Yorkshire Ambulance Service NHS
NHS Trust

MEETING TITLE Public Trust Board		**MEETING DATE** 25/03/2014	
TITLE of PAPER	Board Assurance Framework including Corporate Risk Register	**PAPER REF**	5.3
STRATEGIC OBJECTIVE	All		
PURPOSE OF THE PAPER	To inform the Board on the risks recorded in the Board Assurance Framework and Corporate Risk Register and to provide assurance on the effective management of corporate risks.		
For Approval	☐	**For Assurance**	☒
For Decision	☐	**Discussion/Information**	☒
AUTHOR / LEAD	Executive Director of Standards & Compliance	**ACCOUNTABLE DIRECTOR**	Steve Page Executive Director of Standards & Compliance

DISCUSSED AT / INFORMED BY – include date(s) as appropriate (*free text – i.e. please provide an audit trail of the development(s)/proposal(s) subject of this paper)*:
The BAF and CRR have been subject to the quarterly cycle of peer review through Risk and Assurance Group, Trust Executive Group and Board Committees in February and March 2014. The BAF for the current and coming year was also considered as part of the 11 March Board Development Meeting business planning session.

PREVIOUSLY AGREED AT:	**Committee/Group:** Audit Committee Trust Executive Group	**Date:** 06/03/2014 12/03/2014
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 Register 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)	All
NHSLA Risk Management Standards for Ambulance Trusts	All

1. PURPOSE/AIM

1.1 The purpose of this paper is to inform the Board on the risks recorded in the Board Assurance Framework and Corporate Risk Register and to provide assurance on the effective management of corporate risks.

2. BACKGROUND/CONTEXT

2.1 The Quarter 3 BAF was updated and agreed through the February/March round of Trust High Level Committees. The updated Quarter 3 BAF is shown from page 7.

2.2 In addition to the regular BAF review, the Board also considered the 2013/14 BAF as part of its wider business planning session. The review focused on current risks recorded in the BAF and the anticipated year-end position, together with an initial view of the key risks to be captured in the 2014/15 BAF. This paper summarises the anticipated position for the close of 2013/14. The draft 2014/15 BAF will be developed for presentation to the May Public Board meeting.

2.3 The strategic objectives and risks recorded 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.

2.4 Good progress has been made in migrating risk registers into the Datix system and work is progressing well to ensure that all risk register entries are fully validated and aligned.

2.5 The Corporate Risk Register (all risks rated at 12 or above) is reviewed live in each Risk and Assurance Group meeting, together with any newly emerging risks. It is also reviewed by Trust Executive Group. Board Committees now receive this information for review, with risks aligned to the remit of each Committee for ease of reference.

3. OVERVIEW OF BAF RISKS AND PROJECTED YEAR-END POSITION

3.1 The BAF summary on page 8 shows the current position at the close of Quarter 3. The following notes provide a further update and assessment of the likely position at the end of the current financial year, based on discussions in the 11 March Board Development Meeting.

3.2 **Risk 1a – Adverse clinical outcomes due to failure of reusable medical equipment**

The current risk rating is moderate, with a low likelihood of occurrence. Good progress has been made through review and updating of procedures and through use of targeted external support to support the medical device management function. Further work will continue into the coming year, focused on ensuring that the new operational processes are fully embedded and on completion of the departmental restructure process.

It is anticipated that this will enable achievement of the planned residual risk score of 5 by September 2014.

3.3 **Risk 2a – harm to patients, staff and others die to deficiencies in the data flagging process leading to potential for data flags not being brought to the attention of interested parties.**
Actions to mitigate this risk have been completed during 2013/14 and this risk has now been removed from the BAF and residual risk is being managed by EOC via the departmental risk register.

