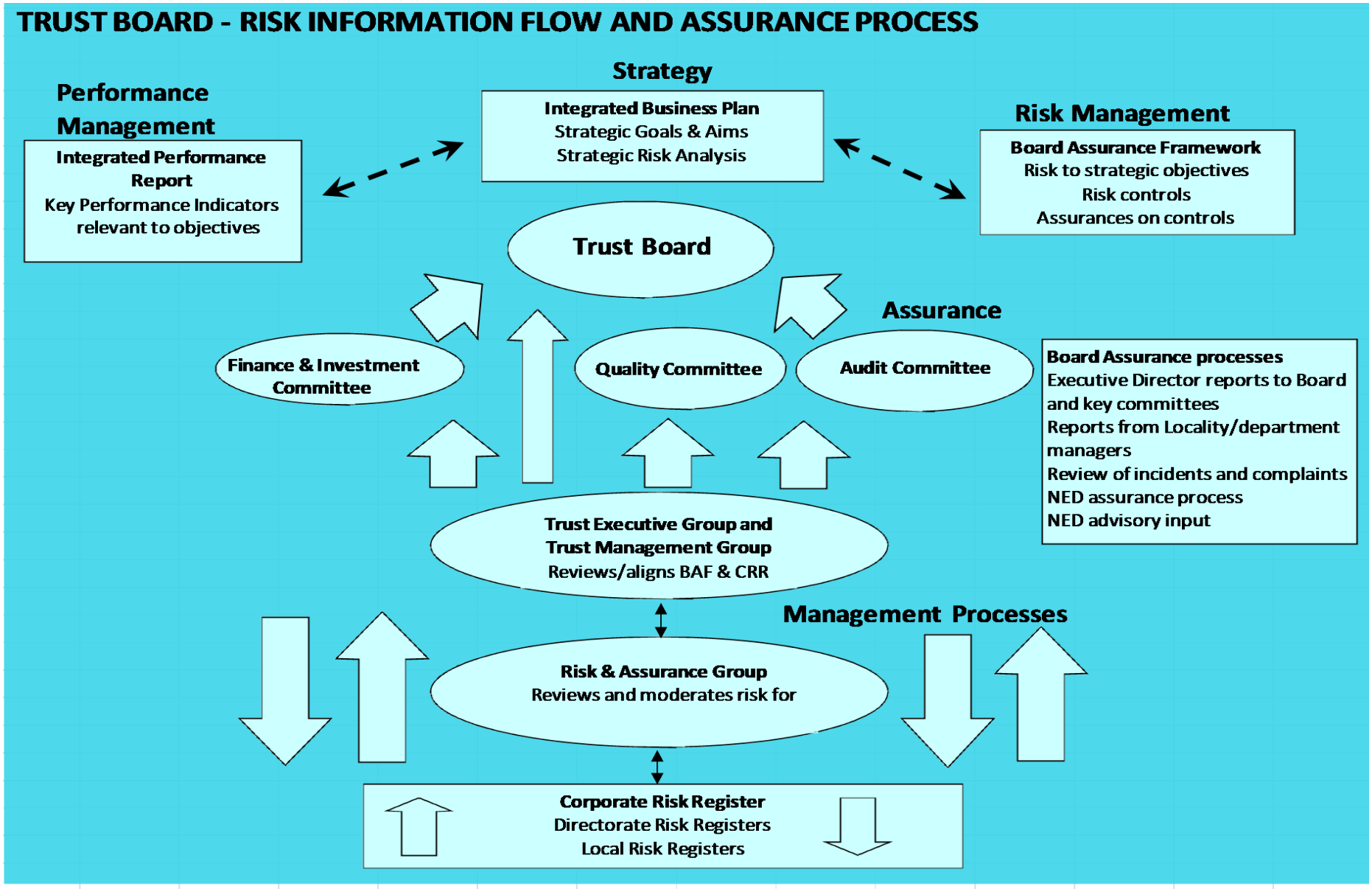
Yorkshire Ambulance Service NHS
NHS Trust
An Aspirant Foundation Trust

BOARD ASSURANCE FRAMEWORK

2015/2016 – March 2016


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
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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 Trust Management Group
Reviews/aligns BAF & CRR
Management Processes
Risk & Assurance Group
Reviews and moderates risk for
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 2015/2016. They form the basis of the Trust's Integrated Business Plan 2012-2017 and the Annual Business Plan for 2015/16.

