Yorkshire Ambulance Service NHS
NHS Trust

MEETING TITLE Public Board Meeting		**MEETING DATE** 26 November 2013	
TITLE of PAPER	Board Assurance Framework (BAF) and Corporate Risk Report (CRR)	**PAPER REF**	5.5
STRATEGIC OBJECTIVE	All		
PURPOSE OF THE PAPER	To provide assurance to the Trust Board that the Board Assurance Framework has been peer reviewed, and processes are in place or planned to ensure that the actions are monitored and updated towards completion within agreed timescales, and to provide information around the identified strategic risks escalated from the Risk Management processes within the Trust.		
For Approval	☐	**For Assurance**	☒
For Decision	☐	**Discussion/Information**	☐

AUTHOR / LEAD	Mark Hall, Associate Director for Risk & Safety	**ACCOUNTABLE DIRECTOR**	Executive Director of Standards & Compliance

DEBATED AT:	**Committee/Group:** Audit Committee Senior Management Group Quality Committee	**Date:** 17/10/2013 06/11/2013 12/11/2013
PREVIOUSLY AGREED AT:	**Committee/Group:** Audit Committee Senior Management Group Quality Committee	**Date:** 17/10/2013 06/11/2013 12/11/2013
RECOMMENDATION	It is recommended that the Trust Board notes the key risks outlined in the report and is assured with regard to the risk management processes and action.	

RISK ASSESSMENT	**Yes**	**No**
Corporate Risk Report and/or Board Assurance Framework amended *If 'Yes' – expand in Section 4. / attached paper*	☒	☐
Resource Implications (Financial, Workforce, other - specify) *If 'Yes' – expand in Section 2. / attached paper*	☐	☒
Legal implications/Regulatory requirements If 'Yes' – expand in Section 2. / attached paper	☒	☐
Quality and Diversity Implications If 'Yes' – please attach to the back of this paper	☐	☒

ASSURANCE/COMPLIANCE	
Care Quality Commission Registration Outcome(s)	16: Assessing and monitoring the quality of service provision
NHSLA Risk Management Standards for Ambulance Trusts	1: Governance

1.0 PURPOSE/AIM

1.1 To provide assurance to the Trust Board that the Board Assurance Framework (BAF) for the financial year 2013 – 2014 has been updated following peer review and to validate that the Audit Committee support the progress toward achievement of the objectives.

1.2 To present High Level Trust Committees with the high level risks identified via the Risk Management processes within the Trust, that have been escalated from Incident, Risk Assessment, Risk Register, and Committee/Group management of risk.

2.0 BACKGROUND/CONTEXT

2.1 The Quarter 1 BAF was updated and agreed through the July round of Trust High Level Committees. The Quarter 2 BAF is presented during the October round following closure of Quarter 2 data collection. The updated Quarter 2 BAF is shown from page 4.

2.2 The strategic objectives on the BAF are underpinned by Risk Registers and high level risks from other sources, and these are used to support the key objectives of the business panning cycle and Annual Governance Report as described within the Risk Management Strategy.

2.3 Good progress has been made in migrating risk registers into the Datix system and work is now continuing to validate and align all risk register entries.

3.0 PROPOSALS/NEXT STEPS

3.1 The next steps are to review processes that support the rolling programme of monitoring and update of the BAF and Trust Risk Management processes to ensure that high level risks are mitigated or managed with the approval of the high level Committees and the Board.

3.2 The Trust's Risk Register process requires that the full Risk Registers are considered by the Board annually. For reference between the formal annual review, ***there is a hyperlink to the full Datix risk register on page 26 of this report.*** Please return any comments or observations on the entries and issues captured here to the Associate Director for Risk & Safety.

4.0 RECOMMENDATIONS

4.1 It is recommended that the Trust Board notes the key risks outlined in the report and is assured with regard to the risk management process and action.

