BOARD ASSURANCE FRAMEWORK OVERVIEW												QUARTER 1 - 2018/19
Strategic Objective	**Risk appetite**	**Strategic Risk**	**Quarterly Assurance Rating**				**Reason for Current Assurance Rating**	**Executive Lead**	**Assuring Committee**	**Current Risk Score**	**Change**	
			Q1	**Q2**	**Q3**	**Q4**						
1. We deliver great care that is high quality and improves lives	tion to that openness but the board would not take risks that either compromise our compliance with its duty of care to staff and patients or egislative frameworks within which it has a licence to operate.	**SR1. (Risk 637) Due to an inability to align our workforce capacity to planned models of care, there is a risk that we are unable to deliver high quality, evidence based, person centred care.**	Partial (remains same)	Partial (remains same)	Partial (remains same)	Partial (remains same)	There are national shortages of qualified staff across the system which impacts on our ability to recruit to some areas. Alongside an increasing private and third sector healthcare provision which provides further competition and market forces in the recruitment market. Continued pay restraints and work pressures across the NHS also adding to the whole picture. There are also ongoing high numbers of vacancies in some areas.	Claire Holmes (Director of Organisational Development and Workforce)	Board	**12**	→	
		SR2. (Risk 636) We are unable to maintain compliance with regulatory requirements relating to the quality and safety of our services due to a failure to provide care in line with national standards and best practice.	Significant (remains same)	Significant (remains same)	Significant (remains same)	Significant (remains same)	We have put in place a number of controls to ensure that we comply with our regulatory standards and we are not in breach of any of our regulatory requirements.	Cathy Woffendin (Director of Nursing and Professions)	Quality Committee	**1**	→	
		SR3. (Risk 638) Due to inadequate systems to support continuous learning, improvement and innovation, there is a risk that our services deliver poor outcomes for service users.	Partial (remains same)	Partial (remains same)	Partial (remains same)	Partial (remains same)	There is some evidence that there is continuous learning, improvement and innovation in the Trust but this is insufficiently mature and embedded to give significant assurance.	Dr Clare Kenwood (Medical Director)	Quality Committee	**12**	→	
		SR4. (Risk 632) We are unable to maintain effective, productive relationships with key external stakeholders, with the result that we are unable to work successfully with partners to support innovative care and exceptional outcomes for service users.	Significant (remains same)	Significant (remains same)	Significant (remains same)	Significant (remains same)	The Trust has a good relationship with both local and national partners and plays an influential role in working with partners to look at and bring about innovative ways of working together; ensuring there is high quality care provided to our service users. This is evidenced by the number of forums on which the Trust is represented and the work-streams currently underway including the establishment of a committee in common with other mental health partners (West Yorkshire and Harrogate STP, the Mental Health Collaborative, Leeds Plan, Health and Wellbeing Board, Humber Coast and Vale STP).	Dr Sara Munro (CEO)	Board	**4**	→	
		SR5. (Risk 640) If we cannot produce and effectively use information about our services to support the operation of our governance structures, there is a risk that there will be a lack of confidence in our management information and that we will be unable to ensure the safety of our services.	Partial (remains same)	Partial (remains same)	Partial (remains same)	Partial (remains same)	We currently provide a range of information across our Organisation in the form of Workforce, Finance, Performance, Activity and Quality measures and metrics. We also have existing mechanisms in place to share this information internally and with external agencies and to enable scrutiny and provide assurance to our Board and our regulators. The risk identified is reduced by these arrangements being in place but could have considerable consequences and impact from a regulatory, confidence, governance and reputational perspective if they failed. In addition we are seeking to make further improvements in light of the work we have undertaken to strengthen our governance arrangements which will further mitigate and minimise the risk in the new year.	Joanna Forster Adams (COO)	Finance and Performance Committee	**6**	↓	

2. We provide a rewarding and supporting place to work	**3 - Open - ('high') We have a risk appetite which is 'open' to considering all potential options and solutions. It is classed as 'high' in rela compromise compliance with the core regulatory and l**	**SR6. (Risk 620) We are unable to deliver an effective and attractive programme of training and development opportunities for our staff due to inadequate capability and capacity, corporately and within care services.**	Partial (remains same)	Partial (remains same)	Partial (remains same)	Partial (remains same)	The Trust provides high level of compulsory training as evidenced by the compliance rates. There is high intake for our internal leadership programmes and a managers essential programme for existing and aspiring managers. CPD is offered and identified through learning and development as part of the appraisal process. Significant funding is available to support external training and educational courses. Clinical skills training needs are identified through clinical leads and practice development posts. Andrew Sims Centre provides high quality training and courses to medical staff.	Claire Holmes (Director of Organisational Development and Workforce)	Board	**6**	→
		SR7. (risk 633) As a result of a culture of blame which does not foster a psychologically safe environment for our staff we are unable to reduce patient harms or provide a positive experience for our service users.	Partial (remains same)	Partial (remains same)	Partial (remains same)	Partial (remains same)	The Trust has in place a number of policies, procedures and processes in place which allow staff to speak out and raised their concerns. There is still work to be done to embed some of these, to live the values and create a psychologically safe environment for staff eliminate a culture of blame and evidence systematically the work in learning and improvement. We also need to agree and embed the Workforce and OD Strategic Plan and the Quality Plan which are scheduled for sign off in the next three months.	Dr Sara Munro (CEO)	Quality Committee	**9**	→
3. We use our resources to deliver effective and sustainable services		**SR8. (Risk 619) A lack of financial sustainability results in us having insufficient funds to sustain and develop our services and invest in high quality outcomes for our service users.**	Significant (remains same)	Significant (remains same)	Significant (remains same)	Significant (remains same)	We have maintained good working relationships with commissioners and have a track record of meeting our financial regulatory requirements. Our previous financial performance has generated a strong risk rating and high liquidity levels which acts as a buffer and mitigates against deterioration in our financial position.	Dawn Hanwell (Chief Finance Officer)	Finance and Performance Committee	**8**	→
		SR9. (Risk 615) Due to inadequate, inflexible or poorly maintained estates and facilities we are unable to provide a safe and positive environment for service users and staff.	Partial (remains same)	Partial (remains same)	Partial (remains same)	Partial (remains same)	Overall the estate is managed to an adequate standard but development and improvement is constrained by the ownership and control model in operation. Long term this can only be addressed by significant change to the PFI contractual arrangements and will require investment. This is an ongoing process.	Dawn Hanwell (Chief Finance Officer)	Finance and Performance Committee	**8**	→
		SR10. (Risk 635) As a result of insecure, inadequate or unstable information technology systems and infrastructure, the quality and continuity of our services is compromised.	Partial (remains same)	Partial (remains same)	Partial (remains same)	Partial (remains same)	There are a number of significant controls in place and assurances that these controls are robust however, the Trust is constantly in a position of threat from external sources and must maintain a position of vigilance at all times.	Dawn Hanwell (Chief Finance Officer)	Finance and Performance Committee	**8**	→