3.4 **Risk 2b – Reduced ability to evidence that patient care is of a sufficiently high standard, due to inadequate capacity to audit clinical practice.**
The current risk rating is moderate, with a medium likelihood of occurrence, based on the current position in relation to the patient record scanning system. Good progress has been made in the current year to mitigate the risk through temporary staffing support and work with the scanning software company to improve functionality of the system. This has enabled essential audit activity to be maintained. Progress has also been made to support greater staff awareness and engagement with clinical audit processes. The scanning system remains fragile, however, and further work is needed to reduce the risks to its desired residual level. This will focus on both medium term options for scanning and verification and implementation of electronic patient records. This risk will therefore be retained on the BAF for 2014/15.

3.5 **Risk 3a – Inability to deliver performance targets and clinical quality standards.**
This risk is broadly defined and reflects challenges across the Trust's service lines, and in particular A&E Operations and NHS 111. Good progress has been made on the mitigating actions during the current year, but the current risk is still assessed as high, with a medium likelihood of occurrence. Work will continue into 2014/15 to further mitigate the risk, focused on implementation of the workforce plan and clinical leadership framework, managing the outcome of NHS 111 funding discussions and the ongoing service optimisation programme, and the A&E the Red performance plan. The mitigation plan for 2014/15 will also include an increased focus on early warning indicators and measures of clinical outcome and on measures of safe staffing, reflecting the increased national emphasis and guidance in these areas. It is anticipated that a residual moderate risk level may be achieved by the end of Quarter 3 2014/15.

3.6 **Risk 3b – Lack of compliance with key regulatory requirements (CQC, HSE, IGT, NHSLA) due to inconsistent application across the Trust.**
This risk is currently assessed as moderate, with a low likelihood of occurrence. The Trust is currently acting on minor concerns identified by the CQC in their most recent inspection with anticipated closure of these issues during summer 2014. In addition, new CQC and Monitor inspection and assessment processes will be introduced by October 2014 and these introduce a new level of uncertainty with regard to future compliance requirements.

Further work will continue into 2014/15 focused on management and leadership development, on embedding performance, quality and risk processes in departments and on preparation for the new inspection regimes. The risk is unlikely to be reduced to its low residual level until December 2014.

3.7 **Risk 4a – Loss of income due to inability to secure/retain service contracts, adversely influencing future service commissioning intentions.**
This risk is broadly defined and reflects challenges across the Trust's service lines. Mitigating actions have been completed in-year with a positive impact on PTS and NHS 111 service lines, but the current risk is still assessed as high with new issues coming to the fore in a still evolving commercial environment. Further mitigating action is required into 2014/15, including a focus on delivery of the PTS KPIs, attention to risks in elements of the A&E contract, ensuring sustainability of the NHS 111 service and anticipating the new national model, development of the West Yorkshire Urgent Care model and delivery of CQUINs across the service lines. The risk is likely to be reduced as a result of Quarter 4 actions in 2013/14 but is unlikely to acheive its moderate residual level until December 2014.

3.8 **Risk 5a – Inability to deliver service transformation and organisational change, including non-delivery of cost improvement programmes.**
Progress has been made in-year on programme management, development of service improvement skills and in rigour of CIP management. This will remain a key risk over the coming 2 years, given the magnitude of transformational change required. The focus in 2014/15 will be on delivery of clearly defined major service developments and ongoing delivery of CIPs. It is recognised that management and leadership development, service line management and staff engagement and management of employee relations will also be key to mitigating this risks over the medium term. Whilst further progress will be made during 2014/15, the view in the Board Development Meeting was that this risk is unlikely to be mitigated to its residual level until 2016.

3.9 **Risk 5b – failure to learn from patient and staff experience and adverse events within the Trust or externally.**
This risk is currently assessed as moderate, with a low likelihood of occurrence. Progress has been made during the year to mitigate the risk, with a focus on implementation of the Clinical Quality Strategy and on improving and embedding investigation and learning processes and this will continue into Quarter 4. Further work during Quarter 1 of 2014/15 to fully embed the clinical leadership framework will help to mitigate this risk. The additional focus following the Mid-Staffordshire Public Inquiry on the professional caring culture and on staff survey and other feedback and related action will need to be factored into the risk and mitigation plan for the coming year. It is anticipated in the light of the developing nature of this risk, that the low residual risk score will be achieved by March 2015.

