BOARD ASSURANCE FRAMEWORK OVERVIEW												QUARTER 2 - 2020/21
Strategic Objective	Risk appetite	Strategic Risk	Quarterly Assurance Rating				Reason for Current Assurance Rating	Executive Lead	Assuring Committee	Current Risk Score	Change	
			Q3	Q4	Q1	Q2						
1. We deliver great care that is high quality and improves lives	ential options and solutions. It is classed as 'high' in relation to that openness but the board would not take risks that compromise compliance with the core regulatory and legislative frameworks within which it has a licence to operate.	**SR1. (Risk 636) If there is a breakdown of quality and safety assurance processes we risk not being able to maintain compliance with regulatory requirements.**	Partial (remains same)	Partial (remains same)	Partial (remains same)	Partial (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, Professions and Quality)	Quality Committee	16	→	
		SR2. (Risk 829) There is a risk that we fail to make the improvements outlined in the quality strategic plan and that this has an adverse impact on the care of those who use our services.	Partial (remains same)	Partial (remains same)	Partial (remains same)	Partial (remains same)	There is evidence that there is continuous learning, improvement and innovation in the Trust but this is in the process of being embedded .	Chris Hosker (Medical Director)	Quality Committee	15	→	
		SR7. Changes in the roles of commissioners and providers and the move to system-level working will require changes in the role and function NHS Trust boards and new governance arrangements There is a risk we do not have appropriate governance arrangements in place nor the capacity and capability to fulfil all our statutory functions.	Partial (remains same)	Partial (remains same)	Partial (remains same)	Partial (remains same)	Whilst some of the infrastructure is in place to govern the work of the ICS and MHLDA Collaborative there is still more work to do to understand the impact of the emerging governance arrangements.	Sara Munro (Chief Executive)	Board	12	→	
2. We provide a rewarding and supporting place to work		**SR3. (Risk 830) Due to an inability to recruit and retain sufficient numbers of staff with the appropriate skills experience and behaviours, there is a risk that we are unable to deliver high quality, evidence based, person centred care to meet new models of care now and in the future.**	Partial (remains same)	Partial (remains same)	Partial (remains same)	Partial (remains same)	There are a number of significant workforce challenges which the Trust is working to address.	Darren Skinner (Director of HR)	Workforce Committee	16	→	

3. We use our resources to deliver effective and sustainable services	**3 - Open - ('high') We have a risk appetite which is 'open' to considering all pote either compromise our compliance with its duty of care to staff and patients or**	**SR4. (Risk 619) A lack of financial sustainability results in a destabilisation of the organisation and an inability to deliver services.**	Partial(remains same)	Partial(remains same)	Partial (remains same)	Partial (remains same)	Whilst we have maintained good working relationships with commissioners and have a track record of meeting our financial regulatory requirement, and 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 there is still uncertainty in relation to a number of factor which could adversely impact on the Trust's financial performance	Dawn Hanwell (Chief Financial Officer)	Finance and Performance Committee	**12**	→
		SR5. (Risk 615) Due to inadequate, inflexible or poorly managed estates we compromise the safe environment which places staff, service users and visitors at risk.	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 Financial Officer)	Finance and Performance Committee	**8**	→
		SR6. (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	4	Committee	Quality Committee
SR1. (Risk 636) If there is a breakdown of quality and safety assurance processes we risk not being able to maintain compliance with regulatory requirements.	**Current Risk Score**	**16**	**Executive lead**	Cathy Woffendin (Director of Nursing, Professions and Quality)

Assurance rating (quarterly) (limited, partial, significant)	Q1 (end June 2021)	Q2 (end September 2021)	Q3 (end December 2021)	Q4 (end March 2022)
	Partial	Partial	Partial	Partial

Contributory risks from the directorate risk register				Risk Score			
Datix Ref	**Description**	**Risk Lead / responsible director**	**Overseeing group**	**Q1 (end June 2021)**	**Q2 (end September 2021)**	**Q3 (end December 2021)**	**Q4 (end March 2021)**
803	Our current information system does not enable us to carry out live monitoring of the use of urgent treatment on inpatient wards. The Code of Practice states that hospital managers should monitor the use of these exceptions to the certificate requirement to ensure that they are not used inappropriately or excessively.	Oliver Wyatt / Chris Hosker	Mental Health Operational 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*
636	Governance Structure in place which sets out where performance and compliance is discussed and assurance is received and provided	Following an operational restructure and consultation process resulting in moving to 9 service lines from 2 care groups the clinical governance arrangement s have been strengthened with additional resource of three Heads of clinical governance and additional resource at clinical director level. These posts have been working together to review the new arrangements and have provided a proposal which has been signed off by the executive management team. The previous governance current arrangements are still in place to mitigate any risks. 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. The Governance Assurance Accountability and Performance Framework (GAAP) was audited and given significant assurance. In addition the CQC Well led inspection report DEC2019 gave an overarching rating of good which included our governance system and processes.The organsation commissioned Deloittes to undertake a Well led review , the findings of which were fed back In January 2022 and were positive with recognition that work was ongoing to move to one overarching governance meeting .	Jan-22
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 2020/21. Self certifications were signed off by the Board for 2020/21which also highlighted if there were any risks to compliance for 20210/22 and how these would be addressed. The Board has also comfirmed compliance with all standards in the provider licence and the self certification has been published on the Trust website	Jun-21
636	Process in place for reporting serious incidents to Board and Quality Committee	NHSE investigation reports were presented to the May 2019 Board and Quality Committee and assurance was provided and received as to the process of reporting and the content of the cases provided	May-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 in place. There has also been an audit on Learning from deaths in April 2019 which gave significant assurance	May-19
636	Head of Clinical Governance and Regulation and Clinical Governance Team in place to oversee compliance with CQC Standards.	From April 2022 the Trust's Peer Reviews will re-commence and CQC actions will be incorporated into the visits to ensure actions have been embedded and sustained within services. Reports from all Peer Reviews are reported through the Trust's governance structures and updates provided to Trust-wide Clinical Governance to ensure oversight. Regular updates are provided to Trust Board and Quality Committee through DoN quarterly reporting and CQC update report.	Jan-20