Strategic Objective	1. We deliver great care that is high quality and improves lives			Risk appetite: 3 - Open ('High')
Strategic Risk	**Initial Risk Score**	**12**	**Committee**	Board
SR1. (Risk 637) Due to an inability to align our workforce capacity to planned models of care, there is a risk that we are unable to deliver high quality, evidence based, person centred care.	**Current Risk Score**	**12**	**Executive lead**	Claire Holmes (Director of Organisational Development and Workforce)

Assurance rating (quarterly) (limited, partial, significant)	Q1	Q2	Q3	Q4
	Partial	Partial	Partial	Partial

Contributory risks from the directorate risk register				Risk Score			
Datix Ref	**Description**	**Risk Lead / responsible director**	**Overseeing group**	**Q1 (end of June)**	**Q2 (end of September)**	**Q3 (end of December)**	**Q4 (end of March)**
56	The Care Group currently has a high number of vacancies impacting on quality and safety.	Andy Weir / Joanna Forster Adams	**Care Group Management Meeting**	9	9	9	9
109	Inability to recruit permanent staff across the Trust resulting in the need to rely on bank and agency staff within services	Lindsay Jensen / Claire Holmes	**Workforce and Organisational Development Committee**	12	12	12	12
469	There is a continued annual increase in referrals through the Single point of access. These referrals are triaged by Crisis staff and the resource has not increased to match the demand. This could lead to a poor quality of service for people in crisis.	Judith Barnes	**Community Redesign Project**	9	9	9	9
688	Unable to appoint to all vacancies in the Leeds and Wakefield CT scheme predicting 12 vacancies for the August rotation	Abhijit Chakrabarti / Claire Kenwood	**TBC**	16	12	12	Archived
705	7 x General Adult Inpatient/Acute Care. 5 x Community. 3 x Older Peoples Services vacancies within these areas. Maintaining continuity of medical input is unstable due to the use of temporary contracts and agency staff.	Jamie Pick	**TBC**	16	16	16	16

Key controls in place		Assurance that controls are effective	Date
Ref	*The main controls/systems in place to manage principle risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*
637	Regular planned recruitment events for nursing posts	Regular monthly recruitment planning meetings are held each month with the Deputy COO and Service Managers where discussions take place around any potential recruitment "hotspots", the current recruitment pipeline, and planned recruitment activities and campaigns for the coming months. Reporting of recruitment activity in monthly Workforce Development Board Report. In 2018 to date there have been 72 Nursing related roles (in addition there are also preceptee Nursing Posts of circa 31) filled and over 1105 applications for Nursing related roles in our Trust, with 507 applicants shortlisted for interview and 270 interviews. There are two planned recruitment events for Student Nurses in January 2019.	Nov-18
637	Implemented TRAC recruitment system to support candidate management	The TRAC system has now been operational for 12 months and the improved functionality using the system relating to checks and reduction in time to hire was also noted in an external Audit in May 2018 which found that the Trust was able to demonstrate "significant" assurance around the controls and responsiveness of the Trust's Recruitment processes. The introduction of the TRAC system has seen a significant reduction in overall time to hire, mainly reflected in the reduction around time taken for completion of pre-employment checks from 45.03 days to 27.4 days.	Nov-18
637	Workforce and OD strategic plan agreed by the Board	The Workforce and OD Strategic Plan sets out how the Trust will address shortages of staff and the training and development of staff to meet the needs of the organisation	Nov-17

637	Exec-led Workforce and OD Group established	The group meets on a regular basis and has representation from clinical services / corporate services and Staffside - minutes of the meeting reflect the work of the group	May-18
637	Nursing and AHP strategies have been agreed and launched	The Nursing and AHP strategies have been developed, agreed and launched into the organisation	Oct-18
637	Well established internal nursing and HSW bank to provide a flexible workforce	Bank and Agency Fill Rate Report produced on a monthly basis demonstrating a positive picture in bank fill rates over agency for clinical posts. Of the shifts filled 78% of shifts filled by bank and 22% by agency for qualified nurses; 85.4% bank fill rate and 14.6% agency for Health Support Workers.	Sep-18

