2 = 10	1) Procedures regarding levels of sign off and expenditure - organisational cost control are in place 2) Monthly budget monitoring between finance, senior and operational managers. 3) Authorisation procedures for contractor spend.	1) Monthly review by the Board through Integrated Performance Report 2) Bimonthly F&I committee review 3) CIP group monitoring led by the CEO	1) The authorisation procedure for contractor spend, although developed needs to be applied consistently across all areas 2) Full financial implications not yet realised as some aspects of the operational business are not yet fully operational		AMBER RED