636	Quarterly meetings with the CQC leads	An update was provided to the council of governors and board members at the board to board in September 2020, by the executive director of Nursing , Quality and Professions providing assurance that all actions were progressing and the oversight of this had been re-established from July 21 following hibernation as agreed with our CQC relationship managers. Evidence has been collated against all of the CQC actions to demonstrate compliance. All actions are now incorporated into the Trust's Peer Review Process to ensure on-going compliance and that actions have been embedded across services.	Sep-20
636	Monthly CQC Engagement Meetings	On-going monthly CQC Engagement Meetings are held with the CQC Relationship Manager. Assurance is provided in relation to on-going enquiries, complaints and serious incidents to demonstrate compliance with regulatory requirements. The process has been strengthened in line with the CQC strategy and services are invited to attend the Engagement Meeting to provide assurance on the quality and safety of their services.	Mar-22
636	Ethical Advisory Group established	Minutes of meetings are evidence of the discussions that are undertaken in regard to staff and service user ethical considerations and impacts of decisions taken	Jan-21
636	Nursing Strategy , AHP Strategy , Pyschological professions strategy in place	oversight of all three professional strategies and progress is now monitored through the newly established professions &Nursing Council	Jan22

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*
636	Due to the Covid pandemic some of our systemS and processes have been hibernated	Work has commenced to restart audits, care director reports,consultation commenced in April on our proposed new governance arrangements .A care director goverenance meeting has been established in August and is chaired by the medical Director	Jun-22

Strategic Objective	1. We deliver great care that is high quality and improves lives			Risk appetite: 3 - Open ('High')	
Strategic Risk		Initial Risk Score	9	Committee	Quality Committee
SR2. (Risk 829) There is a risk that we fail to make the improvements outlined in the quality strategic plan and that this has an adverse impact on the care of those who use our services.		Current Risk Score	15	Executive lead	Chris Hosker (Medical Director)
Assurance rating (quarterly) (limited, partial, significant)	Q1 (end June 2021)	Q2 (end September 2021)	Q3 (end December 2021)		Q4 (end March 2022)
	Partial	Partial	Partial		Partial