Significant gaps in control / assurance		Actions	Deadline
Ref	*The main areas of weakness which result in ineffective or absent controls / assurance*	*Actions required to mitigate the weakness*	*Target date for completion*
637	Establishing a programme for apprentices (gap in control)	To use new apprentice roles and opportunities to support recruitment into vacancies whilst also focusing on occupations with shortages	Dec-19

Strategic Objective	1. We deliver great care that is high quality and improves lives	Risk appetite: 3 - Open ('High')

Strategic Risk	Initial Risk Score	4	Committee	Quality Committee
SR2. (Risk 636) We are unable to maintain compliance with regulatory requirements relating to the quality and safety of our services due to a failure to provide care in line with national standards and best practice.	Current Risk Score	1	Executive lead	Cathy Woffendin (Director of Nursing and Professions)

Assurance rating (quarterly) (limited, partial, significant)	Q1	Q2	Q3	Q4
	Significant	Significant	Significant	Significant

Contributory risks from the directorate risk register				Risk Score			
Datix Ref	Description	Lead / responsible director	Overseeing group	Q1 (end of June)	Q2 (end of September)	Q3 (end of December)	Q4 (end of March)
646	Risk that we are not detaining people in line with mental health legislation, so that the detentions are defective.	Oliver Wyatt / Cathy Woffendin	Operational Mental Health Legislation Group and Mental Health Legislation Committee	1	1	1	1

Key controls in place		Assurance that controls are effective	Date
Ref	*The main controls/systems in place to manage principle risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*
636	Governance Structure in place which sets out where performance and compliance is discussed and assurance is received and provided	The governance structure was signed off by the Executive Management Team and there is executive director oversight of the reporting arrangements through the executive-led groups with assurance reports to the Board sub-committees which will identify any risks to compliance with regulatory requirements	Mar-19
636	Annual process for reporting on the controls in place in relation to risk including risks to compliance (Annual Governance Statement - Compliance with the provider licence)	The Annual Governance Statement was signed off by the Audit Committee, the Auditors and the Chief Executive for 2017/18. Self certifications were signed off by the Board for 2017/18 which also highlighted if there were any risks to compliance for 2018/19 and how these would be addressed.	May-18
636	Process in place for reporting serious incidents to Board and Quality Committee	NHSE investigation reports were presented to the October Board and Quality Committee and assurance was provided and received as to the process of reporting and the content of the cases provided	Mar-19
636	Serious incident reporting and investigation process in place	The action plan from the audit carried out in April 2017 have all been completed and evidence provided back to the internal auditors. A new process for reporting on serious incidents was signed off and presented to the Board for assurance in September 2017. Regular reports are sent to commissioners on each SI and they are assured of the processes.	Mar-17
636	CQC Project Team in place to oversee compliance with CQC Standards. CQC Project Team Meeting chaired by the Director of Nursing	The CQC Project Team Meeting has received assurance and supporting evidence from leads responsible for CQC actions and compliance of robust processes and procedures in place. Regular updates are provided to Trust Board through DoN quarterly reporting.	Mar-18
636	Quarterly meetings with the CQC leads	Through dialogue with the CQC leads no concerns have been raised in relation to the Trust's progress in relation to compliance with the standards	Sep-18
636	Nursing Strategy and AHP Strategy launched	The Nursing and AHP strategies have been developed, agreed and launched into the organisation	Oct-18

Strategic Objective	1. We deliver great care that is high quality and improves lives	Risk appetite: 3 - Open ('High')

Strategic Risk	Initial Risk Score	12	Committee	Quality Committee
SR3. (Risk 638) Due to inadequate systems to support continuous learning, improvement and innovation, there is a risk that our services deliver poor outcomes for service users.	Current Risk Score	12	Executive lead	Dr Clare Kenwood (Medical Director)

Assurance rating (quarterly) (limited, partial, significant)	Q1	Q2	Q3	Q4
	Partial	Partial	Partial	Partial

Contributory risks from the directorate risk register				Risk Score			
Datix Ref	Description	Lead / responsible director	Overseeing group	Q1 (end of June)	Q2 (end of September)	Q3 (end of December)	Q4 (end of March)
643	Quality improvement, organisational development and clinical governance offering is not integrated and operates in silo, as a result our Quality Improvement approach is siloed, and not widely available/visible	Richard Wylde / Claire Kenwood	Trustwide Clinical Governance Group	9	9	9	9
645	Risk that there is no systematic approach to identifying and helping those teams who need support from the Service Improvement Team	Richard Wylde / Claire Kenwood	Trustwide Clinical Governance Group	6	6	6	6

Key controls in place		Assurance that controls are effective	Date
Ref	*The main controls/systems in place to manage principle risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*
638	Serious incident reporting and investigation process in place	The action plan from the audit carried out in April 2017 have all be completed and evidence provided back to the internal auditors. A new process for reporting on serious incidents was signed off and presented to the Board for assurance in September 2017. Regular reports are sent to commissioners on each SI and they are assured of the processes.	Mar-18
638	Complaints, Litigation, PALs report	This is sent monthly to the services to outline any learning	Mar-19
638	Peer reviews have been established in the Trust	Peer review process established and embedded in the Trust and we have evidence which is held corporately and shared with teams following the peer review process being completed. A rolling programme has been established through the year. All services have a KLOE document	Oct-17
638	Ward to Board governance	A consistent use of highlight reports are in place and ensure transparent escalation and linkage across the organisation.	Jan-19
638	Freedom to Speak up Guardian	There is a report provided to the Board detailing the themes of the issues staff have raised. The themes identified by the guardian are used to inform learning.	Nov-18
638	Quality Plan	The quality plan has been developed and agreed which defines the metrics and methods of evidencing continuous learning, improvement and innovation	Feb-18