5.0 APPENDICES/BACKGROUND INFORMATION

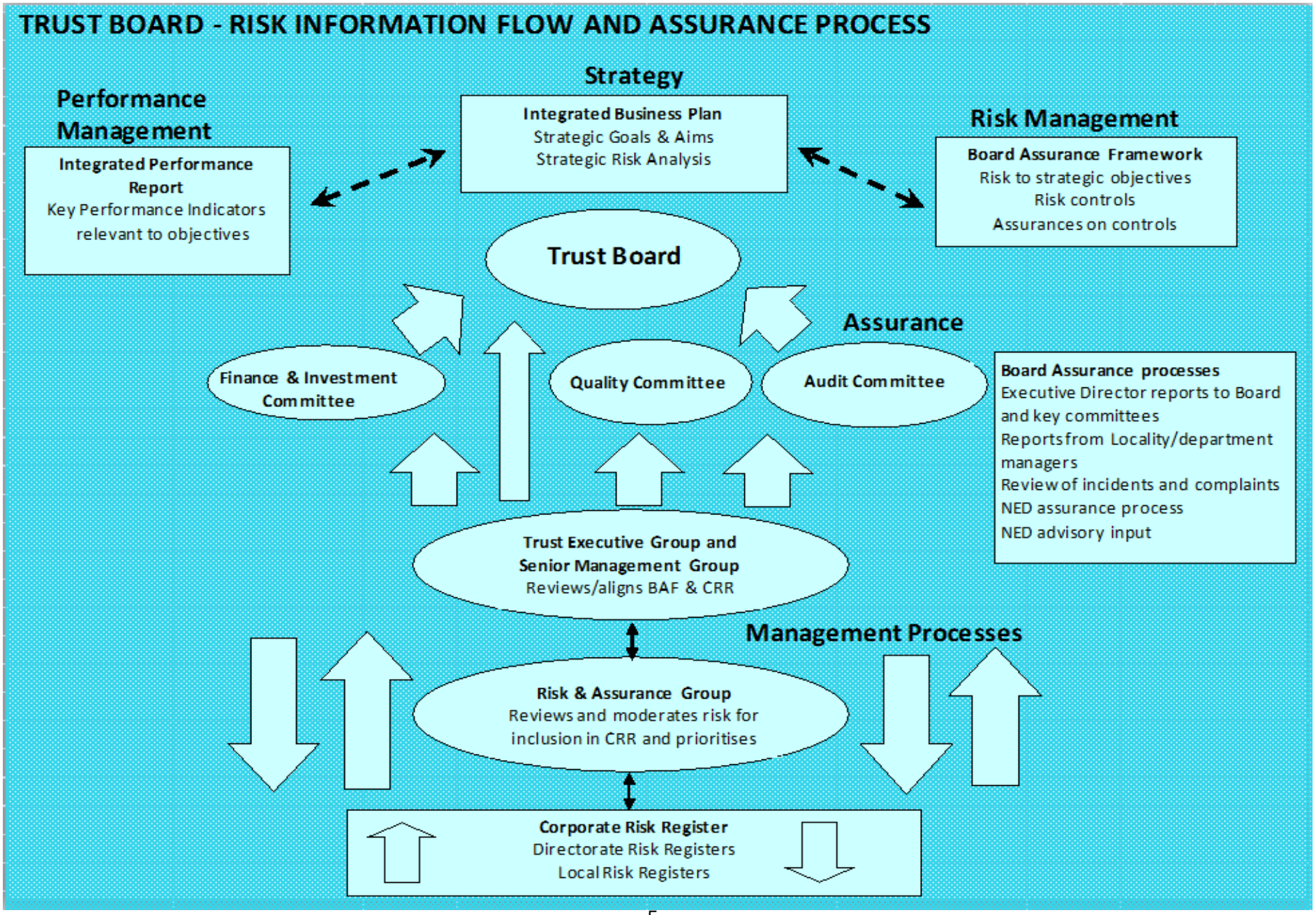
Appendix 1: **Table 4:** High Level risks identified during Quarter 2.

Appendix 2: Strategic Risk Register detail.

Yorkshire Ambulance Service NHS
NHS Trust
An Aspirant Foundation Trust

BOARD ASSURANCE FRAMEWORK

Quarter 2 - 2013/2014


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 2013/2014. They form the basis of the Trust's Integrated Business Plan 2012-2017 and the Annual Business Plan for 2013-14.

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

Table 1: showing progress toward Objectives from initial risk grading through to Q2. (There has been little movement in the risk grading between Q1 and Q2 as this is a broad spectrum, however progress has been made toward the objectives, and strengthening action plans (see progress notes))

Objective	Risk Description	Q1 Grading	Risk Movement	Q2 Grading	Progress Notes
1a	Adverse clinical outcomes due to failure of reusable medical devices and equipment.	10	⇔	10	The recent review of the Medical Devices Policy and procedures in place, led to a refocus of the key gaps and 2 new actions were added in relating to recruitment to professional positions. On balance the new controls were added and new actions meaning that t was agreed to keep this graded as 10
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.	10	⇩	8	Review of this objective with the lead highlighted that new controls had been added as some actions were completed and became controls, hence the improvement in risk rating
2b	Reduced ability to evidence that patient care is of a sufficiently high standard, due to inadequate capacity to audit clinical practice	12	⇔	12	Following peer review this objective has been significantly strengthened, although the key function of clinical audit remains a significant concern, therefore the risk rating remains the same
3a	Inability to deliver performance targets and clinical quality standards.	15	⇔	15	The mapping across the framework has improved for this objective, however there are some large pieces of work that may take until year end or beyond to complete relating to workforce & strategy and CLF action plans
3b	Lack of compliance with key regulatory requirements (CQC, HSE, IGT, NHSLA) due to inconsistent application across the Trust.	10	⇔	10	As these are full year compliance plans an improvement in risk score will not be apparent until year end, although IGT has improved following an internal audit significant assurance, as has HSE with significant assurance
4a	Loss of income due to inability to secure/retain service contracts, adversely influencing future service commissioning intentions	16	⇔	16	This objective includes the PTS transformation programme and is therefore a longer term objective, improvement in risk grading may not be seen until Q4
5a	Inability to deliver service transformation and organisational change, including non-delivery of cost improvement programmes	20	⇔	20	This objective includes the Service Transformation programme and CIP programme and is therefore a longer term objective, improvement in risk grading may not be seen until Q4
5b	Failure to learn from patient and staff experience and adverse events within the Trust or externally.	8	⇔	8	4 of the 8 actions from Q1 have been achieved, and controls have increased, however it was agreed at peer review that the risk grading remains the same at this time as clinical audit has not yet been fully implemented as an internal review tool for quality
6a	Adverse impact on clinical outcomes due to failure to embed the clinical leadership framework.	8	⇔	8	6 of the 8 actions from Q1 have been achieved, and controls have increased, however it was agreed at peer review that the risk grading remains the same at this time as the CLF is yet to be realised
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.	15	⇔	15	At peer review this objective was significantly strengthened, however the recruitment and workforce plan and abstraction management remain high risk
7a	Adverse impact on organisational performance and clinical outcomes due to significant events impacting on business continuity.	10	⇔	10	It is expected that this objective will reduce to green in the next review due to the current testing of resilience plans that had not taken place by Q2
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	15	⇔	15	It was expected that this risk would remain the same by Q2 as most of the Urgent Care and surge planning is geared towards Q3 and Q4, and 111 service optimization plan is in progress
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.	20	⇔	20	Although progress has been made and controls increased with actions being achieved, remains high risk due to the implications of 8a above

