BOARD ASSURANCE FRAMEWORK OVERVIEW

Strategic Objective	Risk appetite	Strategic Risk	Quarterly Assurance Rating Q1	Q2	Q3	Q4	Changes in strategic risk score	Executive Lead	Assuring Committee	Current Risk Score	Change
1. We deliver great care that is high quality and improves lives	**ons. It is classed as 'high' in relation to that openness but the board would not take risks that either compromise our 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 including safety assurance processes, we risk not being able to maintain standards of safe practice, meeting population health needs and compliance with regulatory requirements.**	Partial (remains same)	Partial (remains same)	Partial (remains same)	Partial (remains same)	SR1 - (June 2023) The risk score for SR1 remains the same. This recognises the risk is well controlled and has robust governance arrangements in place. In relation to staffing, workforce issues are specifically picked up in SR3, but it should be noted that any issues around safe staffing as a consequence of those workforce issues have robust reporting arrangements.	Nichola Sanderson (Director of Nursing, Professions and Quality)	Quality Committee	**12**	→
		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 impact on how we understand and act on the care of those who use our services.	Partial (remains same)	Partial (remains same)	Partial (remains same)	Partial (remains same)	SR2 - (June 2023) The score for this risk has remained the same. to reflect the interconnectivity there is with the workforce risk / issues and the ability to make quality improvements within a workforce that has its current challenges.	Chris Hosker (Medical Director)	Quality Committee	**12**	→
		SR8. (Risk 1111) There is a risk we fail to understand, plan and deliver services that meet the health needs of the population we serve.	NEW N/A	Partial (remains same)	Partial (remains same)	Partial (remains same)	SR8 - (June 2023) It was agreed this risk score will stay the same because we are as far ahead as we can be with the work and the systems processes and procedures needed at this point are in place and effective.	Joanna Forster Adams (Chief Operating Officer)	Finance and Performance Committee	**12**	→
2. We provide a rewarding and supporting place to work		**SR3. (Risk 1109)There is a risk that we fail to deliver a culture and environment that recruits, retains, and attends to the wellbeing of staff to enable them to be their best and deliver quality services now and in the future.**	NEW N/A	Partial (remains same)	Partial (remains same)	Partial (remains same)	SR3 - (June 2023) the risk score for SR3 has remained the same the scale of the workifrce risk and the direct impact this is having on the ability to provide current services has not changed since the last review of the BAF.	Darren Skinner (Director of HR)	Workforce Committee	**16**	→

3. We use our resources to deliver effective and sustainable services	**ave a risk appetite which is 'open' to considering all potential options and solutio compliance with its duty of care to staff and patients or compromise compliance**	**SR4. (Risk 619) There is a risk that a lack of financial sustainability results in the destabilisation of the organisation and an inability to meet our objectives.**	Partial(remains same)	Partial (remains same)	Partial (remains same)	Partial (remains same)	SR4 - (June 2023) the score for this risk has been increased to refelct the uncertainty around CIPs both at a system and Trust level, noting this will likely impact service delivery.	Dawn Hanwell (Chief Financial Officer)	Finance and Performance Committee	**12**	↑
		SR5. (Risk 615) Due to an inability to provide adequate working and care environments we risk being unable to deliver safe and effective services.	Partial (remains same)	Partial (remains same)	Partial (remains same)	Partial (remains same)	SR5 - (June 2023) the score for SR5 remains the same. There is a regional workshop to look at the impact of national capital regime and how the West ICS will be impacted by this. When the outcome of the workshop is known and the impact on the Trust's estate is evaluated there will be a further review of the risk score.	Dawn Hanwell (Chief Financial Officer)	Finance and Performance Committee	**12**	→
		SR6. (Risk 635) As a result of insecure, inadequate and poorly utilised digital technologies there is a risk the quality and continuity of services is compromised.	Partial (remains same)	Partial (remains same)	Partial (remains same)	Partial (remains same)	SR6 - (June 2023) there is an acknowledgement that there have a number if incidents and this may impact on the risk score. However; we awaiting the outcome of a debrief on the incident to determine if there are any gaps in our controls which might impact on the scoring of this risk.	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 including safety assurance processes, we risk not being able to maintain standards of safe practice, meeting population health needs and compliance with regulatory requirements.		**Current Risk Score**	**12**	**Executive lead**	Nichola Sanderson (Director of Nursing, Professions and Quality)