Significant gaps in control / assurance		Actions	Deadline
Ref	*The main areas of weakness which result in ineffective or absent controls / assurance*	*Actions required to mitigate the weakness*	*Target date for completion*
638	Serious incident reporting and investigation (gap in control)	We are developing metrics to assess the strength of the recommendations	Aug-19
638	There is a gap in the processes in place to quantify and audit learning (gap in control)	The processes that need to be put in place are: an audit of the effectiveness of learning; methods of quantifying learning; and methods of quantifying there is a learning culture	Aug-19

Strategic Objective	1. We deliver great care that is high quality and improves lives	Risk appetite: 3 - Open ('High')

Strategic Risk	Initial Risk Score	6	Committee	Board
SR4. (Risk 632) We are unable to maintain effective, productive relationships with key external stakeholders, with the result that we are unable to work successfully with partners to support innovative care and exceptional outcomes for service users.	Current Risk Score	4	Executive lead	Dr Sara Munro (CEO)

Assurance rating (quarterly) (limited, partial, significant)	Q1	Q2	Q3	Q4
	Significant	Significant	Significant	Significant

Contributory risks from the directorate risk register				Risk Score			
Datix Ref	Description	Lead / responsible director	Overseeing group	Q1 (end of June)	Q2 (end of September)	Q3 (end of December)	Q4 (end of March)
650	Not being able to make the case for Mental Health services at STP & City footprint could lead to insufficient income growth to meet need, leading to fragmentation of care and loss of influence.	David Brewin / Dawn Hanwell	Finance and Performance Committee	12	6	6	6
658	There is a risk that we will be unable to achieve planned growth and deliver our strategy if we are unable to further strengthen our relationships with the 3rd sector	Cath Hill / Sara Munro	Executive Management Team	6	6	6	6

Key controls in place		Assurance that controls are effective	Date
Ref	*The main controls/systems in place to manage principle risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*
632	Continue to be influential players in local and national forums working with NHS, public, third sector partners and universities.	The Chief Executive is an integral and influential part of the work to develop our services both locally and nationally this is evidenced through the minutes of meetings, CEO report to the Board.	Mar-19
632	CEO and executive directors leading on a number of projects across the STP / mental health providers to look at innovative ways of working together to enhance the care provided to service users	The CEO and executive directors lead on a number of projects across the STP and report these for assurance into the Trust's governance structure. This is evidenced through minutes of meetings and the work to establish a committee in common.	Feb-19
632	Established the Trust's profile both locally and nationally	Sought out partnership opportunities both locally and nationally and ensure that executive directors are involved in and sighted on the impact of these opportunities	Sep-18
632	Committee is Common has been established amongst partners / CCG in Leeds to determine the future direction of services (LPICC)	This formalises the way in which we will work with partners	Sep-18
632	Committees in common established with mental health partners in West Yorkshire (WYMHC)	This formalises the way in which we will work with partners	Apr-18
632	CEO is an influential member of a number of groups across the West Yorkshire patch	SRO for the Workforce Partnership Executive Group, Representative for the development of the Mental Health STP MoU, CEO for the West Yorkshire Mental Health Group, Programme Chair for the New Care Model's for Mental Health in West Yorkshire	Sep-18

Significant gaps in control / assurance		Actions	Deadline
Ref	*The main areas of weakness which result in ineffective or absent controls / assurance*	*Actions required to mitigate the weakness*	*Target date for completion*
632	Use role as SRO to influence and shape agenda locally and within the STP (gap in assurance)	Help to shape the local agenda within the Health and Care Partnership	Dec-19

Strategic Objective	1. We deliver great care that is high quality and improves lives					Risk appetite
						3 - Open ('High')
Strategic Risk		Initial Risk Score	12	Committee	Finance and Performance Committee	
SR5. (Risk 640) If we cannot produce and effectively use information about our services to support the operation of our governance structures, there is a risk that there will be a lack of confidence in our management information and that we will be unable to ensure the safety of our services.		Current Risk Score	6	Executive lead	Joanna Forster Adams (COO)	

Assurance rating (quarterly) (limited, partial, significant)	Q1	Q2	Q3	Q4
	Partial	Partial	Partial	Partial

Contributory risks from the directorate risk register				Risk Score			
Datix Ref	Description	Lead / responsible director	Overseeing group	Q1 (end of June)	Q2 (end of September)	Q3 (end of December)	Q4 (end of March)
104	Business continuity plans have not been completed for some services. Some of the plans that have been completed are not endorsed by operational staff as being appropriate responses for a selection of threats	Andrew Jackson / Joanna Forster Adams	Emergency Preparedness Resilience and Response Group	9	9	9	9
487	Operational managerial staff have not had training in incident response to ensure they can meet the required expectation in responding to a critical or major incident.	Andrew Jackson / Joanna Forster Adams	Emergency Preparedness Resilience and Response Group	12	12	12	12
561	The data quality and business performance teams have seen key resources leave the organisation and need to be restructured and re-aligned and there is the potential risk of to data accuracy and reporting that could compromise the Trust's contractual reporting and operational activity.	Bill Fawcett / Dawn Hanwell	Information Steering Group	6	6	6	9