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	Internal Assurance	Gaps in Controls and/or Assurances	Action to Address Gaps and Timeframe
Exec Lead/Risk Area	Initial	Current	Target		External Assurance		
1a. Adverse clinical outcomes due to failure of reusable medical devices and equipment. NHSLA 4: Safe Environment CQC 11: Safety, availability and suitability of 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 automated on Cleric 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 Vehicle & Equipment Group. 2) Monthly reports to SMG 3) Tracking of KPIs in the IPR 1) Internal Audit progress report to Quality Committee 2) NHSLA L1 Report	1) Robust audit of activity and adherence to maintenance schedules 2) Complete the restructure of the Medical Devices Team and process review	1a) Enhance performance monitoring linked to IPR, Dir F&P, **Dec 13** 1b) Collate evidence of tracking and recording equipment maintenance processes, Dir F&P, **Feb 14** 2a) Complete the recruitment processes to strengthen the management resource, Dir of F&P, **Mar 14** 2b) Complete a review of audit and maintenance processes prior to the management recruitment process completion, Dir of F&P, **Oct 13**

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	Internal Assurance	Gaps in Controls and/or Assurances	Action to Address Gaps and Timeframe
Exec Lead/Risk Area		Initial	Current	Target		External Assurance		
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 2) Assurance reports to SMG and Quality Committee not yet in place	1a) Monitor compliance with the Emergency Operations Centre procedures for management of data flags, Dir of Ops, Aug 13 **Oct 13** 1b) Continue pilot developments with police, probation and social services to support effective information sharing, Dir of Ops, Dec 13 **Oct 13** 2) Provide assurance reports on data flagging group activity to the Senior Management Group and Quality Committee, Dir of Ops, July 13 **Oct 13**

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	Internal Assurance	Gaps in Controls and/or Assurances	Action to Address Gaps and Timeframe
Exec Lead/Risk Area		Initial	Current	Target		External Assurance		
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 audit account 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	1a) Reconfiguration of the audit department and the implementation of ePRF. Head of Clinical Effectiveness, **Dec 13** 1b) Maintain staffing capacity to deliver required scanning/verification pending implementation of new IT solution Head of Clinical Effectiveness Mar 14 2) Development of functional scanning and verification solution, AD for ICT **Mar 14** 3a) Fully establish Clinical Leadership Framework, Dir of Ops, Sep 13 **Mar 14** 3b) support and encourage clinical audit as part of clinical education programmes, AD Education & Training, Dec 13 **Mar 14** 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)

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	Internal Assurance	Gaps in Controls and/or Assurances	Action to Address Gaps and Timeframe
Exec Lead/Risk Area		Initial	Current	Target		External Assurance		
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) 7) Early warning indicators developed and monitored	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. 4) Red performance plan requires updating	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 **Mar 14** 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) Implement Clinical Leadership Framework, Dir of Ops Dec 13 **Mar 14** 4) Agree and implement Red plan, Dir of Ops **Nov 13**

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	Internal Assurance	Gaps in Controls and/or Assurances	Action to Address Gaps and Timeframe
Exec Lead/Risk Area	Initial	Current	Target		External Assurance		
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 3) IG Toolkit approved at Level 2 4) Deloitte Quality Governance Assessment. 5) HSE inspection reports. 6) 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 including actions arising from July CQC inspection. 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**