Contributory risks from the directorate risk register				Risk Score			
Datix Ref	Description	Lead / responsible director	Overseeing group	Q1 (end June 2021)	Q2 (end September 2021)	Q3 (end December 2021)	Q4 (end March 2021)
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*
829	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
829	The IHI 'Safe Effective Reliable Care Framework' has been adopted and adapted for the organisation	This was set out in the Strategic Quality Plan which was reviewed by the Trustwide Clinical Governance Group, the Quality Committee and the Board	Sep-18
829	Improvement methodology adopted and adapted for the organisation	IHI methodology has been adopted and is being rolled out and embedded across the Trust	Mar-19
829	Serious incident reporting and investigation process in place	A 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
829	Reporting and investigation of deaths process in place	The internal audit into the reporting and investigation of deaths provided significant assurance	Mar-19
829	Complaints, Litigation, PALs (CLIP) report	This is sent monthly to the services to outline any learning	Mar-19
829	Governance structure and map in place and agreed	There is a ward to Board governance structure which was recommended by Deloittes; approved by the Board, EMT and care services. This has been reviewed on a number of occasions to ensure it reflects the needs of the organisation. Its last iteration was reviewed in July 2019	Jul-19
829	Sets of Quality performance information available published and used across the organisation (HR, Finance, Quality and Operational)	Cognos information is available and accessed routinely across services. HR data set circulated across the organisation on a weekly basis. The 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 direct reports and their teams.	Jan-19
829	Performance data is consolidated and relevance checked and shared at every level of the organisation.	Work has been undertaken to ensure that suites of information are produced and used at every level of the organisation in relation to quality and performance (ward to Board)Performance Management Reporting was audited and given significant assurance	Jul-19
829	Governance, accountability, assurance and performance framework in place including performance framework and review cycle providing ward to Board reporting	A consistent use of highlight reports are in place and ensure transparent escalation and linkage across the organisation. The Governance Assurance Accountability and Performance Framework set out ward to Board reporting and was audited and given significant assurance	Sep-18
829	Freedom to Speak up Guardian appointed and available to all staff	There is a report provided to the Board detailing the themes of the issues staff have raised. The themes identified by the guardian are reported into our governance structure and used to inform learning including a report to the Board of Directors.	May-19
829	Established a partnership with the IHI to support embedding a culture of quality improvement	Contract with IHI signed and they carried out a diagnostic report which highlighted areas of good practice and where systems and structures need strengthening	May-19
829	Research Annual Report	Research annual report was approved by TWCG in Oct 2020 and presented to Quality Committee for assurance also in Oct 2020	Oct-20
829	The IHI 'Five Core Components 'and the model for improvement have been chosen as the methodology for the organisation	IHI shared the five core components model which was subsequently selected as the chosen methodology. This has been seen in Trustwide Clinical Governance Group and Quality Committee and assurance provided that this is an appropriate methodology.	Nov-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*
829	The establishment of a multi-disciplinary group to support change (from local teams to organisational wide priorities)	To continue to develop the relationship between specific support services for example Continuous Improvement Team, Informatis and Organisational Development Team.	Sep-22
829	The culture of innovation and improvement needs to be developed	This will be picked up and developed through the Culture Collaborative, along with the collabrative leadership development work and ongoing development of the Improvement and Knowledge Department	Jul-22
829	Serious incident reporting and investigation (gap in control)	We are developing metrics to assess the strength of the recommendations	Sep-22
829	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	Sep-22
829	There is limited use of both the Safe, Effective, Reliable Care Framework and the Five Core Components model across the organisation	To continue to raise awareness and apply to all new improvement activity. A maturity matrix for the Safe, Effective, Reliable Care Framework is being piloted with a range of services	Ongoing
829	As a result of the COVID-19 pandemic continuous improvement work will not take place at the pace expected whilst staff focus on maintaining day to day delivery of operational services (gap in control)	The continuous improvement team will provide any support necessary to teams who identify any urgent improvement work that needs to take place. Most improvement activity is now restarting, any services with hibernated improvement activity are being contacted and the plan is being reviewed.	Jun-22

Strategic Objective	2. We provide a rewarding and supporting place to work	Risk appetite: 3 - Open ('High')

Strategic Risk	Initial Risk Score	15	Committee	Workforce Committee
SR3. (Risk 830) Due to an inability to recruit and retain sufficient numbers of staff with the appropriate skills experience and behaviours, there is a risk that we are unable to deliver high quality, evidence based, person centred care to meet new models of care now and in the future.	Current Risk Score	16	Executive lead	Darren Skinner (Director of HR)

Assurance rating (quarterly) (limited, partial, significant)	Q1 (end June 2021)	Q2 (end September 2021)	Q3 (end December 2021)	Q4 (end March 2022)
	Partial	Partial	Partial	Partial

Contributory risks from the directorate risk register				Risk Score			
Datix Ref	Description	Lead / responsible director	Overseeing group	Q1 (end June 2021)	Q2 (end September 2021)	Q3 (end December 2021)	Q4 (end March 2021)
109	Inability to recruit permanent staff across the Trust resulting in the need to rely on bank and agency staff within services	Director of HR	Recruitment and Retention Group	12	12	12	12
900	Higher Trainee on call rota gaps due to COVID realated adjustments	Abhijit Chakrabarti	TBC	N/A	12	12	12
928	Due to infection prevention and control measures in regard to covid 19 the capacity for training has been reduced. This has resulted in the workforce not meeting the Trust 85% KPI, and risking staff and patient safety.	Director of HR	Workforce and Communications Group	N/A	N/A	20	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*
830	Communications and staff welfare group in place as part of emergency response	Any workforce issues will be identified and escalated as part of the new POD Governance Framework which has been agreed by EMT and advised to the Workforce Committee	Jan-21
830	National co-ordination of response providing additional support to maximise staff availability	Regular webinars in place with Chief People Officer enabling two way flow of information and feedback Increased HCSW pipeline being utilised via national funding based on current Trust vacancies. Linking with national bring back staff scheme and voluntary sector to increase staff availability. National NHSE/I HSW Programme involvement to reduce HSW vacancies to zero (or as close to as possible)	Mar-20
830	HRD networks in place across place and MH Collaborative to maximise ability to respond	MH Collaborative Project Manager has been redeployed to wholly support the three mental health trusts within the ICS with implementing a co-ordinated workforce support where it is efficient and effective to do so to	Mar-20
830	Regular planned recruitment activities to support workforce supply and current vacancies, including nursing vacancies	Ongoing recruitment taking place for nursing posts. Work in partnership with care services to identify identifying priority areas and new services areas. Proactive recruitment for aspirant nurses through national programmes and bring back service. Supporting current staff to apply for nursing associate posts. Successfully secured funding for international recruitment across the ICS. Developing career pathway to support future supply of nursing through apprenticeship training. Kickstart Scheme, working in partnership with the DWP to support and develop unemployed communities in to work through a new entry pathway, including pastoral and career support to aid their development to become a substantive employee. Running incentivised recruitment offers for key recurrent vacancies. Let's Talk quarterly recruitment campaigns with key focus (latest one targeted bring back staff). Kickstart sheme ongoing, expecting circa 15 staff via this route, scheme ends in March 2021. Succesion plans/pastoral care in place to support retention of this workforce. International Nurse Recruitment - Trust supporting 5 RMNs in 2021 and have bid for 5 in 2022.	Sep-20