3.10 **Risk 6a – Adverse impact on clinical outcomes and operational performance due to failure to embed the clinical leadership framework.**
This risk is currently assessed as moderate. Progress has been made on supporting full implementation although completion has taken significantly longer than originally planned, with some outstanding action focused on supporting the operational delivery of the Clinical Supervisor role and assurance from monitoring of key indicators. It is anticipated that this work will be sufficiently completed to reduce the risk to its residual level in Quarter 2 2014.

3.11 **Risk 6b – Adverse impact on clinical outcomes and operational performance due to inability to deliver the A&E workforce plan and associated training requirements.**
This risk is currently rated as high, with a medium likelihood of occurrence. Mitigating actions have been completed relating to definition and delivery of the workforce plan, implementation of new Occupational Health arrangements, and management of training abstraction. Further mitigating action will continue into 2014/15, focused on continued delivery of the workforce plan, managing pressures on recruitment across service lines, delivery of the annual training plan. It is recognised that the maintenance of positive employee relations during a period of significant change locally and nationally is also a key to management of this risk over the coming year. The projected date for achievement of the residual low risk rating is September 2014.

3.12 **Risk 7a – Adverse impact on organisational performance and clinical outcomes due to significant events impacting on business continuity.**
This risk is currently rated as moderate, with a low likelihood of occurrence. Work has progressed in-year in development and testing of business continuity plans, which has reduced the assessed level of risk and this will continue with the actions under way in Quarter 4. Further mitigating action is scheduled for early 2014/15 focused on review and delivery of relevant training requirements. It is anticipated that the residual low risk rating will be achieved by September 2014.

3.13 **Risk 8a – Adverse impact on developments in urgent/unscheduled care services in partnership with other providers due to failure to meet the requirements of the NHS 111 service/West Yorkshire Urgent Care contract.**
This risk is currently rated as high, with a medium level of likelihood. Considerable progress has been made in year, with the service performance now stable. Whilst further internal development work is still planned, subject to a positive outcome in the funding discussions with commissioners, this risk will have reduced to its residual low rating by March 2014. Consideration was given in the Board Development Meeting to the replacement of this risk in the 2014//15 BAF, with a broader risk relating a failure to maximise opportunities to further develop urgent care services.

3.14 **Risk 8b – Deficit against planned financial outturn e.g. due to significant overspending on the provision of Patient Transport services, NHS 111 service and A&E service.**
This risk is currently rated a high, with a high risk of occurrence. Mitigation is dependent on NHS 111 commissioner funding negotiations, the PTS transformation programme and A&E Operational Effectiveness plan. In 2014/15 there will be ongoing risks relating to the potential impact of contract target penalties and CQUIN scheme delivery and the risk will be reframed to include these issues. It is anticipated that the moderate residual risk rating will be achieved by the end of March 2015, although the risk rating may reduce towards this with current mitigating actions due for completion in March 2014.

3.15 The Board Development meeting also supported the addition of a new risk to the 2014/15 BAF, specifically related to employee relations, in the light of the pressures generated locally by the significant Trust change programme and national issues involving the health service unions.

4. PROPOSALS/NEXT STEPS

4.1 It is proposed that the notes above will be used to inform production of the final iteration of the BAF for the current year and the development of the initial draft of the 2014/15 BAF, which will be reviewed in Committees and Trust Board over the coming quarter.

5. RISK ASSESSMENT

5.1 The Board assessment of risks and mitigating action will be recorded in the Board Assurance Framework and will be used to inform management action and ongoing Board/Committee review.