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	Internal Assurance	Gaps in Controls and/or Assurances	Action to Address Gaps and Timeframe
Exec Lead/Risk Area		Initial	Current	Target		External Assurance		
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 2) Weekly Contracting and Commissioning Team meetings 3) PTS Transformation Programme 4) Corporate Commercial team 5) Coordination of Urgent Care Board representation 6) Implementation of service line management 7) Service Line management implemented in P&E 8) Senior Managers contribute to regional and local improvement initiatives via Urgent Care Boards	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 2) New business from Urgent Care Boards	1) Further work is needed to develop managerial and leadership capability and capacity 2) There is a complex Commissioner landscape undergoing significant change and the Trust needs to ensure active engagement with new commissioners and other stakeholders 3) The PTS and 111 services have not met commissioner expectations. There are inefficiencies in the use of resources, leading to a historic inability to deliver performance and quality KPI's and desired patient experience	1a) Implementation of PTS management review, Dir F&P, **Mar 14** 1b) Complete the implementation of service line management and reporting in PTS and 111, Dir F&P, **Mar 14** 2a) Develop Trust Commercial and Business Development function, Dir F&P, **Dec 13** 2b) Implement Stakeholder Engagement Plan, Dir P&E, **Dec 13** 3a) Hold commissioner engagement events beginning Oct 13, Dir F&P **Nov 13** 3b) Complete the PTS Transformation project, Dir F&P **Mar 14** 3c) Complete the 111 Service Optimisation Plan, Dir S&C **Mar 14**

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	Internal Assurance	Gaps in Controls and/or Assurances	Action to Address Gaps and Timeframe	
Exec Lead/Risk Area	Initial	Current	Target		External Assurance			
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**	

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	Internal Assurance	Gaps in Controls and/or Assurances	Action to Address Gaps and Timeframe	
Exec Lead/Risk Area	Initial	Current	Target		External Assurance			
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, Med Dir, Dec 13 **review Mar 14**	

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	Internal Assurance	Gaps in Controls and/or Assurances	Action to Address Gaps and Timeframe
Exec Lead/Risk Area		Initial	Current	Target		External Assurance		
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) Action plan developed and monitored via OMG	1) Performance reports to Quality Committee 5 times a year 1) Bradford University CL programme evaluation	1) Lack of positive assurance from dashboard/staff feedback that the CLF is functioning consistently 2) Recruitment to vacancies not taking place as they arise	1) Monitor dashboard ad staff feedback via TEG and Quality Committee, Dir of Ops, Dec 13 **Mar 14** 2) TEG approved recruitment mitigation actions in respect of recruitment and initial training resource requirements, Dir of Ops, July 13 (see 6b) **Oct 13**

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	Internal Assurance	Gaps in Controls and/or Assurances	Action to Address Gaps and Timeframe
Exec Lead/Risk Area		Initial	Current	Target		External Assurance		
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) STP/TEG/SMG monitoring of key post recruitment activity. 3) Monitoring via Directorate Management Group. 1) Positive feedback from NHS employers observers on value based recruitment process.	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. Dir W&S, **Review Dec 13** 2a) 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. Dir W&S, **Review Dec 13** 2b) Review of recruitment materials. Dir W&S **March 14** 2c) Implementation of new occupational health service. Dir W&S **March 14** 2d) Recruitment of Well-being Advisor, Dir W&S **Dec 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. Dir W&S **Dec 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. Dir W&S **Dec 13**

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	Internal Assurance	Gaps in Controls and/or Assurances	Action to Address Gaps and Timeframe	
Exec Lead/Risk Area	Initial	Current	Target		External Assurance			
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. (e.g. Osprey)	1) All departmental business continuity plans need to be live tested 2) Appropriate training programmes not completed 3) Lack of clarity on external escalation processes, surge planning in new health systems	1) Test all business continuity plans**,** AD Resilience**, Dec 13** 2) Implement training programme for business continuity leads and key staff, AD Resilience **Dec 13** 3) Engagement with Urgent Care Boards, NHSE, Resilience leads to agree system response, AD Resilience**, Dec 13**	

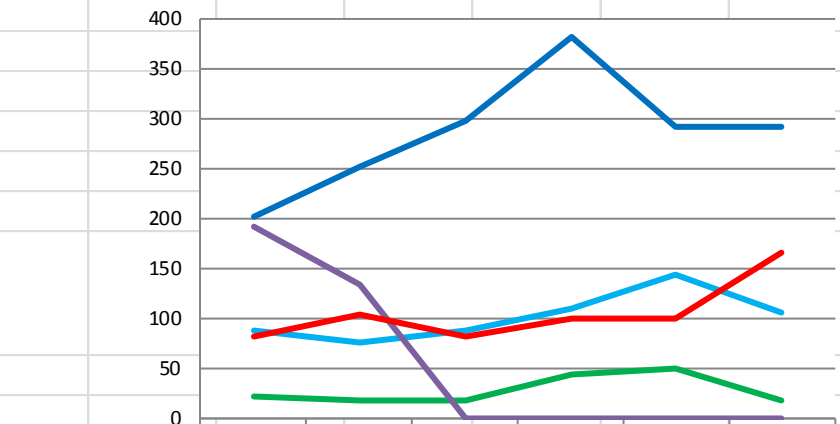
STRATEGIC GOAL: VALUE FOR MONEY AND PROVIDER OF CHOICE								
Ref No:	**Strategic Objective 8: To provide cost-effective services that contribute to the objectives of the wider health economy.**							**Objective Owner: Director of Finance & Performance**
Principal Risk Ref No:		Risk Score			Key Controls	Internal Assurance	Gaps in Controls and/or Assurances	Action to Address Gaps and Timeframe
Exec Lead/Risk Area		Initial	Current	Target		External Assurance		
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 5) West Yorkshire Urgent Care Capacity review with Commissioners completed	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) Continue to implement service optimization plan Dir S&C Oct 13 **Mar 14** 1b) Review service expenditure and identify in year opportunities for cost savings/secure 111 income, Dir S&C Sep 13 **Oct 13** 1c) Resolve in year financial discussions with Commissioners and sub-contractors, Dir S&C **Oct 13** 1d) Review performance plan for 2013/14 with Commissioners and sub-contractors Dir S&C **Mar 14** 2) Continue to work with Commissioners to address known wider system challenges, Dir S&C, **Mar 14**