	Key controls in place	Assurance that controls are effective	Date
Ref	*The main controls/systems in place to manage principle risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*
640	Sets of Quality performance information available published and used across the organisation (HR, Finance, Quality and Operational)	Cognos information available and accessed routinely across services. HR data set circulated across Organisation on a weekly basis. Information Team validation process established across key metrics. Finance system accessible and used routinely by managers (supported by Management accountants). Contracts manager collates and validates activity information. Performance report shared on a cascade basis through Board to SLT and their teams.	Jan-19
640	EPRR arrangements strengthened and reviewed at Board in October 2018	Full review of EPRR arrangement and supporting training and development undertaken. Assurance report provided at Board in October 2018.	Oct-18
640	Business continuity planning programme of work established	Business continuity plans established in key operational areas across the Organisation with oversight provided by the Exec led Resilience group.	Nov-17
640	Sets of information which are produced and shared with external partners, regulators and commissioners	Information routes established and operational through Information reporting team, Finance dept. and Contracts Manager.	Dec-18
640	Performance review process established across care Groups led by members of the SLT.	Minutes and logs capturing key performance indicators in each Service within Care Groups (Specialist).	Sep-17
640	Performance data is consolidated and relevance checked and shared at every level of the organisation.	Work has been undertaken to ensure that quality and performance consolidated suites of information are produced and used at every level of the organisation.	Mar-18
640	Governance, accountability, assurance and performance framework in place including performance framework and review cycle.	Internal Audit rated the GAAP as significant assurance	Mar-19
640	Data validation process established and in place within the information department of the Trust (working together with operational services).	Monthly validation process in scheduled routine activities overseen by the Head of Informatics. Enhanced by outputs including internal and external audit reviews of key quality and performance metrics.	Dec-18

	Significant gaps in control / assurance	Actions	Deadline
Ref	*The main areas of weakness which result in ineffective or absent controls / assurance*	*Actions required to mitigate the weakness*	*Target date for completion*
640	Partial compliance declared in regard to the Emergency Preparedness, Resilience Response assurance statement (gaps in controls)	Action plan in place which is monitored through the EPRR group. Actions are expected to be completed during 2019/20	Sep-19

640	Business Continuity Plans are not in place in all corporate areas (gap in control)	Work is to be concluded on the care service plans and also in the corporate departments.	Jul-19

Strategic Objective	2. We provide a rewarding and supporting place to work			Risk appetite: 3 - Open ('High')	
Strategic Risk		Initial Risk Score	6	Committee	Board
SR6. (Risk 620) We are unable to deliver an effective and attractive programme of training and development opportunities for our staff due to inadequate capability and capacity, corporately and within care services.		Current Risk Score	6	Executive lead	Claire Holmes (Director of Organisational Development and Workforce)

Assurance rating (quarterly) (limited, partial, significant)	Q1	Q2	Q3	Q4
	Partial	Partial	Partial	Partial

Contributory risks from the directorate risk register				Risk Score			
Datix Ref	Description	Lead / responsible director	Overseeing group	Q1 (end of June)	Q2 (end of September)	Q3 (end of December)	Q4 (end of March)
5	Requirement for new skills in the workforce to support new models and also lack of staff engagement and involvement in the new models.	Lindsay Jenson	Workforce and OD Group	9	9	9	9
642	Risk that we have inadequate leadership capacity to grow and deliver our research portfolio as the AMD for research is retiring in 2018.	Alison Thompson / Claire Kenwood	Research Committee	9	9	Archived	Archived

Key controls in place		Assurance that controls are effective	Date
Ref	*The main controls/systems in place to manage principle risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*
620	Regular monitoring of compulsory training compliance	Monthly reports showing a consistent achievement of Trust target of 85% compliance - 85.4% as at September 2018	Jan-19
620	Medical Revalidation	There are systems and processes in place to ensure that medical revalidation requirements are met. Assurance is provided through the Annual Responsible Officer Report	Jul-18

Significant gaps in control / assurance		Actions	Deadline
Ref	*The main areas of weakness which result in ineffective or absent controls / assurance*	*Actions required to mitigate the weakness*	*Target date for completion*
620	Lack of training support and provision (gap in control)	Systematic review of trust wide learning and development needs, linked to strategic plans and personal development plans	Mar-19
620	Appraisal process audit	The internal audit provided limited assurance to the appraisal process an action plan is in place	Jun-19
620	Identification of learning and development needs as part of appraisal process (gap in assurance)	Monthly reports showing number of appraisals completed 74.3% at September , which is below the target of 85%	Sep-18
620	Quality of appraisals (gap in assurance)	As still in Year 1 transition phase of appraisal objectives and learning and development needs being recorded on Ilearn- audit of the quality of appraisals will be carried out in Year 2	Dec-19

Strategic Objective	2. We provide a rewarding and supporting place to work				Risk appetite: 3 - Open ('High')
Strategic Risk	Initial Risk Score	9	Committee	Quality Committee	
SR7. (risk 633) As a result of a culture of blame which does not foster a psychologically safe environment for our staff we are unable to reduce patient harms or provide a positive experience for our service users.	Current Risk Score	9	Executive lead	Dr Sara Munro (CEO)	

Assurance rating (quarterly) (limited, partial, significant)	Q1	Q2	Q3	Q4
	Partial	Partial	Partial	Partial