830	Future Workforce Planning Group	The establishment of the Future Workforce Planning Group, exec chaired and supported by the newly appointed Strategic Resourcing Manager will bring together the work undertaken by differing professional groups under on Trust resourcing umbrella, the establishment of this group has been paused, the work has continued, overseen by the Workforce and Communications group. The Strategic Resourcing Manager provides dedicated resource to the creation of clear career pathways and to maximise opportunities for both our staff to progress improving skills and retention and to create a more attractive offer to potential candidates. Work is underway to deliver workforce planning and talent management framework. External partnership with branding company to increase Trust profile to support recruitment and retention of staff. Workforce planning and Talent Management work is paused but support offered to care services in redeploying and deployment of staff to support clinical priority areas. This group was never established as it has been replaced by the People Resourcing and Retention Group under the new POD Governance structure.	Oct-20
830	West Yorkshire & Harrogate Mental Health Workforce Collaborative Group	Work scoped for a shared workforce plan, supported by HEE. The ICS MH Workforce Project Manager has been appointed to support this work.	Nov-19
830	Trust wide Learning Needs Analysis	Work underway to deliver a Trustwide learning needs analysis, enabling the Trust to maximise the return on value of investment in training and development, targeting resources towards the key skill requirements and working in collaboration with other partners to gain greater value for money.	Jun-20
830	Workforce and OD strategic plan agreed by the Board	The Workforce & 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.	Apr-20
830	Workforce Committee (a sub-committee of the Board of Directors) established	This increases Board level scrutiny of workforce issues and assurance to the Board	Dec-20
830	Nursing and AHP strategies have been agreed and launched	Participated in NHSI Recruitment and Retention Programme and continuing to embed good practice, ie career conversations for all staff	Sep-19
830	Regular monitoring of compulsory training compliance	Monthly reports showing a consistent achievement of Trust target of 85% compliance.	Nov-19
830	Medical Revalidation process	There are systems and processes in place to ensure that medical revalidation requirements are met. Assurance is provided through the Annual Responsible Officer Report. Revalidation was audited and given significant assurance. RO AR provided to July 2020 Board	Jul-20
830	Well established internal nursing and HSW bank to provide a flexible workforce	Fully flexible bank workforce established and deployed during the pandemic to support increased workforce supply to services as needed. During the pandemic both redeployment and responsive workforce team have been utilised to support effective deployment. Responsive workforce team evaluation completed and the model is to be implemented as a permenant addition to our resourcing model	Nov-19
830	Education and Learning Steering Group	Education and Learning Steering Group continues to support alignment of learning needs and available funding.	Jul-19
830	New Appraisal and Performance Review Policy	New Policy launched in August 2019. Quality Assurance process for appraisal being developed.	Aug-19
830	Wellbeing Assessments and Career Conversations	Formal appraisal has continued for staff, where capacity in teams has allowed, if this is not possible the wellbeing assessment conversations are being used to support staff. Career conversations are also being used and a Trust wide process has been established for managers and staff to access.	Jan-21
830	Apprenticeship Delivery Plan	We are increasing numbers of clinical apprenticeships including establishing new roles such as nurse associates and associate practitioners and clinical associate psychologists. Utilising apprenticeships to deliver the national health care support worker programme, which will directly impact on our current healthcare support worker vacancies.	Nov-19
830	Medical staff Recruitment (AAC panels) programme	Planned recruitment for consultant posts. Improved AAC process. Partnership working between Workforce and Medical Directorate to develop future workforce plans and ensuring full representation of all areas in panel selection. Exploration of international medic recruitment taking place.	Nov-19

830	Staff engagement and reward and recognition programme	Staff engagement has continued throughout the pandemic and has shaped the Trust response to key issues, including staff wellbeing. Bank staff included in 2020 staff survey and 47% of staff completed the survey. Revised staff recognition and award scheme implemented, including team of the month and revised STAR award. Culture development conversation taken place during summer of 2020 and open access leadership development session delivered virtually as a key response to this. CEO all staff call introduced to improve staff engagement and communications during the pandemic.	Nov-19
830	Appraisal process audit	This process was audited and significant assurance provided	Jan-20
830	Equality Steering Group	Equality Steering Group established as part of pandemic response. This group has supported a number of key actions including, BAME representation on senior recruitment panels and also planning launch of leadership development programme for BAME leaders and reciprocal mentoring for Board members and BAME colleagues WREN network has continued to develop during the pandemic. Wellbeing assessments are being used to support the health and wellbeing all staff including BAME colleagues.	Jan-21