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	Internal Assurance	Gaps in Controls and/or Assurances	Action to Address Gaps and Timeframe	
Exec Lead/Risk Area	Initial	Current	Target		External Assurance			
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 Finance & Performance Executive Director of Standards & Compliance 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) F&I committee review 3) CIP group monitoring led by the CEO	1) Plan for delivery of financial outturn requires mid-year review	1a) PTS A&E, develop Q3/4 plan showing resource and budget outcome and CIP delivery, Dir F&P, **Oct 13** 1b) 111 develop Q3/4 plan showing resource and budget outcome and CIP delivery agree with Commissioners regarding volume and income payment, Dir S&C, **Oct 13** 1c) A&E, develop Q3/4 plan showing resource and budget outcome and CIP delivery, Dir of Ops, **Oct 13**	

COMPARISON OF TRUST RISKS

As part of the work to strengthen the coherence of risk management processes throughout the Trust it is important to look across the risks identified on the BAF and Trust Risk Registers compared to incident reports recorded on DATIX as well as Serious Incident themes.

Datix Reports - Overview



	April	May	June	July	August	September
Incident	203	253	298	382	293	293
Issue/Concern	88	75	87	110	144	105
Near Miss	22	18	17	43	50	17
Uncoded	192	134	0	0	0	0
Harm Caused	81	104	81	99	100	166

These figures show that on average, 470 incidents have been reported per month since Datix went live on March 25th 2013. The number of actual Incidents has increased which is a good indicator of a positive safety culture, with Near Misses, and Issues/Concerns being more accurately coded, and zero uncoded from June onwards.

Risks

Overall reporting (including issues and near misses) figures have decreased possibly as the 111 service has bedded in. The desired pattern of reporting would be increased reporting of Incidents with reduced harm and a reduction in Serious Incidents. YAS is showing a satisfactory profile.

Mitigating Actions

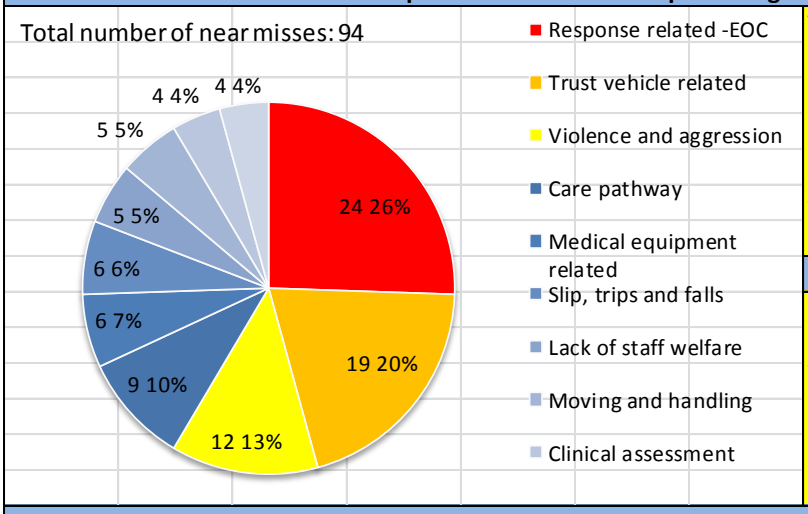
- Discussions are underway regarding the extension of the Datix telephone reporting system to a 24 hour phone line or automated system.
- Toughbook availability could be expanded so that incidents can be reported immediately rather than hours after a shift.
- A Clinical Supervisor (CS) has tested Datix on his Toughbook and reported back that this works well, although other solutions are also being sourced.

Further Recommendations

- Quarter 1, 2013 and Quarter 2, 2013 comparative analysis to be carried out and reported to High Level Committees.
- Evaluation of the Toughbook pilot by the CS to be reviewed, and other solutions including 24/7 phone lines to continue.

Top reported incident and severity categories on DATIX during Q2

Datix Reported Near Misses - Top 10 Categories



The highest category of near miss incidents is EOC response related accounting for 29% of those reported. Care pathways near misses are closely behind this while the other categories are fairly evenly split.

Risks

Potential for a large number of EOC response related incidents if the near misses aren't acted on appropriately.