Assurance rating (quarterly) (limited, partial, significant)	Q1 (end June 2022)	Q2 (end September 2022)	Q3 (end December 2022)	Q4 (end March 2023)
	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 2022)**	**Q2 (end September 2022)**	**Q3 (end December 2022)**	**Q4 (end March 2023)**
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 principal risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*
SR1	Governance structures in place which sets out where Quality, safety, compliance and performance are discussed and assurance is received and provided	Following an internal restructure of our 2 operational caregroups to 9 service lines and an internal consultation of a future model of clinical governance and a focus on strenghtening clinical and professional leadership the new Unified Clinical Governance arrangements commenced in July 22. The monthly meeting has representative from 9 operational service lines, Clinical Directors Heads of Clinical Governance, Professional leads , chaired by the Deputy Director of Nursing, with monthly reports to TWCG and issues escalated to Quality Commitee and other relevant sub commitees as required.A Clinical goverence toolkit has also been produced and is shared with all new NEDs as part of their induction pack .In addition there is executive oversight of the reporting arrangements through the executive led groups with assurance reports to the board sub commitees which will identify any risks to quality,safety,compliance or performance impacting on regulatory requirements.The organisation commissioned Deloittes to undertake a Well Led Review, the findings of which were fed back in Jan 22 with positive recognition that work was underway to move to one overarching governance meeting, in addition the Governance Assurance Accontabilityand Performance framework [GAAP] was audited and given siginificnat assurance.Our current Organisational CQC rating is GOOD following the last in inspection in 2019.	Jan-22
SR1	Head of Clinical Governance and Regulation Team in place to oversee compliance with CQC standards, risk registers,serious incidents and the implemetation of the new Patient Safety Incident Response Framework	CQC peer reviews recommenced from April 22,with a focus on ensuring previous actions have been embedded and sustained within service areas.Reports from all peer reviews are provided through the Trusts governance structures and updates provided to Trust wide Clinical Goverence to ensure oversight.Regular updates in relation to risks, serious incidents are discussed at LIMM and TIRG and any areas of concern are reported to Quality Commitee or provided to trust Board through the quarterly DON reports and updates from the Quality Commitee chairs report. In April 22 a Board development session was held to appraise board members of the organisational preparedeness and planned changes to the CQC framework.A task and finish group has been set up to develop a PID to oversee the implemetation of the new Patient Safety Incident Review Framework ,progess of which is reported through to TWCG and Quality Commitee.PSIRF workshops have been established from February 2023 for all staff and NEDs to attend	Jul-22
SR1	Annual process in place for reporting on the controls in place in relation to risk to compliance incorporating the 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 2021/22. Self certification were signed off by the board for 2021/221 which also highlighted if there were any risks to compliance for 2021/22 and how these would be addressed. The Board has also confirmed compliance with all standards of the Provider licence and the self certification and this has been published on the Trust Website	Jun-22
SR1	Serious Incident reporting and investigation process in Place	NHSE investigation reports were presented to CQC inspectors as part of the Well Led Review which received an overall CQC rating of GOOD. All Si reports are investigated under the current Serious Incident Framework and reported through our Internal governance arrangments with opportunities to share learning . Quarterly reports are provided to Quality Commitee. In addition an audit on Learning from deaths was undertaken in April 2019 which gave significant assurance	May-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*
SR1	Establishement of the ICB and changes to system working since July 22	Terms of Reference considered as part of system groups and expectations and internal and external reporting structures are being agreed with relevant representation across partner organisations	Dec-23
SR1	Ongoing risk of future Covid variants and other associated infections which may impact on our ability to deliver same standard of care to our service users	Booster programme for both flu and Covid 19 in place.Clear PPE guidance in place across the organisation with access to IPC team for advise and guidance.Director of Infection Prevention and Control[DIPC] receives daily outbreak reports from the IPC team advising of number of positive cases across the organisation and provides monthly updates to Quality Commitee and escalates to executive colleagues as required. In addition clear outbreak management of infections is in place for all staff as guidance DIPC also attends NHSE external meetings to obtain national and regional updates	Mar-23