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 15	Projected				Movement	Current	Progress Notes
		Q1	Q2	Q3	Q4			
1a) Adverse clinical outcomes due to failure of reusable medical devices and equipment.	10	8	8	8	4	⇔	8	The projected achievement of target residual risk has been re-scheduled to Q4. Full review of requirements of Medical Devices department has identified additional actions in relation to standard operating procedures and culture and practice. The options appraisal for future management has been discussed in TEG, Department manager recruited. Other actions in improvement plan are now completed. Feb 2016 BDM Policy and SOPs in place, Manager now in post, manager to lead review of future options. Residual risk to be managed at local level. Close on BAF 15/16
3a) Inability to deliver performance targets and clinical quality standards.	25	25	15	15	10	⇩	20	The current A&E performance position is below required levels owing to a combination of demand, staffing & efficiency factors. Processes are in place to mitigate any risk of additional potential harm to patients arising from the performance challenge, and additional monitoring & case review is in place to closely monitor safety and quality. Milestones and trajectory in the A&E improvement plan updated and the overall A&E plan was considered in the Board in December. An interim increase in A&E establishment was agreed pending completion of further work on the longer term plan to enable final sign off. Increase in resources whilst the plan is implemented is being supported through introduction of private providers and increased external recruitment and in-house training. Whilst there is improvement in performance month on month, the residual risk score will not be achieved in 2015/16. Feb 2016 BDM factors identified in other parts of healthcare system, eg turnaround, ARP that impact risk. Risk to remain on the BAF 16/17 recognising the ongoing challenge relating to A&E performance and the associated transformation plan continuing through 2016/17.
3b) Lack of compliance with key regulatory requirements (CQC, HSE, IGT) due to inconsistent application across the Trust.	10	10	10	10	5	⇔	10	Delivery of CQC action plan being monitored by TEG, risk updated to include key CQC findings. Feb 2016 BDM to review risk after follow-up CQC inspection.
4a) Loss of income due to inability to secure/retain service contracts, and challenge to the delivery of Trust strategy within the constraints of the wider commissioning system	12	12	12	12	8	⇔	12	Completion of Executive Portfolio Review, focus on Transformation Programmes, contract discussions, ensure sustainability of the NHS 111 service, development of the West Yorks urgent care Model & delivery of CQUINs and CIPs across all service lines. YAS part of W Yorks Vanguard, providing opportunities for future service development aligned to wider strategy. Feb 2016 BDM risk is inherent in other risks on BAF in relation to delivery of transformation programme, challenge of performance targets and impact of factors in other parts of healthcare system, eg. turnaround. To close as separate risk.
4b) Inability to implement PTS transformation programme resulting in loss of income due to failure to secure/retain service contracts	16	12	12	12	8	⇔	12	Programme Darwin on-going. Managing Director PTS now in post. Feb 16 Risk will remain on the BAF 16/17 reframed to capture impact of current contract negotiations and urgent tier review. Potential for risk to increase
5a) Inability to deliver service transformation and organisational change, including non-delivery of cost improvement programmes	16	16	16	16	12	⇔	16	This objective includes the Service Transformation programme & CIP programme & therefore has a 2-year time frame. The plan for service transformation was been substantially reframed for 2015/16. The CIP process has been strengthened & all CIP's are subject to QIA.. Make Ready pilot site live. Review of programme required for coming year to ensure full alignment with Vanguard and updated Trust strategy. Feb 2016 BDM Project Management Office is established, identified management and leadership development required alongside further work on staff engagement with transformation and CIP and roll out of Service Line Management Remains a significant risk, to be transferred forward to BAF 16/17
5b) Failure to learn from patients and staff experience and adverse events within the Trust or externally.	8	8	8	8	4	⇔	8	The Clinical Directorate function has been strengthened to build capacity & capability to undertake robust investigations work on safety culture survey and embed the Clinical Leadership Framework. Enhanced processes for review of safety and quality in the A&E service have been developed & work to manage the risk of staff MSK incidents continues. Freedom to Speak Up working group with staff Forum and union representation taking forward developments to enhance engagement of staff in raising concerns about safety and quality including appointment of Guardian role. Feb 2016 BDM Strengthened capacity and capability in Clinical Directorate function to undertake robust investigations, work on safety culture survey, and embed the Clinical Leadership Framework. Freedom to Speak Up working group with staff Forum and union representation to enhance staff engagement. CQC follow up inspection will measure progress. To link risk with 6a
5c) Insufficient alignment and responsiveness of corporate services to operational service requirements	16	16	8	8	4	⇔	16	Systematic engagement process between support services and operational service lines needs further development with particular focus on fleet and estates alignment. Executive portfolio review completed. Make Ready pilot and Vehicle Preparation pilots are live. Feb 2016 BDM – Systematic engagement process between support services and operational service lines needs further development. Work required to implement Service Line Management and develop SLAs. To carry forward to BAF 16/17
6a) Adverse impact on clinical outcomes due to failure to embed the clinical leadership framework.	12	8	8	8	4	⇔	8	Full review of clinical leadership framework to be undertaken as part of the current Operational directorate plans. Residual risk target date reviewed and re-scheduled to Q4. Associate Director of Paramedic Practice in post from Sept 2015. Feb 2016 BDM: Implementation of the clinical career framework and associated supervision as part of A&E transformation plan to continue into 2016//17. Carry forward to BAF 16/17 and link with 5b
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	10	⇔	15	Work continues regarding the management of recruitment pressures across service lines ensuring positive employee relations are maintained throughout the period of change. The national shortage of paramedics is impacting on Trust's abilities to deliver the planned level of qualified staff, with specific pressures in South and ABL CBUs. Adjustments to the workforce plan for the current year have been agreed to mitigate this. Further work to refresh workforce plan for 2016 onwards with discussions ongoing with unions. Increase in establishment agreed by Board in Dec 15. Staffing numbers increased in December as a result of recruitment and training initiatives Feb 2016 BDM Risk To remain on BAF 16/17 with focus of mitigation on planned implementation of new clinical career framework and supervision model as part of A&E Transformation Plan to support recruitment and retention, and delivery of A&E workforce plan
6c) Challenge to the delivery of key objectives due to ineffective staff engagement	15	15	15	10	5	⇔	15	Agreed course of training for managers and staff side has been completed facilitated by ACAS. Work continuing on staff engagement plan , including review of Teambrief process, developments relating to staff e-bulletin and social media. Cultural audit completed and feedback and implementation of plan. Feb 2016 BDM Development of Communications and Engagement Strategy ongoing. Work to strengthen relationship with staff forum and union reps. Staff engagement remains a risk to delivery of objectives. To remain on 16/17 BAF