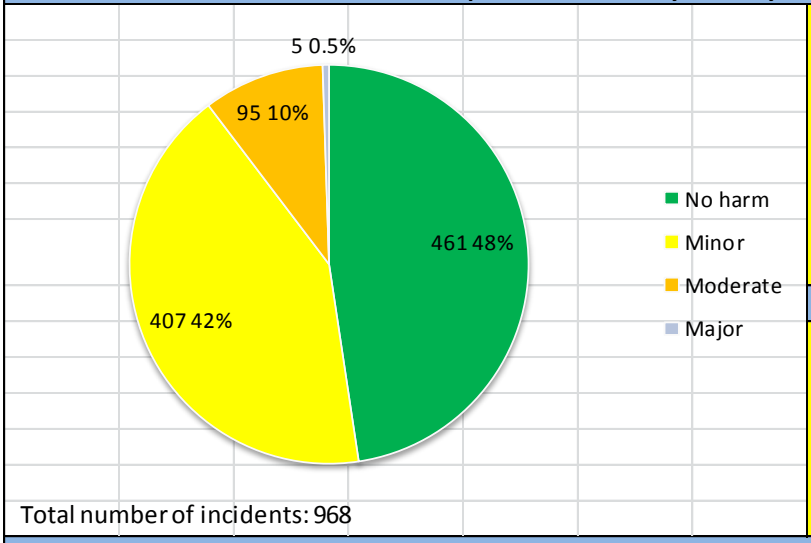
Mitigating Actions

• EOC have a Governance team responsible for monitoring all EOC related incidents and implementing adequate interventions to learn from these.

Further Recommendations

• A full incident and near miss breakdown with analysis will be provided to EOC Locality Board on a quarterly basis to ensure they understand the themes and trends arising from the incidents reported.

Datix Reported Incidents by Severity



As we would hope to forecast, the majority of incidents within YAS are graded as causing negligable levels of harm to those affected. We would hope to see this profile continue with an associated decrease in those incidents categorised as catastrophic and major.

Risks

•Incorrect coding of incidents at source and at manager review leading to external reporting to the NRLS of Catastrophic and Death categories that are not accurate.

Mitigating Actions

• Awareness campaigns throughout stations highlighting the importance of reporting incidents, even if they are of negligable harm to others - this includes near misses and issues/concerns.
• Further analysis by the R&S Team and quality checks to analyse the data and ensure accurate external reporting
• Datix headings have been included to capture incidents, near misses, and issues, to enable more accurate analysis of data.

Further Recommendations

• The Risk & Safety Team will continue to report on severity of incidents to committees and groups across the Trust.

Table 2: Serious Incidents themes and trends analysis (Q1 April - Jun2013 – Q2 Jul - September 2013)

This data analysis comprises 15 SI's in total reported in Q1 and Q2.

SI Heading	Theme / Trend	Key Actions taken
Falls (A&E and PTS)	3 SI's reported in Q2 related to falls within vehicles both PTS and A&E. A similar number were reported in Q1. Investigations have shown that staff were not securing patients correctly using the four-point safety harness. Analysis has also shown that these harnesses were not always in place on the vehicles as staff were removing them. An issue arising in PTS related to patients refusing to be secured and a lack of guidance for staff around the correct process to follow should this happen.	• Harnesses replacement roll out commenced across the Trust. Ops directive issued that harnesses must not be removed. • Recommendation made to Vehicle and Equipment Group and Operations Management Group to consider a new harness that is more user-friendly. • Guidance being reviewed for staff in the event that a patient refuses to be secured.
Delayed response	A number of delayed response incidents were reported at the start of 2013 prompting action to be taken. These incidents ranged from staff failing to pick up on priority symptoms, resources not being allocated promptly, and failure to adhere to policy.	• Head of Service Delivery commenced in post, amended rota plan across EOC and aligned all EMDs and dispatchers to 'teams' with a team leader responsible for each area. • Overall sickness rates have dropped across EOC allowing the service to run at normal capacity. • Time-out sessions introduced to allow for EMDs and dispatchers to have refresher training and become familiar with new procedures.
111	During Q1 and Q2 a total of five 111 SI's were reported. Two of these were Adastra failings and not SI's for YAS however the Trust agreed to lead on these to ensure appropriate action was taken. The other 3 occurred in the early stages of the service launch with call takers new to the role and processes requiring minor amendments. These have since been corrected and further training has taken place with call takers and no SI's of a similar nature have occurred since April.	• Improved audit systems introduced. • Mentorship and refresher training in place for call takers. • Increased staffing levels since introduction of service
A&E	3 SI's were reported relating to the A&E Operational service at YAS during Q1 and Q2. One of these has now been transferred to South Tees NHS FT. One relates to an allegation against staff, and one related to the sudden deterioration of a child. All were individual in nature and are being dealt with through the individuals and any themes being fed into training.	• Review of paediatric skills across the Trust. • Review of structured clinical handovers across the Trust. • Themes and issues shared with Education and Training for future course development

Table 3: This table is currently under development and when populated will look across the key high risk themes common to risk identification processes within the Trust to allow an overview of those top risks that may present strategic challenges for further consideration.