6. RECOMMENDATIONS

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

7. APPENDICES/BACKGROUND INFORMATION

7.1 Appendix 1 – Board Assurance Framework – Quarter 4 2014/14

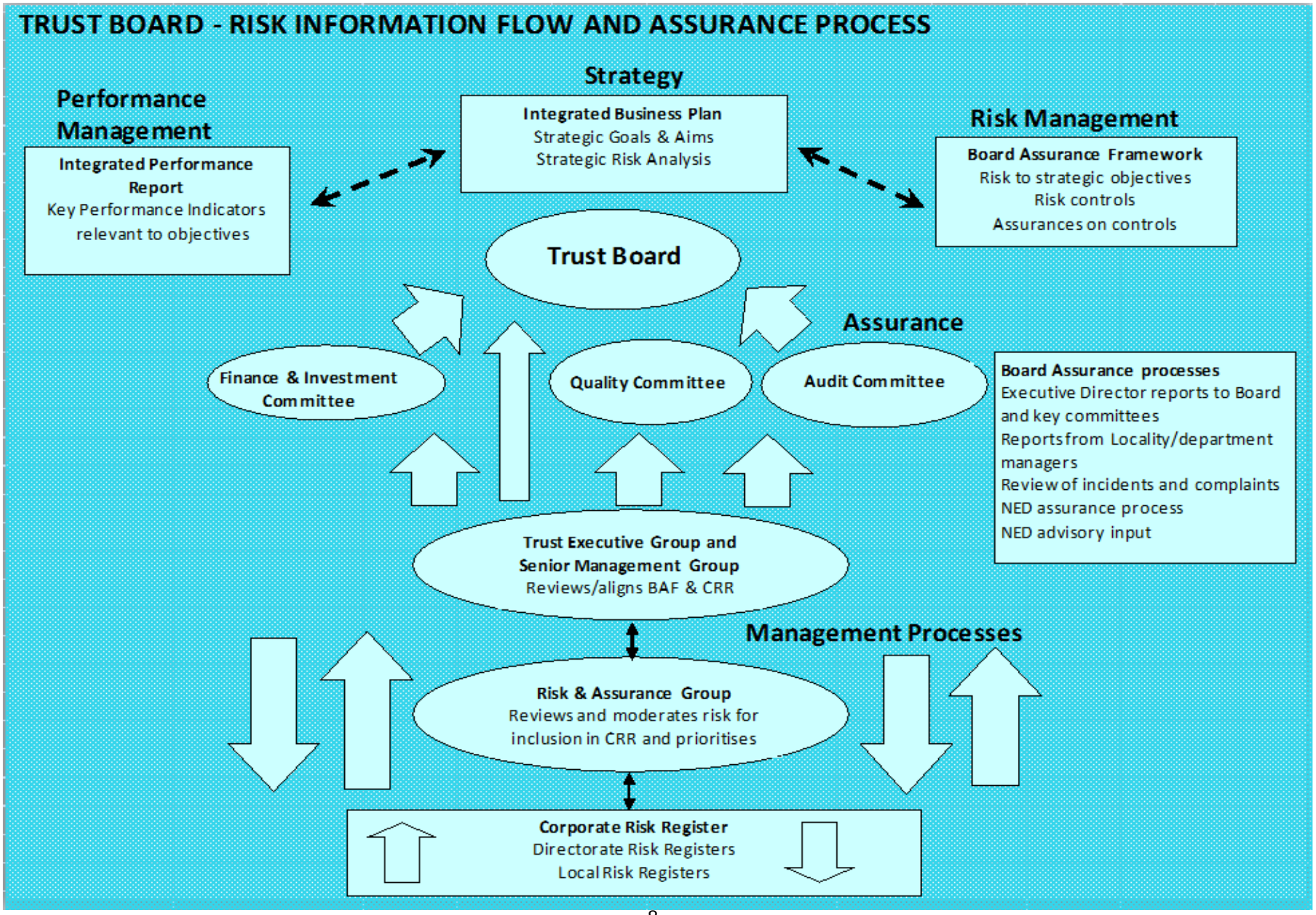
7.2 Appendix 2 – Corporate Risk Register

Appendix 1

Yorkshire Ambulance Service NHS
NHS Trust
An Aspirant Foundation Trust

BOARD ASSURANCE FRAMEWORK

Quarter 3 - 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 Q3.