7a) Adverse impact on organisational performance and clinical outcomes due to significant events impacting on business continuity.	15	10	5	5	5	⇔	10	Additional exercise testing of key resilience plans on-going. Significant live testing of BC plans in A&E, NHS 111 and ICT services over Christmas period as a result of flood event. To remain on BAF for 16/17 in recognition of the changing nature of risks to business continuity.
8a) 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 improvement plan & NHS 111 cost improvement plan, & on meeting CQUIN targets. Plans are in place in each of the service lines & programme management arrangements have been agreed for CIP & CQUIN delivery. Additional financial stretch targets have been set nationally. Capacity review requested for NHS 111 in light of current level of activity. Paramedic pathfinder CQUIN income at risk and subject to further discussions with commissioners Feb 2016 BDM Current contract negotiations for 16/17 are ongoing and there are a range of internal, local and national factors impacting on this risk for 16/17. Risk to remain open for BAF 16/17 and reframed in light of the changing context

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: / Exec Lead/Risk Area	Risk Score: Initial	Risk Score: Current	Risk Score: Target	Key Controls	Internal Assurance / External Assurance	Gaps in Controls and/or Assurances	Action to Address Gaps and Timeframe
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	Internal Assurance: 1) Monitoring of incidents at Vehicle & Equipment Group. 2) Quarterly reports to TMG 3) Tracking of KPIs in the IPR External Assurance: 1) Internal Audit progress report to Quality Committee 2) NHSLA L1 Report	1) Policy and procedural documents require review and update 2) Complete the restructure of the Medical Devices Team and process review 3) Robust local management processes required to ensure a significant improvement in governance culture	1a) Develop current procedural documents specific to the Medical Engineering Department (MED) Dir F&P **September 2015 Completed September 2015** 1b) Develop new MED Standard Operating Procedures (SOP) Dir F&P **Completed September 2015** 1c) Develop MED management systems and processes Dir F&P **Completed September 2015** 2a) Complete department restructure process. Decision on options appraisal for future department provision and management reviewed in TEG. Dir F&P **Completed September 2015** 2b) Recruit to Medical Devices Manager post following options appraisal decision. Dir F&P **January 2016 – complete, manager in post** 2c) Develop the competence of all MED staff to meet Trust and regulatory standards Dir F&P **March 2016** 2d) Develop an effective communication process to inform and educate staff Dir F&P **Completed September 2015** 3a) Develop Health & Safety Culture and Practice, following full risk assessment which showed significant gaps - to include monitoring to H&S committee Dir F&P **Completed September 2015** 3b) Develop local risk management process and practice Dir F&P **July 2015 – complete June 2015** 3c) Develop performance management framework and robust PDR implementation in practice Dir F&P **Completed September 2015** 3d) Develop an assurance framework Dir F&P **Completed September 2015**