Contributory risks from the directorate risk register				Risk Score			
Datix Ref	Description	Lead / responsible director	Overseeing group	Q1 (end of June)	Q2 (end of September)	Q3 (end of December)	Q4 (end of March)
654	A risk that we do not embed the Trust's values and do not model them at all levels of leadership resulting in disengagement of our staff and a lack of collective ownership of our mission	Cath Hill / Sara Munro	Workforce and Organisational Development Group	6	3	3	3
655	There is a risk that if we do not establish and apply a consistent behaviour and accountability framework that our staff will recognise inconsistency and this will undermine our desired culture of increased accountability at all levels of the organisation.	Cath Hill / Sara Munro	Executive Management Team	6	4	4	4
656	If we are unable to set a clear strategy and supporting plans which staff are able to understand and see the delivery of, then we will be unable to secure their engagement in the success of the Trust.	Cath Hill / Sara Munro	Senior Leadership Team	6	3	3	3

Key controls in place		Assurance that controls are effective	Date
Ref	*The main controls/systems in place to manage principle risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*
633	Agreed our Trust strategy including values which includes having integrity and be caring of our staff and service users	The Trust values have been developed in conjunction with our stakeholders, agreed by the Board and widely publicised. The Trust's strategy will be signed off by the Board in November 2017	Nov-17
633	Have developed the governance, accountability and performance framework which will ensure that staff not only know how to escalate issues they will be encouraged to do so	the internal audit provided significant assurance on the GAAP	Mar-19
633	Developed a model of inclusive leadership within our senior managers which will be rolled out within the organisation	There have been a number of session which have taken place with our senior managers and senior leaders to develop their capacity to promote and model an inclusive leadership style. This is evidenced by the agendas from the Leadership Forum and the work programme for the Senior Leadership Team at their development events.	Dec-18
633	Supporting strategies developed and signed off by the Board	Five supporting strategies have been developed and signed off by the Board in April 2018	Apr-18
633	Staff engagement events carried out by the Chief Executive who is talking to all staff about their experiences	Feedback from the CEO listening events as provided to the Senior Leadership Team 6 September 2017	Sep-18

Significant gaps in control / assurance		Actions	Deadline
Ref	*The main areas of weakness which result in ineffective or absent controls / assurance*	*Actions required to mitigate the weakness*	*Target date for completion*
633	Establishment of the Culture Club	This group will look at how leaders can be empowered to change the culture of the organisation	Sep-19
633	The supporting strategies need to be embedded in the organisation (gap in control)	The supporting strategies are to be launched into the organisation and embedded fostering a supportive culture for staff	Mar-20

Strategic Objective	3. We use our resources to deliver effective and sustainable services	Risk appetite: 3 - Open ('High')

Strategic Risk	Initial Risk Score	8	Committee	Finance and Performance Committee
SR8. (Risk 619) A lack of financial sustainability results in us having insufficient funds to sustain and develop our services and invest in high quality outcomes for our service users.	Current Risk Score	8	Executive lead	Dawn Hanwell (Chief Finance Officer)

Assurance rating (quarterly) (limited, partial, significant)	Q1	Q2	Q3	Q4
	Significant	Significant	Significant	Significant

Contributory risks from the directorate risk register				Risk Score			
Datix Ref	Description	Lead / responsible director	Overseeing group	Q1 (end of June)	Q2 (end of September)	Q3 (end of December)	Q4 (end of March)
3	Potential inability to maintain a strong financial position in context of: increasing demand (and a largely fixed block contract, with out of area responsibility being solely with the Trust), and challenged commissioner and local authority funding positions.	David Brewin / Dawn Hanwell	Finance & Performance Committee	8	6	6	6
469	There is a continued annual increase in referrals through the Single point of access. These referrals are triaged by Crisis staff and the resource has not increased to match the demand. This could lead to a poor quality of service for people in crisis.	Judith Barnes	Community Redesign Project	9	9	9	9
570	Errors in outgoing correspondence (letter to wrong address, letter for one patient in correspondence to another etc) & other reportable IG breach incidents persist in care services. There has been an increase in reportable incidents year-on-year since the current reporting mechanism was established in 2012 with a risk of a fine from ICO.	Bill Fawcett / Dawn Hanwell	Information Governance Group	15	15	15	9
649	Evolution of New Care Models (NCM) impact on clinical income and sustainability. TEWV led CAMHS NCM involves the development of local CAMHS community services aimed at reducing out of area placements, this could reduce Tier 4 CAMHS (Mill Lodge) income and activity. Eating Disorders NCM results in LYPFT taking the full financial risk for out of area placements.	David Brewin / Dawn Hanwell	Finance & Performance Committee	9	9	9	9
650	Not being able to make the case for Mental Health services at STP & City footprint could lead to insufficient income growth to meet need, leading to fragmentation of care and loss of influence.	David Brewin / Dawn Hanwell	Finance & Performance Committee	12	6	6	6
651	Failure to achieve ongoing CIP requirements and demonstrate efficient and effective care will lead to a deterioration in the financial position.	David Brewin / Dawn Hanwell	Finance & Performance Committee	9	9	9	9
653	There is a risk that the Trust could be unsuccessful in maintaining or attracting new business in a competitive/ tendering process, including national procurement approaches (Gender Identity) and approaches to service redesign at local and STP footprint (Forensics). This would result in a deterioration in the financial position and also be detrimental to the Trust's reputation.	David Brewin / Dawn Hanwell	Finance & Performance Committee	12	6	6	6
731	Increasing agency spend could cause a deterioration in the Trusts Finance Score.	David Brewin / Dawn Hanwell	Financial Planning Group	N/A	9	9	9

Key controls in place		Assurance that controls are effective	Date
Ref	*The main controls/systems in place to manage principle risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*

