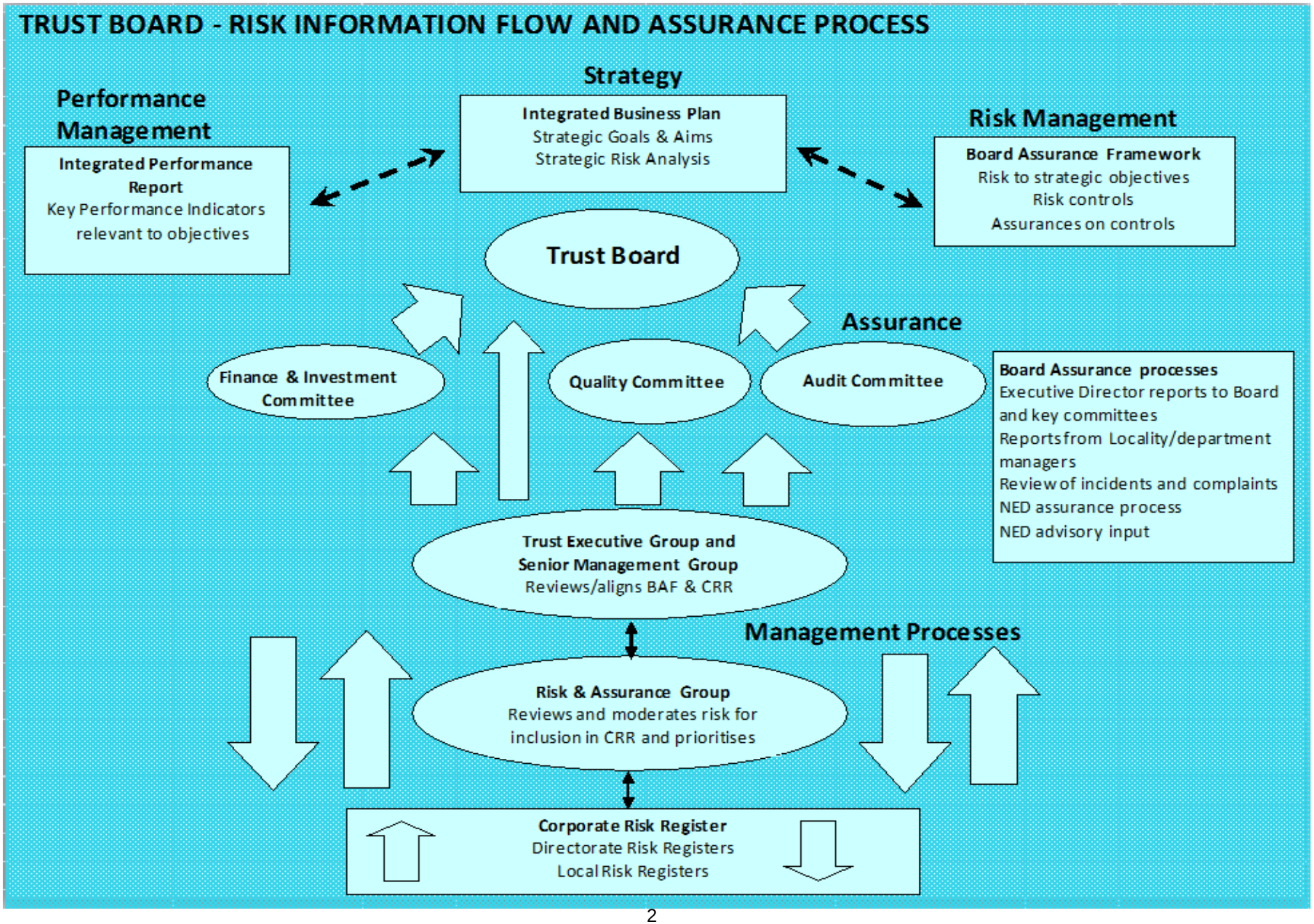
Yorkshire Ambulance Service NHS
NHS Trust
An Aspirant Foundation Trust

BOARD ASSURANCE FRAMEWORK

2014/2015 – April 2014


TRUST BOARD - RISK INFORMATION FLOW AND ASSURANCE PROCESS
Strategy
Integrated Business Plan
Strategic Goals & Aims
Strategic Risk Analysis
Performance Management
Integrated Performance Report
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NED advisory input
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Risk & Assurance Group
Reviews and moderates risk for inclusion in CRR and prioritises
Corporate Risk Register
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STRATEGIC GOALS AND OBJECTIVES

The Yorkshire Ambulance Service NHS Trust Board have identified, agreed and published the following Strategic Goals and Objectives for 2014/2015. They form the basis of the Trust's Integrated Business Plan 2012-2017 and the Annual Business Plan for 2014/15.