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 in A&E Operations NHSLA: 1: Governance CQC: 16: Assessing and monitoring the quality of service provision Exec Director of Operations	5 x 3 = 15	5 x 4 = 20	5 x 2 = 10	1) Major trauma project completed and processes in place 2) On-going recruitment, education and training as part of the Workforce Strategy and Plan. 3) AQIs and CPI's developed with national benchmarking 4) 2015/16 Training Programme agreed and established 5) Service Delivery and performance recovery plan in place and monitored 6) Spring into Action initiative 7) Early warning indicators developed and monitored 8) Operational improvement plan	1) Monthly IPR reports, including workforce KPI's to executive groups. 2) Weekly Executive Project Board and risk review established 3) STP dashboard reporting and monitoring in place 4) Quality Committee reports and annual Board level service line Quality Review. 5) Safety Monitoring Reporting in place 1) CQC Registration 2) Internal Audit review of training rated as substantial assurance. 3) NHS England positive benchmarking of AQI and CPI 4) Weekly national benchmarking	1) Lack of alignment between resources and demand 2) inefficiencies in management of resources 3) workforce staffing and capacity not fully developed in line with service need 4) potential for implementation of further measures to support performance	1a) ORH commissioned to analyse demand over the last 9 months and to produce indicative modelling for the new workforce plan Dir ops **June 15 Complete** 1b) Board review and decision on implementation of work programme arising from ORH modelling and Trust review Dir Ops **Sept 15 Internal plan agreed. Further Board review following completion of contract negotiations.** 2a) Complete review undertaken by planning forum Dir Ops **Sept 15 Completed** 2b) Implement recommendations to improve planning cycle Dir Ops **March 16** 2c) Implement interim plan for increased recruitment and training pending Board approval of new workforce plan Dir Ops **Sept 15 Completed** 3a) Workforce Strategy revisions and recruitment plan are being reviewed for Board approval in the light of the ORH intelligence, **Dir P&E, Board agreed interim increase in A&E establishment Dec 15 whilst the plan is implemented through introduction of private providers and increased external recruitment** 3b) Deliver recruitment in line with revisions described in 3a. **Dir P&E Aug 15 – March 16** 3c) AP to Technician training to commence to train approx. 40 staff **Dir P&E May 15 completed** 3d) Review and implement Clinical Leadership Framework and scope of practice for new roles. Dof Ops, Med Dir. **Review Oct 15 Implement March 16. Dec 15 – work continuing as part of updated A&E plan.** 4a) Enhanced NHS 111 clinical intervention to reduce 999 referrals Dir S&C **July 2015 Complete** 4b) Implement milestones in the Fire co-responder scheme plans Dir Ops **July 2015 – March 16 Scheme development progressing to plan** 4c) Staff responder scheme Dir Ops **Dec 2015** 4d) Increase static defibrillators Dir Ops **March 16** 4e) Ensure delivery of milestones in the Performance improvement plan. **Dir Ops June 15**. Milestones and trajectory being reviewed and updated **Sept 15 Implementation of Transformation plan continuing** 4f) Introduce interim provision of private providers to increase resources until benefits realised from updated workforce plan **Dir Ops Completed Sept 15**