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*
830	Trust Workforce Planning and |Governance Framework still in development	Resource is now in place facilitate the development of the framework and establish robust assurance measures to be implemented from November 20 but could be delayed if a surge in Covid 19 over winter, Work on this has been paused due to continued pandemic response work. Plan to re-start in April 2021 but could be subject to further delay if pandemic continues. The Leeds and York Partnership NHS Foundation Trust Strategic Workforce Plan 2021-2024 was signed off at EMT on 21st July 2021. The planning cycle was integrated with the annual operational and financial planning cycle, therefore the plan focuses solely on our clinical service lines. A separate workforce planning cycle for our corporate services will take place later in 2021 with the aim to have a signed off corporate plan by the end of the FY.	Mar-22
830	Most of the planned workforce activity and developments have been paused or hibernated to support Business continuity and Covid response.	Recovery and reset plans being worked through with some areas of workforce activity stepping up from October 2020 and the development of the Trust's People Plan. Re-set and recovery work including development of the People Plan paused as a result of covid response from November 2020. Work has been undertaken on the People Plan refresh, identifying revised Strategic Objectives which have been aligned to the new POD Governance Framework for task, finish and assurance work. An external resource has been commissioned to assist with the development of a People Plan roadmap - an initial outline document will be presented to the Workforce Committee on 5/8/21 with a comprehensive plan and roadmap of a 3 year strategy to be delivered to the October 2021 Workforce Committee. Organisation-wide engagement is planned as part of the delivery plan during September/October 2021. The LYPFT 'Our People Plan' will be presented at the December 2021 Workforce Committee for approval and will be presented to the Board in December 2021 for sign-off. The plan contains a 3-year road map with comprehensive detail, measures and targets which has been embedded into the POD Governance Framework for oversight and assurance. The LYPFT Our People Paln will be launched in January 2022 with a comprehansive communications and engagement plan.	Jan-22
830	Embedding the use of apprenticeships in Trust workforce planning to address strategic resourcing challenges	To use new apprentice roles and opportunities to support recruitment into vacancies whilst also focusing on occupations with shortages. Working with the Mental Health Collaborative to maximise opportunities to benefit from apprenticeship programmes. Continued to deliver apprenticeship programmes throughout the pandemic to ensure future development and growth into workforce supply. Work continues and has been incorporated as part of the Stategic Workforce Planning process. Workforce plans identify suitable roles for apprenticeships and encourage skills mixing LNA to inform apprenticeship strategy Minimum L2 H&SC qualification introduced for HSW workforce, if this qualification is not already obtained at point of recruitment the role would be offered as an apprenticeship so the new recruit can work towards this on the job. Work taking place to establish a minimum qualification for administrative staff, if this qualification is not already obtained at point of recruitment the role would be offered as an apprenticeship so the new recruit can work towards this on the job. Apprenticeship strategy and policy to be developed in 2022.	Jun-22

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
SR4. (Risk 619) A lack of financial sustainability results in a destabilisation of the organisation and an inability to deliver services.		Current Risk Score	12	Executive lead	Dawn Hanwell (Chief Financial Officer)

Assurance rating (quarterly) (limited, partial, significant)	Q1 (end June 2021)	Q2 (end September 2021)	Q3 (end December 2021)	Q4 (end March 2022)
	Partial	Partial	Partial	Partial

Contributory risks from the directorate risk register				Risk Score			
Datix Ref	Description	Lead / responsible director	Overseeing group	Q1 (end June 2021)	Q2 (end September 2021)	Q3 (end December 2021)	Q4 (end March 2021)
649	Provider Collaborative Risks: CAMHS tier 4 (Red Kite View) revenue gap and Provider Collaboratives risks for CAMHS and Adult Eating Disorders as Lead provider and risk share implications associated with other Provider Collaboratives in development (WY Secure and HC&V CAMHS and Secure Provider	David Brewin / Dawn Hanwell	Finance & Performance Committee	9	9	9	12
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
834	The Trust is vulnerable to fraud by inadequate systems and processes or those in a position to bypass controls. The risk is both internal and external and involves intent to evade detection	Gerard Enright / Dawn Hanwell	Audit Committee	5	5	5	5
731	Increasing agency spend could cause a deterioration in the Trusts regulatory Finance Score.	David Brewin / Dawn Hanwell	Financial Planning Group	9	9	9	9
907	Change in ICS regulation and the impact this will likely have on the financial regime	David Brewin / Dawn Hanwell	Financial Planning Group	N/A	9	9	9
908	Reliance on non-core income to support underlying financial position	David Brewin / Dawn Hanwell	Financial Planning Group	N/A	9	9	9
949	Changes to the capital funding regime may impact on the ability to secure sufficient capital (CDEL) allocations to deliver our long term capital planning objectives, including reprovision of PFI. Capital resources are allocated to each ICS to help address ICS priorities, there is a risk that LYPFT capital requests may not be prioritised in the context of the other ICS priorities. The operational methodology used for allocating capital resources between organisations may not benefit LYPFT, and be lower than historic planned levels. The Health & Social Care bill introduced a requirement to manage within capital allocations, however there is a risk that other system partners do not.	David Brewin / Dawn Hanwell	Financial Planning Group	N/A	N/A	12	12