619	Good working relationships established with commissioners. Actively engaging commissioners and putting forward proposals that promote efficient and effective models of care.	Short term sustainability controls are in place following the signing contract variations with Leeds CCG and NHS E for 2018/19 following a number of positive contractual discussions. Further joint working with NHS E resulted in the development of a new forensic model in HC&V. Throughout 2018/19 we have continued to engage in regular and positive dialogue with Leeds commissioners to promote efficient and effective models of care, the key discussions in 2018/19 centred on Leeds Community services redesign and out of area	Apr-18
619	Commissioning activity around new and existing business is monitored through the Financial Planning Group: attended by Chief Financial Officer, Chief Operating Officer and Director of Nursing, Professions and Quality.	Agendas and minutes from Activity & Finance meeting / service reviews with commissioners demonstrate there is a process of providing assurance to the executive directors in relation to commissioning activity.	Sep-18
619	Oversight by Finance and Performance Committee: in relation to financial and clinical impact of tenders, in the context of the overall sustainability of the organisation.	An assurance paper is provided to the Finance and Performance Committee which is scrutinised by the non-executive directors on behalf of the Board.	Mar-19
619	Tender opportunities are reviewed by Financial Planning Group on a case by case basis along with considerations of whether to bid or not bid on any given tender. (led and including executive directors)	Operational metrics are presented to the Financial Planning Group for assurance in respect of tender opportunities	Sep-18
619	Partnership working arrangements in Leeds and STP level, to ensure strategic influence is maintained on how resources are distributed and management of system wide risks (including city wide Director of Finance forum, Partnership Executive Group).	Minute of the PEF and citywide Director of Finance Group show a level of assurance on the what in which organisations are working in partnership across the city	Dec-18
619	Cost Improvement plans developed to be robust and subject to clinical impact assessment. Develop approach to identifying longer term cost improvement plans, engaging Care Groups to target areas for consideration. The approach is to carry out a full diagnostic and full sharing of information relating to cost pressures, agency spend, discretionary spending, viability of services, performance against activity targets.	The Director of Nursing and the Medical Director sign off the CIP programme and assess the quality impact. The Board and its sub-committees receive assurance on the CIPs though reports. Minutes of the committees / Financial Planning Group / Star Chambers show a level of assurance and check and challenge on the programme	Mar-19
619	Robust budgetary control framework and budget holder training in place	There is online training on Staffnet for all budget holders. Financial training for managers is also an integral part of the management essential training programme that is being developed.	Ongoing
619	Achieved the control total and the 2017/18 financial plan	Accounts were audited at the end of 2017/18 to verify the financial outturn	May-18
619	Financial modelling and forward forecasting in place to identify risks early.	NHS Improvement Financial Plan and monthly and quarterly forecast. Leeds Plan forecast	Dec-18

	Significant gaps in control / assurance	**Actions**	**Deadline**
Ref	*The main areas of weakness which result in ineffective or absent controls / assurance*	*Actions required to mitigate the weakness*	*Target date for completion*
619	Establish a process for identifying longer-term CIPs (gap in control)	Develop an approach to identifying longer term cost improvement plans, engaging Care Groups to target areas for consideration. The approach is to carry out a full diagnostic and full sharing of information relating to cost pressures, agency spend, discretionary spending, viability of services, performance against activity targets	Dec-19

Strategic Objective	3. We use our resources to deliver effective and sustainable services			Risk appetite: 3 - Open ('High')		
Strategic Risk		Initial Risk Score	8	Committee	Finance and Performance Committee	
SR9. (Risk 615) Due to inadequate, inflexible or poorly maintained estates and facilities we are unable to provide a safe and positive environment for service users and staff.		Current Risk Score	8	Executive lead	Dawn Hanwell (Chief Finance Officer)	

Assurance rating (quarterly) (limited, partial, significant)	Q1	Q2	Q3	Q4
	Partial	Partial	Partial	Partial

Datix Ref	Description	Lead / responsible director	Overseeing group	Q1 (end of June)	Q2 (end of September)	Q3 (end of December)	Q4 (end of March)
	Contributory risks from the directorate risk register			**Risk Score**			
9	The majority of operational estate is not under the direct ownership/control of the Trust and is managed through contract/lease arrangements with third parties.(NHS Property services and Equitix). There is risk of unacceptable delays in executing identified environmental changes and also responsiveness to maintenance requests if these contracts are not robustly managed and process are not clearly understood by all parties involved (3 way relationships exist with sub contracting arrangements between property owners, maintenance providers and Trust staff)	David Furness / Dawn Hanwell	Estates Steering Group	15	9	9	6
111	The Trust currently sub let Little Woodhouse Hall, a PFI owned premise, to Leeds Community Healthcare ('LCH') who utilise the premise as an inpatient unit for Children and Adolescents ('CAMHS'). LCH are currently looking at other estates solutions to allow them to expand and improve the service and there is therefore a risk that the premise will be vacated and empty within the next 12 months.	David Furness / Dawn Hanwell	Estates Steering Group	15	6	6	6
169	LYPFT have been informed by LTHT estates that they are withdrawing all maintenance activity of all internal works on the NICPM ward.	Gareth Flanders	Estates Steering Group	4	4	Archived	Archived
450	On review of some ward medication fridges the temperature was identified out of range. this can lead to degradation of medication due to inappropriate storage.	Jane Riley	Clinical Environments Group	9	9	9	9
672	There is an increased risk of fire caused through smoking & intentional or reckless arson by service users/visitors within the estate.	Sara Munro	Fire Safety Task and Finish Group	N/A	20	20	20
700	The Trust does not have a dedicated decant facility capable of receiving service users evacuated from a ward or unit due to an emergency - fire, flood, loss of power or other environmental/ security threat.	Andrew Jackson	Emergency Preparedness Resilience and Response Group	12	12	12	12
727	We have had several incidents of key and lock failure in the forensic service. Despite reassurance that they are all working, incidents continue to occur. Keys issued to patients are found to be opening additional doors including staff offices and clinic rooms. Locks to the main entrance have failed. We also have identified domestic staff working across the Newsam Centre having master keys that open doors within the secure area.	Seven Dilkes	Clinical Environments Group	8	8	8	8