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 projected for Q4 end.

	Risk Description	Apr 14	Projected				Movement	Current	Progress Notes
			Q 1	Q 2	Q 3	Q 4			
1a	Adverse clinical outcomes due to failure of reusable medical devices and equipment.	8	8	4	4	4	⇔	8	Good progress has been made through review and updating of procedures and use of targeted external support for the medical device management function. Further work to continue into 2014/15, focused on ensuring that the new operational processes are fully embedded and completion of the departmental restructure.
2b	Reduced ability to evidence that patient care is of a sufficiently high standard, due to inadequate capacity to audit clinical practice	8	8	8	8	8	⇔	8	Reconfiguration of the audit department, including functional scanning, inclusion in training and reinforcement of priority are complete. Temporary staff support and work to improve functionality of the system have been used to mitigating the risk. Medium to long term plans include review of options for scanning and finally progression to electronic records.
3a	Inability to deliver performance targets and clinical quality standards.	15	15	15	15	10	⇔	15	Progress has been made with scheduled work plans, elements of the Quality Governance action plan and the workforce redesign project. However this risk remains high and work will continue into 14/15 as it includes projects relating to workforce & strategy and the Clinical Leadership Framework, on-going service optimisation programme and West Yorkshire urgent care review in NHS 111, and the Red performance plan.
3b	Lack of compliance with key regulatory requirements (CQC, HSE, IGT, NHSLA) due to inconsistent application across the Trust.	10	10	10	10	5	⇔	10	Minor concerns highlighted by CQC are currently being addressed. New CQC & Monitor assessment processes in 2014 will require preparation. Further work required to fully embed performance, quality and risk processes along with a focus on management and leadership development including the Clinical Leadership framework.
4a	Loss of income due to inability to secure/retain service contracts, adversely influencing future service commissioning intentions	12	12	12	12	8	⇔	12	Mitigating actions have been completed 13/14 with a positive impact on PTS and NHS 111 and the risk has been reduced accordingly. New issues are evident in this still evolving commercial environment, and further mitigating action is required in 14/15, including a focus on delivery of the PTS KPI's, attention to risks in A&E contract, ensuring sustainability of the NHS 111service and anticipating the new national model , development of the West Yorks urgent care Model and delivery of CQUINs across all service lines.
5a	Inability to deliver service transformation and organisational change, including non-delivery of cost improvement programmes	10	10	10	10	10	⇩	10	This objective includes the Service Transformation programme and CIP programme and therefore has a 2-year time frame; further mitigating action is required in 2014/15 with this risk likely to be reduced to a residual risk level in 2016. Progress has been made against service improvement skills and leadership development programme. The plan for service transformation has been substantially refined for 2014/15. The CIP process has been strengthened and all CIP's are subject to QIA. Service line management project will continue into 2014/15.
5b	Failure to learn from patient and staff experience and adverse events within the Trust or externally.	8	8	8	8	4	⇔	8	The Corporate clinical audit function has been strengthened. Work is planned to build capacity and capability to undertake robust investigations of all learning events, and focus on the professional caring culture post the Hard Truths report continues. Work on pulse survey and safety culture survey and Clinical Leadership framework will be continued into 14/15. Due to the developing nature of the risk it is likely that the low residual score will be achieved by March 15.
6a	Adverse impact on clinical outcomes due to failure to embed the clinical leadership framework.	8	8	4	4	4	⇔	8	Implementation of the CLF has taken longer than first envisaged due to outstanding actions associated with the operational delivery of the clinical supervisors' role and assurance from monitoring of key indicators. It is anticipated that this work will be sufficiently completed in Q2 2014/15, reducing the risk to a residual level.
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	15	15	15	⇔	15	Mitigating actions have been completed relating to definition and delivery of the workforce plan, implementation of the new occupational health service and management of training abstraction. Further mitigating actions will continue into 14/15, focusing on delivery of workforce plan and management of recruitment pressures across service lines ensuring positive employee relations are maintained throughout the period of change.
7a	Adverse impact on organisational performance and clinical outcomes due to significant events impacting on business continuity.	10	10	5	5	5	⇔	10	Testing of remaining resilience plans were completed during Q4 reducing this risk towards the desired residual level. Further mitigating action is scheduled for early 2014/15 and focused on the review and delivery of relevant training requirements. Residual risk rating to be achieved by September 2014.
8a	Failure to maximise opportunities to further develop urgent care services	15	15	15	10	10	⇔	15	The urgent care agenda is developing through a wide range of local forums and initiatives. Mitigation of this risk includes development of clear delivery models and business cases for the priority service developments, effective stakeholder engagement at national and local levels and the development of internal capacity and capability.
8b	Deficit against planned financial outturn e.g. due to contract target penalties and non-delivery of CQUIN scheme.	15	15	15	10	10	⇩	15	Mitigation is dependent on delivery of the PTS transformation programme, A&E operational effectiveness plan and NHS 111 cost improvement plan, and on meeting CQUIN targets. Plans are in place in each of the service lines and programme management arrangements have been agreed for CIP and CQUIN delivery.