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.	Whilst COVID-19 interim contracting arrangements did not require signed contracts for 20/21 or 21/22, minutes of discussions with commissioners demonstrate good working relationships and good progress on key priority investments including agreeing the safer staffing business case and access to mental health investment standard growth in 21/22, based on a list of jointly agreed priority investments in efficient and effective models of care. Further positive joint working with NHS E resulted in agreeing a funding baseline for the Adult Eating Disorders Provider Collaborative and NHSE approval to operate as Lead Provider on 1st October 2020. Throughout 2021/22 we have continued to engage in regular and positive dialogue with Leeds commissioners to promote efficient and effective models of care. Evidence of growing business from existing commissioners and winning tenders provides further assurance.	Jan-21

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 Financial Planning Group and further assurance provided to Finance & Performance Committee in relation to new and existing business. Service reviews with commissioners demonstrate there is a process of providing assurance to the executive directors in relation to commissioning activity. Minutes of meeting demonstrating and evidencing assurance. During COVID response period the frequency of meeting has been reduced but have scheduled meetings when priority decisions needed consideration.	Jan-21
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.	Assurance papers are provided to the Finance and Performance Committee which is scrutinised by the non-executive directors on behalf of the Board.	Jan-21
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. Follow-up audit carried out and significant assurance provided.	Jan-21
619	Partnership working arrangements in Leeds and ICS 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 PEG and citywide Director of Finance Group show a level of assurance on the partnership working arrangements across the city. Minutes of West Yorkshire Mental Health CFOs group (includes lead ICS CFO for mental health) and other key strategic partnership roles (Programme Director for WYICS MHLD&A and CCG	Jan-21
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. This process was audited and significant assurance provided. As a consequence of our COVID response (in line with the national direction) we have paused our efficiency programme.	Oct-20
619	Regular ongoing dialogue with Provider Collaborative partners to agree risk share and actions to minimise and mitigate financial risk Regular monitoring of Provider Collaborative activity levels. Regular engagement with NHS E to ensure the baseline funding for provider collaborative/NCMs is sufficient. Performance metrics developed to track performance and progress against financial target. LYPFT exposure to c34% of the Provider Collaborative financial risk via proposed risk share for WY Provider collaborative based on population. Risk impact relates to spend on out of area placements above baseline funding levels. In addition, similar risk linked to HC&V provider collaboratives for CAMHS and Adult Secure, value yet to be agreed for risk share. Red Kite View staffing and non pay proposal discussed and agreed with partners and reflected within the overall CAMHS Tier 4 Provider Collaborative expenditure plans. Provider collaborative go live for CAMHS Tier 4 is contingent on securing sufficient funding to cover expenditure plans.	Signed Adult Eating Disorders Provider Collaborative risk share agreement. Confirmation from Chief Financial Officers of each provider within the collaborative that the risk share proposals for Adult Secure and CAMHS Tier 4 provider collaboratives are agreed (final sign off once funding baselines confirmed prior to go live dates). Activity and finance monitoring returns presented to WY Specialised MHLDA Programme Board.	Jul-21
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. The internal audit of the budgetary and accounting control framework has provided significant assurance.	Apr-20
619	Consistent achieved of organisational plans in the context of system control targets.	Accounts audited at the end of 2019/20 to verify the financial outturn. Monthly reporting in 20/21 provides assurance that the Trust is on track to achieve the LYPFT element of the system control target.	Jan-21
619	Participate in capital planning forum across the ICS	Longer term capital requirements under review and development of 5 year capital plan as part of ICS capital regime. CFO engaged in ICS capital working group and ICS Capital Board to influence strategic approach to capital planning and allocations. Submitted Expression of Interest relating to new hospitals programme to register our financial requirements.	Apr-20
619	Financial modelling and forward forecasting in place to identify risks early.	NHS Improvement Financial Plan submitted in September 2020 which included a detailed assessment of cost pressures and commissioning intentions based on wide ranging engagement within the Trust. Subsequently, monthly and quarterly forecasting provided to NHSEI, Leeds Plan forecast and ICS reporting and forecasting update each month.	Jan-21

	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	Weakening of financial governance and controls as consequence of focus on clinical operational work and reduced capacity to attend to efficiency plans	Mitigated by current underlying run rate, and interim changes to finance business rules nationally. Work also now commenced on budget rebasing for 22/23 to	Mar-22
619	Excess expenditure not covered by exceptional income	Mitigated by current underlying run rate, and interim changes to finance business rules nationally.	Mar-22
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.	Mar-22

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
SR5. (Risk 615) Due to inadequate, inflexible or poorly managed estates we compromise the safe environment which places staff, service users and visitors at risk.	Current Risk Score	8	Executive lead	Dawn Hanwell (Chief Financial Officer)

Assurance rating (quarterly) (limited, partial, significant)	Q1 (end June 2021)	Q2 (end September 2021)	Q3 (end December 2021)	Q4 (end March 2022)
	Partial	Partial	Partial	Partial