	BAF	High Level Risk Registers	SI's	Incidents	Near Misses	Issues/Concerns
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						

Appendix 1

TRUST HIGH LEVEL RISK SUMMARY FROM RISK REGISTERS

Table 4: In future reports this section will summarise those high level risks identified during the Quarter, where the risk forecast suggests a need for the high level Committees to review the proposed action plans. This section has not been completed in this report, pending completion of the current risk register review and Director sign-off process.

TOP HIGH LEVEL RISKS IDENTIFIED FROM THE TRUSTS RISK REGISTERS ON DATIX	
Risk description	**Current status**

The FULL Risk Register for YAS can be viewed in PDF format at the following link:

\\swkvmstorage.yas.nhs.uk\Departmentalshares\Regulatory Compliance\YAS Procedural Documents

High Level Risk Register detail

(These risks have been identified as 'Strategic' on the Datix Risk Register Module; all others are identified as 'Operational')
Work is continuing to validate all risk register entries to Datix to ensure consistency of grading, clarity of risk assessments and action.

ID	Directorate	Specialty	Description	Controls in place	Adequacy of controls	Gap in controls	Actions	Risk level (initial)	Risk level (current)	Risk level (Target)
119	Corporate Affairs	Corporate Legal Services	Hillsborough-adverse publicity/loss of reputation due to the publication of the Panel report and subsequent legal processes	Focus on early identification of potential adverse media through case management. Extensive liaison with Corporate Comms for advice/management of media. Appropriate high level awareness within YAS through Exec/NED membership of Hillsborough Team.	Adequate	Lack of control over external media and high likelihood of sensational journalism.	Media review and engagement tabled at monthly meetings. Corp Comms/Legal reactive updates in timely manner.	High Risk	High Risk	High Risk
121	Corporate Affairs	Corporate Legal Services	Hillsborough-adverse verdicts from new inquests ordered by High Court	Robust internal inquest management process and established cross directorate working on inquests. YAS Hillsborough Team established based on expertise. Focus on early analysis of issues, evaluation of current practice, consideration of content of PFD submission.	Adequate	Unprecedented database of document disclosure creating difficulties in managing knowledge/identifying issues	Constant review of workload and workflow on analysis of documents.	High Risk	High Risk	High Risk

120	Corporate Affairs	Corporate Legal Services	Hillsborough-organisational and individual criminal prosecutions due to Criminal and IPCC investigations	External process, evidentially documentation has been preserved. Lawful and proportionate disclosure taken place. Open dialogue with Operation Resolve. Early information requested on status of witnesses. Staff support programme in development.	Adequate	Decision for criminal prosecution lies outside YAS control	Maintain dialogue with Operation Resolve. Formation of defence in event of prosecution	Moderate Risk	Moderate Risk	Moderate Risk

ID	Directorate	Specialty	Description	Controls in place	Adequacy of controls	Gap in controls	Actions	Risk level (initial)	Risk level (current)	Risk level (Target)
261	Finance and Performance	Business Development	Adverse impact on financial service delivery due to competitive tendering and loss of associated business.	Major tender assurance process Finance and Investment Committee scrutiny TEG review SMG review Weekly review of tenders within the wider external market	Adequate	External meetings with commissioners/urgent care boards due to the high number of meetings, means that information collation, and intelligence around risks to core business is difficult to manage.	Improve Commissioner and YAS communications New process for reviewing potential tender opportunities Ensure that all Associate Directors and 'Head's of' are aware and complying with the major tender assurance process. Re-introduction of the Intelligence Register to store centrally all information on threats and new service developments.	Extreme Risk	Extreme Risk	High Risk

							Develop Business Intelligence 'drop in' sessions to work with all service lines to gather key contracting information			
262	Finance and Performance	Business Development	Adverse impact on finances due to ineffective contract management through lack of capacity within the Business Development team	Standing Financial Instructions in place Weekly review of tenders within the wider external market	Inadequate	Current staffing levels mean that there is no back fill or contingency to cover the main contracts for the organisation. This means that key contractual documents can be missed and risk to timely responses which may cause financial penalties.	Weekly discussions with Exec Director of Finance and Performance on contracting issues/status updates Monthly meetings with key operational Directors/contract leads to ensure full engagement and awareness of contractual risks Consistent and robust contract monitoring Regular contract performance review meetings with commissioners and DoF/Ops lead to ensure more robust contract management Review the Business Development structure and appoint a Business Development Manager for one year fixed term.	High Risk	High Risk	High Risk