STRATEGIC GOAL: CONTINUALLY IMPROVING PATIENT CARE - PROJECTED Q1 POSITION							
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	4 x 2 = 8	4 x 1 = 4	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 systems and practices, Dir of F&P, **June 14** 2a) Maintain SLA established with Mid Yorks Teaching Hospitals to provide interim management cover with review of this in line with hub and spoke plans and implementation, Dir F&P, **Sept 14** 2b) Complete department restructure process. Dir F&P, **Sept 14**

STRATEGIC GOAL: CONTINUALLY IMPROVING PATIENT CARE - PROJECTED Q1 POSITION							
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 2 = 8	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. Director of F&P **Sept 15** (NOTE: ePRF is a 2-year out project) 1b) Continuous service review in light of ePRF implementation plans**.** Med Director, **Sept 15** 2a) Review option to provide service out with YAS until ePRF in place. Med Director, **Mar 15** 3a) Fully establish Clinical Leadership Framework, Dir of Ops, **June 14** 3b) Implement annual clinical audit plan. Med Director, **March 15** 3c) Implement milestones in clinical professional leadership and clinical supervision service transformation plan. Med Director, **March 15**

STRATEGIC GOAL: HIGH PERFORMING - PROJECTED Q1 POSITION								
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) Red delivery plan and performance recovery plan in place and monitored 6) NHS 111 service optimisation plan 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 4) Quality Committee reports and annual Board level service line Quality Review. 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 delivery plan requires updating to address Red performance challenges	1) On-going work to implement Workforce Strategy and Training Plan, Dir Workforce & Strategy, **March 15** 2a) On-going work to implement NHS 111 service optimisation and plan, Dir S&C **March 15** 2b) Review of 111 warm transfer KPI with commissioners – Dir S&C, **June 14** 3a) Review and implement 14/15 Quality Governance action plan. Includes actions from TDA quality review. Dir S&C, **March 15** 3b) Implement 14/15 Risk and Safety Team work plans, Dir S&C, **March 15** 3c) Continue with Service Transformation Plan, Dir S&C, **March 15** 3d) Review and implement Clinical Leadership Framework, Dir of Ops **June 14** 3e) Increased focus on early warning indicators, measures of clinical outcome and measurement of safe staffing levels. Dir of Ops **Dec 15** 4) Implement Red performance recovery plan Dir of Ops, **May 14**	