Contributory risks from the directorate risk register				Risk Score			
Datix Ref	Description	Lead / responsible director	Overseeing group	Q1 (end June 2021)	Q2 (end September 2021)	Q3 (end December 2021)	Q4 (end March 2021)
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 Sanderson / Dawn Hanwell	Estates Steering Group	6	6	6	6
125	The estate is not being used in an agile manner due to it being inflexible	David Sanderson / Dawn Hanwell	Estates Steering Group	6	6	6	6
128	Delay in rolling out clinical strategy to which the SEP is aligned may result in delays or the provision of interim solutions, resulting in abortive costs	David Sanderson / Dawn Hanwell	Estates Steering Group	6	6	4	4
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
1006	Current PFI contract ending in 2028 – The PFI estate is under contract till 2028 at which point the property reverts to the Landlord (SPV) if we don't have a suitable Estates Plan in place ahead of 2028	David Sanderson / Dawn Hanwell	Estates Steering Group	n/a	n/a	n/a	16
1008	Sustainability -The Trust is unable to meet the NHS Carbon Neutral requirements by 2040 and to implement a sustainable culture within the organisation	David Sanderson / Dawn Hanwell	Estates Steering Group	n/a	n/a	n/a	16
1010	The trust is unable to maintain the condition of all our properties to Category B standard (as defined by NHSI/E) through financial constraints, inability to access areas to undertake improvements or changes to operational practice	David Sanderson / Dawn Hanwell	Estates Steering Group	n/a	n/a	n/a	12

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 supported by risk assessments	Significant reduction in Ligature Anchor Points through prioritised programme of works. Action plan has been developed reporting to the Clinical Environments Group and CQC weekly meetings.	May-20
615	Clinical Environments Group overseeing risk assessment to determine work required	Clinical Environments Group meets 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	Dec-20
615	SLA in place for the Estate in York	SLA approved and signed with NHS Property Services	Sep-18

615	Estates strategy agreed by the Board	The internal audit of the Estates Strategy has provided significant assurance	May-19
615	Scheduled programme of maintenance on all leased and owned properties	This is monitored regularly through the Estates Steering Group	Dec-20
615	Lack of ability to plan longer term estates requirements in context of wider service collaboration	Active engagement with city wide Strategic Estates Group and ICS level Capital and Estates Group to develop clearer joined up planning	Dec-20

615	Contractual performance requirements on PFI estate to 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. NHSI Lease and SLA need to be agreed formally, Legal representatives dealing with matter currently	Jul-22

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	Inpatient estate remains sub optimal	Strategic Asset Plan to develop PFI options, and PFI management in line with DHSC guideline to 2028. Revised assessment of NICPM options- Healthcare planners procured and programme of clinical engagement agreed, this will provide an estates plan for the future which can then be developed.	Jun-22
615	NICPM business case not progressed	Revised assessment of options for NICPM in context of uncertain commissioning landscape is being progressed- the service and estates are reviewing if any enhancements can be done insitu which may reduce bed capacity and we are working with West Yorks MH commissioners to look at long term commissioning	May-22
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- No current Decant facility are available and increased pressure on clinical services will limit the amout of work that can be completed in this financial year, works that can be completed are agreed and progressing and monitored through CEG/ ESG. Planning is taking place for an early start in the new financial year on projects that have not been able to be completed.	May-22
615	Added demand on facilities service (in particular domestic, cleaning, catering) impacting environments for service users and staff	Business Continuity Plans in place which have been enacted due to COVID-19 - eg changing to cleaning regimes, food supply options, BC plans inacted but currently being reviewed again including RKV/ closure of LWHH	Mar-22
615	Disruption of the planned programme of maintenance due to COVID-19 as a result of a reduced workforce capacity and restricted access to some clinical areas	Focus only on essential work to continue to maintain the estate where possible- Work on planned maintenance now restarted and enhanced	May-22

Strategic Objective	3. We use our resources to deliver effective and sustainable services				Risk appetite: 3 - Open ('High')
Strategic Risk		Initial Risk Score	12	Committee	Finance and Performance Committee
SR6. (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 (end June 2021)	Q2 (end September 2021)	Q3 (end December 2021)	Q4 (end March 2022)
	Partial	Partial	Partial	Partial