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) 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. 6) TEG monitoring of CQC action plan	1) Compliance reports to Trust Board, SMG, and Quality 2) I4I Process positive findings from review 3) Evidence collation in relation to the CQC action plan 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.	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, risk management and compliance monitoring and action at departmental level throughout the Trust. 3) Variation in standards of cleaning and infection prevention and control 4) Variation in checking and maintenance processes for vehicles and equipment 5) Variation in completion rates for mandatory training	1a) Review plans for 15/16 and implement Clinical Quality Strategy. Implement Service Transformation Programme, Dir of S&C **March 16** **On track** 1b) Implement milestones in the Management and leadership transformation plan, Dir P&E, **March 16** **Portfolio review completed. Recruitment to newly defined posts progressing well.** 2a) Implement Risk and Safety Team work plans and ensure risk management processes are fully embedded in service lines Dir S&C, **March 16** **On track** 2b) Maintain and enhance the internal Inspections for improvement programme ensuring actions are completed Dir S&C, **Aug 15** **Complete – programme ongoing, reporting to TMG** 2c) Implement Quality Governance action plan including actions arising from CQC inspections Dir S&C **March 16** **Actions on track for completion** 2d) Review and implement refined performance management processes for all service lines. Dir of F&P **July 15** Draft reviewed by TEG June 15. For further review aligned to current business planning round – **Jan 16** **Completed. Draft framework reviewed and agreed In TEG** 2e) Sustain a robust document management process, including records management Dir S&C **Dec 15** **Enhanced document management processes in place, work plan continuing.** 2f) Implement IG Work plan 2015/16, Dir S&C **Mar 16** **on track** 3a) Implement actions in CQC action plan including DIPC deep clean monitoring, review of cleaning SOPs, actions and audit to ensure consistent implementation of HCAI policy. Dir S&C **Oct15.** **Dec 15 – work plan implementation on track** 4a) Implement actions in CQC action plan including review and update of SOPs, improved alignment of support and operations functions and increased monitoring of vehicle and equipment maintenance KPIs Dir F&P **Jan 16** **– work plan implementation on track with audits of compliance scheduled** 4b) Implementation of make ready and Vehicle Preparation pilots CEO, Dir F&P **March 16** **Dec 15 – make ready pilot operational** 5a) Implement actions in CQC action plan including review of training plan, enhanced training needs analysis and additional monitoring of attendance. Dir P&E **Completed Oct 16**

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, and challenge to the delivery of Trust strategy within the constraints of the wider commissioning system. 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) 15/16 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. 4) Further work is required to support development of the workforce in line with changing urgent care requirements	1a) Complete the implementation of service line management and reporting in PTS,111 and A&E – Dir F&P Plans for implementation reviewed, refreshed and new date agreed for 15/16 programme **March 16** 1b) Implement milestones in the Management and leadership development service transformation plan, Dir P&E **March 16** **staffing review completed and recruitment progressing well** 2a) Further work required to develop account manager role –Dir F&P date TBC interim arrangements developed to cover key commissioner forums 2b) Further work with commissioners to develop alignment strategies for urgent and emergency care and ongoing communication and engagement plan - CEO and Commissioners **Dec 15.** **Further development following commissioner session on 4 March** 3a) Deliver NHS 111 service optimisation programme. Dir S&C, **March 16** 3b) Development of West Yorkshire Urgent Care model Dir S&C Further progress made on developing options for discussions with WY Commissioners work continues in liaison with WY Commissioners in line with contract cycle **– revised June 15** Discussions continuing with commissioners. Trust playing a key role in WYs Vanguard programme 3c) Deliver PTS milestones within service transformation plan. CEO, **July 15** - **March 16** 3d) Implement A&E performance improvement plan Dir Ops **Mar 16 (see Risk 3a)** 3e) Delivery of CQUINS across service lines. Dir S&C **quarterly review with completion Mar 16** 4a) Implement agreed milestones in Paramedic Pathfinder plan. Med Dir **March 16** First milestones in CQUIN July 15 not achieved. Currently reviewing indicators for discussion with CCGs. 4b) Develop scope of practice, revised role descriptions and education plans for all operational clinical roles based on national guidance. Med Dir, **Sept 15** Dec 15 – work is continuing as part of the updated A&E plan**. Mar 16 – new clinical career framework has been defined**