STRATEGIC GOAL: HIGH PERFORMING - PROJECTED Q1 POSITION								
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) Clinical Quality Strategy and implementation plan in place 4) Quality Governance plan agreed including review of Francis/Hard Truths recommendations 5) Information Governance plan and network of Information Asset Owners.	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 and Internal Audit Quality Governance Assessment. 5) HSE inspection reports. 6) NHSLA L1 assessment (9/10/12) 7) AACE performance peer review report March 14. 8) CSU performance review April 14	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.	1a) Review plans for 14/15 and continue Clinical Quality Strategy and implementation plan. Implement Service Transformation Programme, Dir of S&C **June 14** 1b) Implement milestones in the Management and leadership development service transformation plan, Dir People and Engagement, **March 15** 2a) Implement Risk and Safety Team work plans, Dir S&C, **March 15** 2b) Maintain and enhance the internal Inspections for improvement programme ensuring actions are completed Dir S&C, **Mar 15** 2c) Implementation of Quality Governance action plan including actions arising from CQC inspections Dir S&C **March 15**. 2d) Prepare for new system of CQC inspection introduced in Oct 2014 & review once inspection complete Dir S&C **Dec 14** 2e) Fully embed performance and risk management processes within departments and CBUs. Dir of Finance & Performance **Dec 14** 2f) Sustain a robust document management process, Dir S&C **Mar 15** 2g) Implement the Information Governance Work plan 2014/15, Dir S&C **Mar 15**

STRATEGIC GOAL: HIGH PERFORMING - PROJECTED Q1 POSITION							
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 3 = 12	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 3) 14/15 contract settlements	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) Challenges to delivery of service performance in line with commissioner expectations in A&E, PTS and NHS 111.	1a) Complete the implementation of service line management and reporting in PTS and 111, Dir F&P, **Sept 14** 1b) Implement milestones in the Management and leadership development service transformation plan, Dir People and Engagement, **March 15** 2a) Participate in national NHS 111+ pilots and prepare for new service spec Dir S&C **Dec 14** 2b) Review the risks within the A&E contract. Dir Ops **Sept 14** 2c) Review and revise arrangements for commissioner stakeholder engagement. Dir People and Engagement, Dir F&P, **Sept 14** 3a) Deliver NHS 111 service optimisation programme. Dir S&C, **March 14** 3b) Development of West Yorkshire Urgent Care model Dir S&C **Sept 14** 3c) Deliver PTS service transformation plan. Dir F&P, **March 15** 3d) Delivery of CQUINS across service lines. Dir S&C **quarterly review with completion Mar 15**

STRATEGIC GOAL: ALWAYS LEARNING - PROJECTED Q1 POSITION							
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 2 = 10	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) Internal Audit report – CQUIN management	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) Continue service improvement skills programme as part of the STP, Dir S&C, **Sept 14** 1b) Implement milestones in the Management and leadership development service transformation plan, Dir P&E, **March 15** 2a) Implement changes to programme management across service transformation programme, CIP and CQUIN programmes, Dir S&C **June 14** 2b) Implement milestones in updated Service Transformation Programme. Dir of S&C **Mar 16** 2c) On-going delivery of Cost Improvement Programme, Dir of F&P, **Mar 15** 3a) Implement milestones in the Staff Engagement Plan, Dir P&E, **Sept 14** 3b) Maintain management of positive Employee relations. Dir of P&E, **Dec 14** 4) On-going delivery of SLM and sustain Quality Impact Assessment of CIP Programmes, Dir of Finance & Performance, **Mar 15**

STRATEGIC GOAL: ALWAYS LEARNING- PROJECTED Q1 POSITION							
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 attending key Committees 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, 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.	1a) Continue to develop review processes for patient and staff experience at department level, aligned to existing Trust systems, including the friends and family test CQUIN. Dir S&C **Sept 14** 2a) Implement milestones in the annual clinical audit plan. Med Dir, **March 15** 3a) Implement updated investigation skills training for managers. Dir S&C, Dec 14 4a) Review the quality governance plan that includes relevant Francis report/Hard Truths recommendations and implement for 14/15 in light of current learning so far – includes CQC listening event and staff survey, Dir S&C, Med Dir, **Sept 14** 4b) Fully embed the clinical leadership framework, Dir of Ops. **June 14** 4c) Implement clinical professional leadership and clinical supervision service transformation programme milestones. Med Dir, **March 15**