Objective	Risk Description	Q2	Risk Movement	Q3	Progress Notes
1a	Adverse clinical outcomes due to failure of reusable medical devices and equipment.	10	⇔	10	Review of medical devices audit & maintenance processes including evidence to ensure tracking and recording equipment is complete, with performance linked to the IPR process. Recruitment remains outstanding with the decision made to provide interim management advice from Mid Yorks Teaching hospitals whilst the Hub and Spoke plans are progressed.
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.	8	⇩	4	Risk reduced and removed from BAF. Risk now managed by EOC Directorate via their Risk Register
2b	Reduced ability to evidence that patient care is of a sufficiently high standard, due to inadequate capacity to audit clinical practice	12	⇔	12	Reconfiguration of the audit department, including functional scanning, inclusion in training and reinforcement of priority are complete significantly mitigating the risk by March 2014.
3a	Inability to deliver performance targets and clinical quality standards.	15	⇔	15	Work continues with projects relating to workforce & strategy and Clinical Leadership Framework. Discussions for 111 service funding for 2014/15 are in progress with CCGs. Some additional winter resilience funding for 13-14 has been obtained from a number of CCGs. Work to embed governance arrangements within service transformation remains a key objective.
3b	Lack of compliance with key regulatory requirements (CQC, HSE, IGT, NHSLA) due to inconsistent application across the Trust.	10	⇔	10	Clinical quality strategy priorities have been agreed for 14/15 in patient safety & experience. Quality and compliance built into performance management review with assurance gained via Quality Committee. Progress made with IAO but further work required to resolve document legacy issues. CQC actions completed for medicines management & progress made with PDR process.
4a	Loss of income due to inability to secure/retain service contracts, adversely influencing future service commissioning intentions	16	⇔	16	This risk includes the PTS transformation programme and is therefore a longer term objective; improvement in risk grading may not be until Q4. The Trusts commercial and business development function has been developed and Commissioner engagement events have been completed.
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 and further mitigating action is likely to be required in 2014/15. Progress has been made against service improvement skills and leadership development programme. All CIP's are processed via a QIA. Service line management project continues.
5b	Failure to learn from patient and staff experience and adverse events within the Trust or externally.	8	⇔	8	The Corporate clinical audit function has been strengthened to ensure clinical audit capacity into 2014/15. Feedback process for learning requires further development as part of the service line management review. Further work will extend into 2014/15 to embed. Risk rating is therefore unchanged.
6a	Adverse impact on clinical outcomes due to failure to embed the clinical leadership framework.	8	⇔	8	Actions related to training and development of the clinical supervisors is on track however in Q4 focus on implementation of operational actions is required in order to embed CS framework. Risk rating therefore remains unchanged.
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	Further recruitment was agreed by TEG (Further recruitment mitigation was required to reflect the increased establishment within A&E ops). Value based recruitment is underway and the new OH contract with PAM has commenced with final completion due by 31-3-14. The recruitment and workforce plan is on track. UNITE continue to seek to disrupt the implementation of the new rota system and ballot for strike action is underway.
7a	Adverse impact on organisational performance and clinical outcomes due to significant events impacting on business continuity.	10	⇔	10	Testing of remaining resilience plans to be completed during Q4 will reduce this risk further towards the desired residual level. All actions are on track.
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	111 service optimization plan remains in progress with focus on workforce and absence management. Work continues with commissioner and other stakeholders in relation to dental services, a directory of services and booking in hours for GP's. Funding for 2014/15 remains under discussion with commissioners.
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	Mid-year delivery plan review was completed and is on track for PTS and A&E ops services. A new gap relating to the 111 service, was identified and associated actions put in place to mitigate.