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 impact on how we understand and act on the care of those who use our services.			Current Risk Score	12	Executive lead	Chris Hosker (Medical Director)	
Assurance rating (quarterly) (limited, partial, significant)	Q1 (end June 2022)	Q2 (end September 2022)	Q3 (end December 2022)		Q4 (end March 2023)		
	Partial	Partial	Partial		Partial		

Contributory risks from the directorate risk register				Risk Score			
Datix Ref	Description	Lead / responsible director	Overseeing group	Q1 (end June 2022)	Q2 (end September 2022)	Q3 (end December 2022)	Q4 (end March 2023)
	There are no contributory risks on the risk register						

Key controls in place		Assurance that controls are effective	Date
Ref	*The main controls/systems in place to manage principal risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*
SR2	Quality Plan	The Quality Strategic Plan is now under review, however the 5 core areas will remain unchanged.	Sep-22
SR2	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
SR2	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
SR2	"The culture of innovation and improvement needs to be developed" The revised Service Annual Reports	The revised Service Annual Reports template was supported by the Clinical Directors, Medical director, Clinical Governance and signed off at TWCG. As of Jan 23, all new Service Annual Reports will be based on the revisesd template and services will continue to be offered support when completing them.	Feb-23

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*
SR2	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, Informatics and Organisational Development Team.	ongoing
SR2	The culture of innovation and improvement needs to be developed	This is linked to the work around collective leadership, the rollout of the revised Service Annual Reports (supported via the QuIK group) and the building improvement capactiy ad capability programme.	ongoing

Strategic Objective	2. We provide a rewarding and supporting place to work		Risk appetite	3 - Open ('High')	
Strategic Risk		**Initial Risk Score**	**12**	**Committee**	Workforce Committee
SR3. (Risk 1109)There is a risk that we fail to deliver a culture and environment that recruits, retains, and attends to the wellbeing of staff to enable them to be their best and deliver quality services 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 2022)	Q2 (end September 2022)	Q3 (end December 2022)	Q4 (end March 2023)
	N/A New risk	Partial	Partial	Partial

Contributory risks from the directorate risk register				Risk Score			
Datix Ref	**Description**	**Lead / responsible director**	**Overseeing group**	**Q1 (end June 2022)**	**Q2 (end September 2022)**	**Q3 (end December 2022)**	**Q4 (end March 2023)**
604	Inability to attract and retain the right workforce supply to meet service plans and needs. This will negatively impact on service user/patient experience and quality of care as well as staff wellbeing.	Angela Earnshaw/ Fiona Sherburn	Retention and Resourcing Group	16	16	16	16
308	Staff do not experience a high quality and supportive PDR. Rates remain below target. This will impact on morale, staff retention and career development as well as the delivery of the workforce plans	Angela Earnshaw/ Fiona Sherburn	Talent and OD Group	8	8	12	12
211	Leaders and managers will not have the skills and capacity to lead and manage staff, teams and services well and lead collectively. This may impact on staff morale and motivation as well as wellbeing.	Angela Earnshaw/ Fiona Sherburn	Talent and OD Group	8	8	8	8
343	The Trust is not able to cover substantive staffing shortfalls using temporary staffing.	Andrew McNichol	Retention and Resourcing Group	16	16	16	16
733	The NHS Pay Award 2022 may result in strike action of particular professional groups impacting on the abilty to staff services safely.	Holly Tetley	People Employment Group	8	8	6	6
734	The national Cost of Living challenges impact on colleagues' ability to attend work	Holly Tetley/Frances Dodd	People Employment Group/People Experience Group	6	6	6	6