STRATEGIC GOAL: ALWAYS LEARNING - PROJECTED Q1 POSITION								
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) Action plan developed and monitored via OMG	1) Performance reports to Quality Committee 5 times a year 2) Quality Committee reports 3) Annual Board level service line Quality Review 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	1a) Implement operational actions required to embed CS framework including issues highlighted in the Internal Audit review. Dir Ops, **Sept 14** 1b) Monitor dashboard and staff feedback via TEG and Quality Committee, Dir of Ops, **Sept 14**	

STRATEGIC GOAL: ALWAYS LEARNING - PROJECTED Q1 POSITION								
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 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 or national industrial action affects the reputation of the Trust as an employer. 3) Enhanced abstraction rates required to be monitored in order to ensure levels for training are delivered by the Operations Directorate.	1a) deliver recruitment plan to fill A&E vacancies, Dir P&E, **Sept 14** 1b) Continued delivery of workforce plan managing pressures on recruitment across service lines. Dir P&E **March 15** 2a) Manage on-going local employee relations with key unions. Dir P&E, **March 15** 2b) Maintain positive employee relations during period of significant change both locally and nationally through implementation of milestones in the Staff Engagement Plan, Dir P&E, **March 15** 2c) Maintain current intelligence on national issues and ensure well-developed business continuity and resilience plans in place. Dir P&E **March 15** 3a) Implement annual agreed annual education and training plan. Dir P&E, **March 15** 3b) 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 **March 15**

STRATEGIC GOAL: VALUE FOR MONEY AND PROVIDER OF CHOICE - PROJECTED Q1 POSITION							
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 3) ISO Accreditation Process 4) National command training/Jesip benchmarking	1) All departmental business continuity plans need to be live tested 2) Appropriate training programmes not completed	1a) Implement additional live test of key functions. Dir Ops, **Sept 14** 2a) Delivery of relevant training requirements via annual Trust training plan. Dir Ops, **March 15**

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 Failure to maximise opportunities to develop urgent care services 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) Urgent care development plan in place 2) Urgent care steering group and programme management as part of service transformation programme 3) Business case development for key service developments 4) Support from the Corporate Commercial/Business development team is in place	1) Established contract monitoring arrangements 2) Bi-monthly monitoring by Quality Committee and Finance & Investment Committee 3) Review via TEG (Service Transformation)	1) Urgent care service development plans are still in early stage of development 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) Further work is required to support development of the workforce in line with changing urgent care requirements	1a) Develop clear operating models and business cases for key service developments identified in the Urgent Care development Plan. Dir S&C **Dec 14** 1b) Establish project plans for implementation of new service developments Dir S&C, **Dec 14** 1c) Participate in national NHS 111+ pilots and prepare for new service spec Dir S&C **Dec 14** 2a) Review and revise arrangements for commissioner stakeholder engagement. Dir P&E, Dir F&P, **Sept 14** 2b) Engage with local commissioners on key service developments relevant to the challenges of local health economies. Dir S&C **Dec 14** 2c) Develop further engagement with regional and local clinical networks. Med Dir **Sept 14** 3a) Implement agreed milestones in Paramedic Pathfinder plan. Med Dir **March 15** 3b) Develop scope of practice, revised role descriptions and education plans for ECPs and Advanced Paramedic roles. Med Dir, **Sept 14** 3c) Review Trust training plans and develop additional content as required to support urgent care delivery. Med Dir, Dir S&C **March 15**

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 contract target penalties and non-delivery of CQUIN scheme. 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 3 = 15	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. 4) CIP and CQUIN programme management	1) Monthly review by the Board through Integrated Performance Report 2) F&I committee review 3) CIP group monitoring led by the CEO	1) Challenges to delivery of A&E Red performance 2) PTS transformation programme still in progress 3) Funding gap reduced but still significant following financial settlement for NHS 111	1a) Implement refreshed Red delivery and recovery plan Dir of Ops, **May 14** 2a) Continue with PTS transformation programme and A&E operational effectiveness plan in order to ensure no deficit against financial outturn Dir F&P **Mar 15** 3a) Deliver NHS 111 cost improvement plan. Dir S&C **March 15**