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		
4b. Inability to implement PTS transformation programme resulting in loss of income due to failure to secure/retain service contracts NHSLA: 1: Governance CQC: 16: Assessing and monitoring the quality of service provision Chief Executive Officer	4 x 4 = 16	4 x 3 = 12	4 x 2 = 8	1) PTS transformation programme management board 2)Programme Darwin 3)Revised PTS Leadership model 4) Revised Financial business case 5) Design of Future Operating Model	1) Executive review at TEGT and Finance and Investment Committee. 2) Contractual KPI's in IPR – reported to TEG and Board. 1) External consultancy Review 2) Commissioner meetings and contract settlements	1) Further work is needed to develop clarity around leadership capability and capacity 2) Future operating model needs to deliver financial business case to ensure future viability of service 3) Disconnect between outcomes and accountability 4) Lack of technology and specialist skills	1a) Recruitment process for Head of PTS – CEO **July 2015.** Complete – Managing Director in post from end of Oct 15 1b) Implementation of leadership development programme Dir P&E **March 16** 2a) Implementation of desired service model CEO **March 16** 3a) Implement a PTS performance management framework in line with new structure Dir F&P Sept 15 Complete via new structure implemented by interim Associate Director. 4a) Identify future leaders and develop capabilities CEO **March 16** 4b) Implement vehicle telematics CEO **Sept 2015** Action completed.

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	4 x 4 = 16	4 x 3 = 12	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	1a) Implement initiatives in corporate workstream of STP CEO **March 16** 1b) Implement milestones in the Management and leadership development service transformation plan, Dir P&E, **March 16** **Executive Portfolio review completed** 2a) Implement revised STP and ensure resources are targeted at priority areas to support effective programme management. Dir of S&C **Sept 15** . Overall delivery on track – **complete.** Elements of the programme still being defined within specific workstreams. Further review of resources vs plan required in light of Vanguard and other developments. **Dec 15.** Dec 15 – review commenced. **Further TEG review completed in Jan/Feb 16 to align to wider strategy and review for April 16** 2b) On-going delivery of Cost Improvement Programme, with oversight through CIP management Group Dir of F&P, **Mar 16** 3a) Implement milestones in the Staff Engagement Plan, Dir P&E **Sept 15** Work continuing, including cultural audit, review of Teambrief process, developments relating to staff e-bulletin and social media. Communication and Engagement under development and will require Board review – **October 15** . Dec 15 - Further update provided in Board - Jan 16. 3b) Maintain management of positive Employee relations. Following decision to move to multi union recognition arrangement work will be undertaken to formalise new consultative arrangements. New consultation arrangements and recognition agreement agreed Dir P&E **May 15 Completed** 3c) Undertake Cultural Audit and implement recommendations to improve employee engagement Dir P&E **Sept 15.** Audit completed. Feedback and implementation under way – Board update scheduled for Dec 15. **Dec 15 -** Cultural Audit completed and presented to TMG and Board in Dec. Action plan following cultural audit being developed. 4) Complete delivery of SLM and sustain Quality Impact Assessment of CIP Programmes, Dir of F&P, **Mar 16** Recruitment into positions to support lead by AD Finance

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 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, TMG, Quality Committee and other executive groups. 2) Bi-weekly **reports** to incident review group 1) CQC assessment January 2015 (awaiting feedback report) 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, to reflect priorities around service delivery. 2) Need to develop clinical audit capability 3) Further work needed to support development of a professional caring culture. 4) Improvement to complaints response times required to ensure that actions and learning and are implemented in a timely way	1a) Refine performance review meetings to give greater assurance on learning process in service lines Dir S&C, Dir F&P **July 15.** Review meetings held in September, with key focus on CQC report. Further refinement to align with current business planning round to be completed and set the new framework for 2016/17. **Jan 2016 . Draft framework reviewed and agreed In TEG** 1b) Implement Risk Management plan in combination with Safety and Risk workplans. Dir S&C **March 16** 1c) Implement Learning from Internal Audit reports Dir S&C **Mar 16 Review of IA reports completed, risk assessment of action plans to inform risk profile** 1d) Build on the Safety Improvement Plan in Sign up to Safety pledges and develop Safety Improvement Fellows to support and disseminate learning Dir S&C **March 16 SUTS workstreams progressing** 1d) Freedom to Speak Up working group to take forward actions to support identification of staff concerns, options appraisal for Freedom to Speak Up Guardian role, effective management as part of the wider risk management systems and effective feedback to staff on lessons learned. Dir S&C **March 16. FTSU Working Group report to Board on progress with workplan March 16** 2a) Implement milestones in the annual clinical audit plan. Med Dir, **March 16** 3a) Review and implement Clinical Leadership Framework to include scope of practice for new roles , Dir of Ops, Med Dir. **Review Oct 15 Implement March 16** 3b) Implement clinical professional leadership and clinical supervision. **Reviewed as part of workforce plan** Med Dir, Dir of Ops **Sept 2015 Work ongoing as part of wider A&E Plan**. 4a) Review of KPI's within Patient Relations Dir S&C **May 15. KPIS reviewed and updated. Complete** 4b) Response time improvement plan to be implemented Dir S&C **Sept 15.** Improvement plan in place with monthly monitoring by AD Quality and Nursing.