Key controls in place		Assurance that controls are effective	Date
Ref	*The main controls/systems in place to manage principal risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*
SR3	Workforce plans in place. Service and Trust wide, . Workforce Matric in place. Trust wide Retention plan and Apprenticeship Strategy/ implementation plan in place. Systemwide work underway to support join recruitment and selection events and share learning.	HEE review of workforce plans, Recruitment and Retention Group monitor plans which are overseen by the Workforce Committee. Workforce planning KPIs form part of the People Plan dashboard which are reviewed at Workforce Committee and appropriate sub groups	Feb-23
SR3	Clear policy in place to support new PDR process along with a Career Conversation Toolkit for staff and managers. Oversight of compliance by Workforce Committee with an Appraisal compliance task and finish group in place with clear actions that are monitored and reviewed monthly. Compliance reports sent monthly to services.	Compliance discussed at Workforce Committee and its sub groups. Monitoring of compliance at the task and finish group with remedial action taken as necessary	Feb-23
SR3	Trust wide Leadership and Management pathway in place. Access to Leadership Academy programmes such as Mary Seacole. Collective Leadership phase two programme in place. Monitoring of attendance overseen by Workforce Committee and its sub groups.	Monitoring by Workforce Committee and Talent and OD group using the People Plan dashboard.	Feb-23
SR3	The Trust has a well-established in-house Bank workforce of both bank only and substantive staff with a bank contract. On-going recruitment plan in place. Neutral vendor arrangement in place with a collective of 10 agencies which is overseen by the Workforce Alliance framework as our tier 1 provider. Access is also available to registered suppliers as a tier 2 option.	Fill rates are monitored reports to safter staffing and recruitment and retention groups.	Feb-23

SR3	Workforce plan in place to address business critical services during strike action. Strong relationships with trade union colleagues to understand appetite for strike action.	EPPR Team fully aware and plans in place. Monitoring by JNCC, JLNC and People Employment Team.	Feb-23
SR3	Cost of Living Task and Finish group established to review and propose supportive measures to address challenges associated with the cost of living increases.	EMT oversee and approve support measures as these are developed and implemented. Recently meeting approved 11 recommendations (05/11/22).	Feb-23

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*
SR3	SupplySide of staff is a national risk.	International Recruitment to help mitigate national supply issues. Further upskilling on new roles to support services and fill vacancies.	Apr-23
SR3	Staff /management engagement in the importance of appraisals is low. Capacity issues impacting on compliance issues. New PDR system has appeared to have negatively impacted on compliance rates.	Line manager training on the importance of high quality PDRs. Training and support on moving to a new PDR system.	Apr-23
SR3	Capacity to release staff to attend the programme	Engagement with services on the importance of leadership and management development. Blended approach being offered along with a development hub to ensure leaners can access development opportunities in a flexible manner.	Apr-23
SR3	Temporary staffing availability and inclusive cultures on the wards.	The temporary staffing register provides temporary workers the ability to choose the shifts and wards on which they wish to work.Engagement with managers about supporting bank staff to integrate into their team/service. Bank Staff Survey, Bank Forums and Bank Staff Awards to support the engagement of bank workers.	Jan-23

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) There is a risk that a lack of financial sustainability results in the destabilisation of the organisation and an inability to meet our objectives.				Current Risk Score	8	Executive lead	Dawn Hanwell (Chief Financial Officer)
Assurance rating (quarterly) (limited, partial, significant)	Q1 (end June 2022)	Q2 (end September 2022)		Q3 (end December 2022)		Q4 (end March 2023)	
	Partial	Partial		Partial		Partial	

Contributory risks from the directorate risk register				Risk Score			
Datix Ref	Description	Lead / responsible director	Overseeing group	Q1 (end June 2022)	Q2 (end September 2022)	Q3 (end December 2022)	Q4 (end March 2023)
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 Collaboratives). 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.	Jonathan Saxton / Dawn Hanwell	Finance & Performance Committee	9	9	9	9
651	Failure to achieve ongoing CIP requirements and demonstrate efficient and effective care will lead to a deterioration in the financial position.	Jonathan Saxton / 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.	Jonathan Saxton / 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	Jonathan Saxton / Dawn Hanwell	Financial Planning Group	9	9	9	9
908	Reliance on non-core income to support underlying financial position	Jonathan Saxton / Dawn Hanwell	Financial Planning Group	9	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.	Jonathan Saxton / Dawn Hanwell	Financial Planning Group	12	12	12	12