Ref	Key controls in place	Assurance that controls are effective	Date
Ref	*The main controls/systems in place to manage principle risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*
615	Ligature anchor points audit	Significant reduction in Ligature Anchor Points through prioritised programme of works. Further works prioritised following updates / audit to Ligature Risk Assessments. Action plan has been developed (submitted to CQC) reporting to the Clinical Environments Group and CQC weekly meetings.	Jan-19
615	Clinical Environments Group overseeing risk assessment to determine work required	Clinical Environments Group meet on a monthly basis, risks are brought to the group via the Clinical leads for the service and discussed actions agreed and entered onto the action log. Where there is a specific Estates / Facilities requirement the work is specified and costed with inclusion of Clinical services and brought back to the group for a discussion. if the work is agreed a business case is produced with Estates and Clinical for consideration / approval at ESG	Mar-19
615	SLA in place for the Estate in York	SLA to be approved and signed with NHS Property Services	Sep-18
615	Contractual performance requirements on PFI estate ensure that the estate is maintained to a good standard. Change control processes are in place to enable variations to the estate (limited by configuration). PFI negotiations strengthened resulting in relationship and contractual improvements	Meetings on performance of PFI and NHS PS contracts . Monitored by Quarterly assurance group.	Mar-19

Ref	Significant gaps in control / assurance	Actions	Deadline
Ref	*The main areas of weakness which result in ineffective or absent controls / assurance*	*Actions required to mitigate the weakness*	*Target date for completion*
615	The Trust still has sub-optimal estate	PFI options appraisal underway and the disposal of long-term nature of this currently being considered	Dec-19
615	Utilising one public estate	Reproviding services in suitable premises in accordance with the clinical plan	Apr-19
615	Development of PFI assets as per a programme of work as agreed with care services	Provide improved environments for service users with an in-patient focus. Work will be delivered in tandem with lifecycle and will be delivered using a decant solution	Jun-19

Strategic Objective	3. We use our resources to deliver effective and sustainable services	Risk appetite: 3 - Open ('High')

Strategic Risk	Initial Risk Score	8	Committee	Finance and Performance Committee
SR10. (Risk 635) As a result of insecure, inadequate or unstable information technology systems and infrastructure, the quality and continuity of our services is compromised.	Current Risk Score	8	Executive lead	Dawn Hanwell (Chief Finance Officer)

Assurance rating (quarterly) (limited, partial, significant)	Q1	Q2	Q3	Q4
	Partial	Partial	Partial	Partial

Contributory risks from the directorate risk register				Risk Score			
Datix Ref	Description	Lead / responsible director	Overseeing group	Q1 (end of June)	Q2 (end of September)	Q3 (end of December)	Q4 (end of March)
105	The danger of a cyber-attack to the Trust's ICT infrastructure through malicious hacking or system virus infection.	Bill Fawcett / Dawn Hanwell	Information Steering Group	12	12	12	12
580	Should a failure occur of the Medchart system due to LYPFT server failure, back up charts can be printed off on each ward so that administration of medication can continue. The back up chart process relies on the dedicated PCs on the wards not being turned off at any time as this prevents the electronic backing up of the drug charts.	Caroline Dada / Claire Kenwood	Medicines Optimisation Group	6	6	6	6

Key controls in place		Assurance that controls are effective	Date
Ref	*The main controls/systems in place to manage principle risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*
635	CareCert alerts are received from NHS Digital on a weekly basis to key stakeholders within Informatics. These alerts are reviewed and actioned regularly within the teams.	The monitoring of these alerts are overseen by the Information Governance Group (IGG) on a monthly basis and the CIO oversees the process	Dec-18
635	The ICT infrastructure has firewalls, intrusion prevention, virus protection software and e-mail protection systems that are continually updated to prevent attack. A working programme to improve our awareness and response to threats is in place. Alerts received from NHS Digital are closely monitored, actioned on a regular basis.	Penetration testing has been conducted by an independent accredited organisation (SEC-1 LTD) earlier this year. This included internal and external testing of the infrastructure to highlight any serious issues or vulnerabilities . SEC-1 found no serious threats or findings.	Aug-17
635	IG Toolkit in particular Information security which includes patching, updating of systems, malware, cyber security etc.	IG Toolkit outcome has one of two results, satisfactory or non-satisfactory. This year we submitted satisfactory and it is anticipated for next year the outcome will also be satisfactory	Mar-19

Significant gaps in control / assurance		Actions	Deadline
Ref	*The main areas of weakness which result in ineffective or absent controls / assurance*	*Actions required to mitigate the weakness*	*Target date for completion*
635	Gaps may exist in the process of monitoring Carecert alerts from NHS Digital and if relevant actions are being dealt with accurately and effectively within given timescales. There is possible room for improvement.	To continuously monitor the alerts received from NHS Digital and to review the process that these are being actioned effectively within the IT and Network teams within reasonable timescales. Also to review the reporting process into Information Governance Group (IGG) and an escalation process is in place.	Jun-19