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			
5c.Insuffient alignment and responsiveness of corporate support services to operational service requirements NHSLA: 1: Governance 4: Safe Environment CQC: 10: Safety and suitability of premises 11: Safety, availability and suitability of equipment 16: Assessing and monitoring the quality of service provision Exec Director of Finance and Performance	4 x 4 = 16	4 x 4 = 16	4 x 1 = 4	1) Procedural documents in place 2) Incident, complaints and claims reporting policies and lessons learned processes in place. 3) Vehicle and equipment procurement and roll out processes in place 4) Risk management software systems are in place in support of the learning process 5) Inspections for Improvement process in place 6) Fleet replacement programme 7) Hub and Spoke / Make Ready programme 8) HR and Finance business partner working model. 9) Service transformation programme	1) Significant events and lessons learned reports to Trust Board, TMG, Quality Committee and other executive groups. 2) Estates Board monitoring of Capital Fleet and Equipment group 1) Assurance gained from Internal Audit findings 2014 whilst recognising the limited assurance of audits into the following • Vehicle Safety and Cleaning • Management of Tenancies • Facilities Management and repairs and maintenance 2) Internal Audit plan 2015/16	1) Systematic engagement process between support services and operational service lines needs further development 2) Fleet and Estates alignment to operational requirements. 3) Monitoring and record keeping in relation to management of tenancies 4) Use of Planet Facilities Management (FM) functionality, routine inspection checks of buildings and quality of works completed, end user feedback.	1a) Implementation of Service Line Management Service Transformation workstream with cross department representation Dir F&P **March 16** in place as part of 15/16 programme 1b) New ways of working to be implemented across Standards and Compliance Directorate to closer align with operational structures Dir S&C **Sept 2015.** Review of current processes completed and priorities for development agreed and scheduled. 1c) New starter process review being undertaken to identify areas of improved efficiency to support operational services Dir P&E **July 2015** Review completed and recommendations identified. Implementation **March 16.** 1d) Workforce planning process underway as co-production with operational services and HR Dir P&E **Sept 2015** 1e) implementation of ICT work streams of transformation plan Dir F&P **March 2016 IT programme board established June 2015** 2a) Review of cleaning, equipment and vehicle maintenance SOPs Dir F&P – **Oct 15 Complete.** 2b) Vehicle preparation programme options appraisal to Board for review Dir Ops **Dec15 Complete. Initial VPS pilot live** 2c) Support services customer survey and follow up action plans to be implemented CEO **March 16.** HR completed, fleet, estates and procurement issued Oct 15. 2d) make ready pilot in Leeds. CEO **Oct 15. Complete – pilot site now live.** 2e) Executive and management portfolio review to support improved alignment and accountability. CEO **March 16 Executive portfolio review complete** 3) New process for monitoring of tenancies to be implemented CEO **June 2015** .Action complete. 4) New FM processes to be implemented CEO **March 2016**	

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 x2 = 8	4 x1= 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 into implementation of the clinical leadership framework with a number of recommendations arising 3) CQC assessment identifying minor concerns 14/15 – awaiting report from inspection Jan 15	1) Lack of positive assurance from dashboard/staff feedback that the CLF is functioning consistently – resolved Awaiting feedback report from CQC	1a) Implement non-clinical support roles in A&E localities to release Clinical Supervisor time Dir Ops **Sept 15. Complete** 1b) Evaluate effectiveness Dir Ops **Oct 15** **March 16 role evaluation positive, further review of coordinated approach required** 1b) Monitor CBU CS dashboards and implement local actions to ensure consistency of delivery across CBU Dir Ops **March 16** 1c) Complete review of CLF guidance documents following production and circulation of draft Dir Ops **Sept 15.** 1d) Review of clinical supervision model Dir Ops **Dec 15** Implement **March 16** Feb 16 Implementation of the clinical career framework and associated supervision as part of A&E transformation plan 1e) Appointment of Associate Director Paramedic Practice. Med Dir **Sept 15**. **Completed.**