Key controls in place		Assurance that controls are effective	Date
Ref	*The main controls/systems in place to manage principal risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*
SR4	Good working relationships established with system partners. Actively engaging with place and ICB and provider collaborative partners and putting forward proposals that promote efficient and effective models of care.	Signed contracts with key commissioners in place, minutes of discussions with place, ICB and provider collaborative partners 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 and 22/23, based on a list of jointly agreed priority investments in efficient and effective models of care. Further positive joint working with NHS E and West Yorkshire mental health providers resulted in agreeing a funding baseline for CAMHS Provider Collaborative and NHSE approval to operate as Lead Provider. Throughout 2022/23 we have continued to engage in regular and positive dialogue with Leeds place based colleagues to promote efficient and effective models of care. Evidence of growing business from existing partners including CAMHS and adult secure developments in North Yorkshire, Community Transformation developments in Leeds and West Yorkshire as lead for Complex Rehab pathway, and winning tenders provides further assurance.	Jun-22
SR4	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.	Jun-22
SR4	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.	Jun-22
SR4	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.	Jun-22
SR4	Partnership working arrangements in Leeds and ICB 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 emerging citywide governance and decision making meetings, including 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 ICB CFO for mental health) and other key strategic partnership roles (Programme Director for WYICS MHLD&A and CCG Lead CFO for mental heath) provides evidence of maintaining influence on how resources are distributed. Minutes of numerous WYICS MHLD&A work streams including Transformation funding opportunities we have secured and business cases for ATU and complex care. LYPFT dedicated finance input to support WY ICS mental health work streams ensures visibility of funding opportunities and assurance that funding is distributed fairly. LYPFT CFO is the ICS CFO Capital lead on the ICS capital and estates Board, which influences capital allocation within the ICS.	Jun-22
SR4	As part of the Operational planning for 2023/24 financial year the Trust will develop a Cost Imporvement Programme to deliver the efficiencies required to meet agreed financial trajectories, assist productivity and improve outcomes and the experience for our service users.	A paper was apprved at FPG in March 2023 to produce a full CIP for the 2023/24 financial year focussing on 4 key areas: 1. Reducing agency spend 2.Reducing out of area pressures (complex rehab and adult acute) 3.Reducing our vacancy position by looking at opportunities to redesign within existing establishment 4.Exploring all opportunities/categories to improve productivity and efficiency The Trust will utilise the data available through Model Hospital, Lord Carter, benchmarking and improvement programmes to identify priorities for productivity and efficiency improvement. As part of our previous CIP governance, the FPG will continue to provide oversight of our whole programme	Mar-23
SR4	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
SR4	Robust budgetary control framework and budget holder training in place	There is online training on Staffnet and opportunity to attend Finance Skills Development courses 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-22

SR4	Consistent achieved of organisational plans in the context of system control targets.	Accounts audited at the end of 2022/23 to verify the financial outturn. Monthly reporting in 23/24 provides assurance that the Trust is on track to achieve the LYPFT element of the system control target.	Jul-22
SR4	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-22
SR4	Financial modelling and forward forecasting in place to identify risks early.	Financial Plans submitted to NHSE included a detailed assessment of cost pressures and commissioning intentions based on wide ranging engagement within the Trust. Subsequently, monthly financial monitoring returns and quarterly forecasting provided to NHSE, Leeds Place based forecasting and ICS reporting and forecasting update each month.	Jun-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*
SR4	Weakening of financial governance and controls as consequence of focus on clinical operational work and reduced capacity to attend to efficiency plans.	Fully re-establish our process for identifying longer-term CIPs (gap in control) during COVID response. Mitigated by current underlying run rate. Trustwide engagement in Strategic Planning events, in conjunction with budget rebasing exercise (engaging Care Groups to target areas for consideration) to inform and develop our approach to identifying longer term cost improvement plans. The approach involves full diagnostic and full sharing of information relating to cost pressures, agency spend, service line financial performance, action planning to address income and expenditure mismatches. Undertake self assessment of financial governance which will be subject to an internal audit.	Dec-22
SR4	Excess expenditure not covered by exceptional income	Mitigated by current underlying run rate, and our enhanced focus on corrective actions/plans to mitigate significant cost pressures. Financial Planning Group principles and business case process for assessing cost pressures and investment requests that are not supported by additional income.	Oct-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 an inability to provide adequate working and care environments we risk being unable to deliver safe and effective services.		Current Risk Score	12	Executive lead	Dawn Hanwell (Chief Financial Officer)