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) Embed new operational practices and structures, Dir of F&P, **June 14** 2a) Discussions underway with Mid Yorks Teaching Hospitals to provide interim management cover with review after this in line with hub and spoke system, Dir F&P, **Sept 14**

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 1 = 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) Implementation of ePRF project. Executive Director Operations **Sept 15** 1b) Maintain staffing capacity to deliver required scanning/verification pending implementation of new IT solution Head of Clinical Effectiveness **Mar 14** 2) Review all options for scanning and verification process, AD ICT **Mar 14** 3a) Fully establish Clinical Leadership Framework, Dir of Ops, **Mar 14** 3b) Ensure clinical audit sustained as part of professional development programme, AD Education & Training, Dec 13 **Mar 14** 3c) 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 completed and processes in place including 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. Service line performance reviews operational. 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 **Mar 14** 3a) Implement Quality Governance action plan. Include actions from TDA quality review. 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) Red plan reviewed in line with rota review - refreshed plan now in place for implementation **from Feb 14**, Dir of Ops **review progress Nov 14**

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. 3) Further work is required to embed an effective FOI process	1) Implement Clinical Quality Strategy and implementation plan. Implement Service Transformation Programme, Dir of S&C **Mar 14** 2a) Maintain 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 Dir S&C **Mar 14** 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** 3) Review management & resources of FOI process, 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** 2b) Implement Stakeholder Engagement Plan, Dir P&E, **Mar 14** 3b) Complete assessment of service sustainability of the PTS Transformation project, Dir F&P **Mar 14** 3c) Complete assessment of service sustainability of 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 3 = 15	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 sustain 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) Strengthen the clinical audit function to embed clinical audit function into 2014/15 plan, Medical Dir, **Mar 14** 3) Implement the new risk management procedures policy that the investigation process, Dir S&C, **Mar 14** 4) Implement quality governance plan including relevant Francis report recommendations, Dir S&C, Med Dir, **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 People & Engagement**
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 2) Internal audit report 3) CQC assessment	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	1a) Implement operational actions required to embed CS framework **March 14** 1b) Monitor dashboard ad staff feedback via TEG and Quality Committee, Dir of Ops, **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 People & Engagement**
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 People & Engagement	5 x 3 = 15	5 x 3 = 15	5 x 1 = 5	1) Clear and prioritised business plan for People & Engagement 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 candidates of sufficient quality to deliver the required numbers to achieve 100% establishment levels within A&E. 2) Local industrial action affects the reputation of the Trust as an employer. 4) Enhanced abstraction rates required to be monitored in order to ensure levels for training are delivered by the Operations Directorate.	1a) Review of recruitment materials. Dir P&E **March 14** 1b) Complete the final phase of implementation of the new occupational health service. Dir P&E **March 14** 2) Local industrial action/disruption effectively managed via a collaborative approach between Operations, HR and Corporate Communications, with well-developed business continuity and resilience plans in place. Dir P&E **Mar 14** 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 P&E **Mar 14**

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) 2) Winter plans agreed with NHS England, Trust Development Agency and Clinical Commissioners Groups	1) All departmental business continuity plans need to be live tested 2) Appropriate training programmes not completed	1) Complete the testing of all business continuity plans**,** AD Resilience**, March 14** 2a) Implement training programme for business continuity leads and key staff, AD Resilience, **March 14** 2b) Ensure business continuity included in training review for 2014/15 **March 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			
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) Implementation of workforce plan and absence management continues 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 **Mar 14** 1c) Ensure in year financial settlement from Commissioners and sub-contractors, Dir S&C **Feb 14** 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) Contractual challenge to address 111 service funding gap to be discussed with Commissioners.	1b) Continue dialog with commissioners to agree 2013/14 resources (111), Dir F&P, **Feb 14**