							Work with Service Transformation Programme Team to manage tender and bid writing processes Regular meetings with finance team (Income and Expenditure)			
263	Finance and Performance	Business Development	Loss of income and potential loss of staff due to the decommissioning of GP Urgent work in to Sheffield Teaching Hospitals booked via the Bed Bureau in Sheffield.	Engagement with commissioners to improve communication Legal position sought to ensure YAS in an informed position if faced with same risk.	Uncontrolled	Clinical Commissioning Groups (CCGs) are now entering in to dialogue with private providers and are able to commission services where they see fit. Legal position may not cover demand that is over activity levels - but would have become baseline contracted activity in the following year Inability to meet with 23 CCGs on a regular enough basis to ensure dialogue is kept open as there are not enough staff to cover this level of activity on top of contracting meetings.	Head of Business Development to attend three locality contract meetings and the main contract board to ensure consistent messages and pick up on early warning indicators of potential tenders / risks to core business. Legal opinion sought to enable better positioning prior to action being taken by commissioners. Increased focus on performance management and monitoring to understand pressures in under performing CCGs and set up targeted meetings.	High Risk	High Risk	High Risk

102	Finance and Performance	Finance	Capacity in the finance team to support Business Development re: pricing/costing, plus changes to NHS environment and commissioning structure, risks YAS income.	The finance senior management team is now at full establishment with the permanent recruitment of a Financial Performance Manager who will lead the Business Finance Managers in costing for business cases.	Adequate	Variety of approaches to business cases and differing quality across the Trust.	Standardise approach and monitor.	High Risk	Moderate Risk	Moderate Risk

ID	Directorate	Specialty	Description	Controls in place	Adequacy of controls	Gap in controls	Actions	Risk level (initial)	Risk level (current)	Risk level (Target)
208	Operations	PTS (Patient Transport Services) - Operations	Risk of financial deficit against planned outturn due to operational budget overspend and inability to secure planned income	1. Monthly budget meetings with all operational leads. 2. Escalation and spend authorisation procedures in place for all sub-contractor use.	Inadequate	To be confirmed	To be transferred from risk treatment plan	Extreme Risk	Extreme Risk	High Risk
159	Operations	PTS (Patient Transport Services) - Operations	Failure to deliver contracts within budgets.	To be confirmed	Inadequate	To be confirmed	To be transferred from risk treatment plan	Extreme Risk	Extreme Risk	Extreme Risk

206	Operations	PTS (Patient Transport Services) - Operations	Risk of loss of income due to the inability to secure / retain PTS contracts adversely influencing future service commissioning intentions	1. PTS Transformation Programme. 2. Monthly commissioner meetings with all four contract consortia. 3. Operational service delivery meetings monthly in each area. 4. Relationships with key acute trust partners. 5. High quality patient service delivery. 6. Monthly patient service audit and action on the results.	Inadequate	To be confirmed	To be transferred from risk treatment plan	Extreme Risk	Extreme Risk	Moderate Risk
214	Operations	PTS (Patient Transport Services) - Operations	Risk of CIP non delivery due to changing factors relating to baseline assumptions (demand profiles, overall activity, patient mobility changes, income)	1. Financial evaluation of the original CIP business case to clearly identify the links between the programmes of work and the CIP delivery. 2. Financial and PTS management review of the assumptions within the original business case and updating these in line with known information. 3. Specific analysis of the establishment changes implemented as of 1 April 13 linked to the requirements and cost improvements associated with the phased plans for rotas and planning / scheduling changes.	Inadequate	To be confirmed	To be transferred from Datix	Extreme Risk	Extreme Risk	Moderate Risk

ID	Directorate	Specialty	Description	Controls in place	Adequacy of controls	Gap in controls	Actions	Risk level (initial)	Risk level (current)	Risk level (Target)
49	Standards and Compliance	Quality and Patient Experience	Inability to deliver service transformation and organisational change, including non-delivery of cost improvement programmes.	TEG approved approach to staff engagement. Clinical Leadership programme agreed. Programme management in place. Quality Impact Assessments completed. CIP Monitoring Group in place.	Adequate	1. Service Transformation Programme not in place. 2. Cost improvement management not yet a key part of the programme. 3.Staff engagement and communication plan not in place. 4. Service line management not in place. 5. Agreed process for quality implact assessment of CIP not in place. 6. Milestones for FT implentation plan not agreed.	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. 5. Implement agreed process for Quality Impact Assessment of CIP Programmes. 6. Achieve actions on FT implementation plan within specified timeframes.	Extreme Risk	High Risk	Moderate Risk

ID	Directorate	Specialty	Description	Controls in place	Adequacy of controls	Gap in controls	Actions	Risk level (initial)	Risk level (current)	Risk level (Target)
112	Workforce and Strategy	Organisational Effectiveness and Education	Failure to utilise capacity of Technician to Paramedic conversion courses - Places on Technician to Paramedic conversion courses are not being fully utilised. These places are fully funded but this funding is finite in that it cannot be rolled over if capacity is not fully utilised.	1) Significant advertising is taking place in advance of the courses 2)OSCE preparation workshops are being offered 3)Locality Managers are having 1:1's with Technicians to discuss available options.	Adequate	1) Clinical Supervisors need to be utilised to review skill gaps with Technicians 2) Concerns in relation to OSCE preparation needs to be reviewed and addressed.	1)Clinical Supervisors to prioritise skill gap review with technicians 2) On-going communication to take place when concerns are identified 3)Information to continue to be made available to Technicians well in advance of the OSCE courses 4) Further joint statements to be issued from management and UNISON.	High Risk	High Risk	Moderate Risk