Contributory risks from the directorate risk register				Risk Score			
Datix Ref	Description	Lead / responsible director	Overseeing group	Q1 (end June 2021)	Q2 (end September 2021)	Q3 (end December 2021)	Q4 (end March 2021)
8	Failure to derive maximum clinical and business benefits from digital technologies	Bill Fawcett / Dawn Hanwell	Information Steering Group	6	6	6	9
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.	Jane Riley / Chris Hosker	Medicines Optimisation Group	6	6	6	6
813	Concerns that EPMA is not recording some administered doses of medication which could lead to double dosing	Jane Riley / Chris Hosker	Medicines Optimisation Group	4	4	4	4
848	Staff creating new public websites without proper consultation from Health Informatics or Procurement Department. The risk is: personal identifiable information is stored on the website and not secured appropriately, therefore potentially compromising the data; relevant security of the websites is not met to current standards and therefore risk of being compromised	Hergy Galsinh / Dawn Hanwell	Information Steering Group	9	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*
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. A new Cyber monitoring system is being installed to provide detailed reporting on vulnerabilities .	Jul-21
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) in 2019 and a further occured in September 2021. This included internal and external testing of the infrastructure to highlight any serious issues or vulnerabilities . Internal audit also provided significant assurance on the IT security and housekeeping arrangements	Oct-21
635	Data security and protection toolkit audit	Internal audit of data security and protection toolkit provided moderaterisk rating but high assurance. Once the Penn tesk has been completed this rating will be rivised upwards.	Mar-21
635	Cyber Security audit	Internal audit of cyber security provided significant assurance	Apr-21
635	Requirement to test the Trusts defences against a cyber attack	Conduct a Penetration test exercise across the Trust to expose weaknesses in the Trusts cyber defences with follow up action programme to address areas of concern.	Oct-21
635	IG Toolkit in particular Information security which includes patching, updating of systems, malware, cyber security etc.	IG Toolkit outcome has provided a moderate assurance	Jul-21
635	Procurement review all web site expenditure with IT prior to giving approval to purchase.	Procurement and IT meet monthly to assess all technology procurements over £10K for the Trust.	Jul-21

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	Cultural and staff ability and aptitude was preventing optimum and appropriate use of technology	Work with staff abnd OD team to understand the barriers to using technology and provide the necessary help and support	Sep-22
635	Requirement to improve knowledge of staff of the dangers of a cyber attack on the Trust	Conduct a Phishing exercise across the Trust to expose the dangers of opening suspicious e-mails with follow up programme.	Jun-22

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 of Directors
SR7. (Risk 932) Changes in the roles of commissioners and providers and the move to system-level working will require changes in the role and function NHS Trust boards and new governance arrangements There is a risk we do not have appropriate governance arrangements in place nor the capacity and capability to fulfil all our statutory functions.		**Current Risk Score**	**12**	**Executive lead**	Sara Munro (Chief Executive)

Assurance rating (quarterly) (limited, partial, significant)	Q1 (end June 2021)	Q2 (end September 2021)	Q3 (end December 2021)	Q4 (end March 2022)
	Partial	Partial	Partial	Partial

Contributory risks from the directorate risk register				Risk Score			
Datix Ref	**Description**	**Lead / responsible director**	**Overseeing group**	**Q1 (end June 2021)**	**Q2 (end September 2021)**	**Q3 (end December 2021)**	**Q4 (end March 2021)**
945	The COVID 19 pandemic removes the ability to work effectively in partnership as Trusts focus on the day to day delivery of services within their own Trust	Sara Munro	Gold Command / Executive Management Team	6	6	4	2

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*
932	Our Executive Team are linked into the governance arrangements for the WY&H ICS and the West Yorkshire Mental Health, Learning Disability and Autism Collaborative (MHLDA Collaborative)	Regular reports are made into the executive meetings and also to the Board through the CEO reports	Mar-22
932	Memorandum of Understanding for the WY&H ICS which has been agreed by all the partner Boards which sets out how the ICS will link into the Board	The MoU has been agreed by the Board and regular reports on the work of the ICS and any decisions that need to be taken are made through the CEO reports	May-21
932	Memorandum of Understanding for the MHLDA Collaborative which has been agreed by all the partner Boards which sets out how the ICS will link into the Board	The MoU has been agreed by the Board and regular reports on the work of the MHLDA Collaborative and any decisions that need to be taken are made through the CEO reports	May-21
932	A Committees in Common has been established for the MHLDA Collaborative which has as its members our Chair and CEO	The Committees in Common meets on a regular basis and reports back to our Board through the CEO reports	May-21
932	NED / Governor engagement events set up for WY MHLDA Collaborative	This provides governors and NEDs with an opportunity to understand and feed into the future plans for the collaborative	Jun-21
932	Board awareness training on partnership governance structures and models	Training provided by external legal adviser - this will be refreshed in June 2022	Jan-20
932	Good representation in relation to Leeds Population Health Management to ensure it connects to the Trust and supports MH and LD services	City-wide meetings	Apr-21
932	The Strategy for the WY&H ICS Collaborative has been published	All partners in the ICS have signed up to the Strategy	Jan-20
932	Established lead provider models	Eating Disorders Lead Provider Collaborative agreed	Sep-20
932	Consitution for ICS and Leeds PBP have been agreed	This sets out how the ICS and its Leeds Office will work together and in partnership with the Trust	Dec-21
932	The Board receives regular updates on changes in governance models and opportunities to be involved	Each private Board meeting	May-21
932	The Trust's CEO is the SRO for the ICS	Regular updates are provided to the Board by the CEO	May-21

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*
932	Further work needed to define the governance arrangements and operating models for the ICS and the Leeds PBP	A working group has been brought together to look at defining the governance strucutre and reporting lines from partner Boards and the ICS - this will need to be signed off by Boards and the ICS	Apr-22