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 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) Workforce plan in place. 3) Continued focus and monitoring of the workforce plan requirements and delivery with staff side through the Joint Steering Group meetings. 4) Approved and costed Annual Education & Training Plan is in place.	1) Board level monitoring of progress via Integrated Performance Report and Quality Committee. PA 2) STP/TEG/TMG 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. 4) National Paramedic shortage impacting on recruitment and retention issues	1a) Deliver interim recruitment and training plan in line with A&E improvement plan, pending Board agreement of updated workforce plan P&E, **Sept 15. Complete** 1b) Updated workforce plan informed by ORH modelling to go to Board for review and approval. Dir Ops **Sept 15.** Dec 15 Board agreed interim increase in establishment agreed pending completion and final sign off of A&E plan delivered by external recruitment and introduction of Private Providers. 2a) Manage on-going local employee relations with key unions. Dir P&E, **March 16** with on-going action throughout year 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 16** 2c) Maintain current intelligence on national issues and ensure well-developed business continuity and resilience plans in place. Dir P&E **March 16** 2d) Revised JSG constitution agreed Dir P&E **Aug 15. Complete** 3a) Implement annual agreed annual education and training plan. Dir P&E, **March 16** 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 16** 4a) Work with HE and LETB to maximise opportunities to recruit Dir P&E **March 16** 4b) Review of skill mix and creation of new roles in line with workforce plan and staff side engagement Dir P&E **June 15** New roles communicated to staff and recruitment/training in place. Final numbers subject to confirmation following ORH modelling and Board review of workforce plan..

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		

6c. Challenge to delivery of key objectives due to ineffective staff engagement NHSLA: 3 Competent & Capable Workforce CQC: 13 Staffing 14 Supporting workers Executive Director of People & Engagement	5 x 3 = 15	5 x 3 = 15	5 x 1 = 5	1) Communications systems and processes 2) Listening Watch programme 3) Whistleblowing and raising concerns processes 4) Clinical Leadership framework 5) Staff-side multi-union agreement 6) engagement strategy	1) Board level monitoring of staff feedback through incident reporting, whistleblowing and Annual Staff Survey 2) Joint Steering Group Meeting 1) Annual Staff survey 2) In-depth staff questionnaire and evaluation by Zeal	1) Local or national industrial action affects the reputation of the Trust as an employer. 2) There is a need to develop management and staff engagement and accountability 3) Processes to support 'Freedom to Speak Up'	1a) Manage on-going local employee relations with key unions. Dir P&E, **March 16** **Positive work to strengthen relations with staff forum and union reps ongoing** 1b) 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 16** 1c) Maintain current intelligence on national issues and ensure well-developed business continuity and resilience plans in place. Dir P&E **March 16** 1d) Implement agreed course of training for Managers and Staff side representatives from ACAS. Dir P&E **June 15** completed 2a) Implement milestones of staff engagement plan Dir P&E **Sept 15.** Work continuing, including cultural audit, review of Teambrief process, developments relating to staff e-bulletin and social media., Cultural Audit completed and presented to TMG and Board in Dec. Implementation of actions ongoing – March 16 2b) Implement management and leadership development milestones in service transformation programme. Dir P&E **March 16** 3a) Options appraisal to be reviewed by task and finish group to ensure effective solution for YAS. Dir S&C **Dec 15** Action complete – proposed solution presented to TEG for review in Dec 15 and scheduled for final Board sign off in Feb 16. 3b) Implement recommendations of task and finish group Dir S&C **March 16**

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) Scheduled reports to Quality Committee 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, **Oct 15.** Dec 15 – significant testing of A&E, NHS 111 and ICT resilience during flood events in December. Debrief and review of learning completed internally and with other agencies. 2a) Delivery of relevant training requirements via annual Trust training plan. Dir Ops, **March 16**

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. 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. Potential requirement for additional staffing. 2) PTS transformation programme still in progress 3) Winter resilience funding not secured for NHS 111 3) National financial stretch targets for NHS Trusts	1a) Implement refreshed operational Improvement plan delivery and recovery plan Dir of Ops **Sept 15** (see risk 3a) 2a) Continue with PTS transformation programme in order to ensure delivery of cost savings CEO **Mar 16** 2b) Continue with A&E operational improvement plan Dir Ops **Mar 16** 3a) Deliver NHS 111 cost improvement plan to mitigate potential risk regarding winter funding. Capacity review requested with commissioners Oct 2015. Dir S&C **March 16** 4a) Review of Operating Plan and re-submission to TDA. Dir F&P Board review Sept 15. Action Complete