Assurance rating (quarterly) (limited, partial, significant)	Q1 (end June 2022)	Q2 (end September 2022)	Q3 (end December 2022)	Q4 (end March 2023)
	Partial	Partial	Partial	Partial

Contributory risks from the directorate risk register				Risk Score			
Datix Ref	Description	Lead / responsible director	Overseeing group	Q1 (end June 2022)	Q2 (end September 2022)	Q3 (end December 2022)	Q4 (end March 2023)
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)	Jonothan Campbell / 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	Jonothan Campbell / 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	Jonothan Campbell / Dawn Hanwell	Estates Steering Group	4	4	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
1008	Sustainability -The Trust is unable to meet the NHS Carbon Neutral requirements by 2040 and to implement a sustainable culture within the organisation	Jonothan Campbell / Dawn Hanwell	Estates Steering Group	12	12	12	12
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	Jonothan Campbell / Dawn Hanwell	Estates 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 principal risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*
SR5	Surveys, Audits of the Physicaal environment	6 facet survey/ Premises assurance Model (PAM)/ Patient Led Assessment iof the care envirnment (PLACE)/ Estates Return Information Collection (ERIC)/ Internal Audit	Jul-22
SR5	sustainability programmes and improvmenets	Sustainability working groups established , Sustainability team established	Sep-22
SR5	Dedicated backlog maintenance within capital budget	Capital planning documentation	Jul-22
SR5	Policy and procedures to manage the estate	Polies, procedures and standard operating procedures	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*
SR5	Healthcare Planning Exercise / Discussions with NHSE/ IPA	SOC being developed , Ongoing meetings	Oct-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 and poorly utilised digital technologies there is a risk the quality and continuity of services is compromised.			Current Risk Score	8	Executive lead	Dawn Hanwell (Chief Finance Officer)
Assurance rating (quarterly) (limited, partial, significant)	Q1 (end June 2022)	Q2 (end September 2022)	Q3 (end December 2022)		Q4 (end March 2023)	
	Partial	Partial	Partial		Partial	

Contributory risks from the directorate risk register				Risk Score			
Datix Ref	Description	Lead / responsible director	Overseeing group	Q1 (end June 2022)	Q2 (end September 2022)	Q3 (end December 2022)	Q4 (end March 2023)
8	Failure to derive maximum clinical and business benefits from digital technologies	Bill Fawcett / Dawn Hanwell	Information Steering Group	6	6	6	6
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
1088	The threat of power cuts over the winter of 2022/23 could mean a loss of power to St Mary's House or Becklin Centre which host the two key data centers for the trust. Both sites has emergency generator capability but if these were to fail then critical digital systems would be taken off line.	Bill Fawcett / Dawn Hanwell	Information Steering Group	N/A New risk	N/A New risk	6	6

Key controls in place		Assurance that controls are effective	Date
Ref	*The main controls/systems in place to manage principal risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*
SR6	Monthly calls between Procurment and the ICT department led by the CIO	Procurement processes have now been implemented. The Procurement team have a processes in place to ensure all requisitions are scrutinised and processed within Trust policy and best practice. Junior Buyers raising orders are trained to check category codes (E Class) and ensure that descriptions on purchase orders are clear, they know to query any orders for cloud software, website maintenance and telephony with IT directly to ensure that what is being ordered is in line with current Trust policies. All orders over £5k will escalate to the category lead for additional checks and approval. Weekly Junior Buyers meetings are held to provide a forum for discussion around workloads and to flag any issues that have been raised in the week so the whole team can discuss and learn from them. Any orders raised incorrectly would be discussed in this forum. The e class Category codes ensure an additional level of approval prior to budgetary approval. This technical approval is used to ensure that relevant IT colleagues have sight of requisitions prior to budgetary approval as well as providing procurement additional assurance that any requisitions they receive to process are known and approved by IT. Category codes that carry a technical approval also mean that buyers can return requisitions that have not been raised with the correct category.	Jan-23
SR6	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 has been installed to provide detailed reporting on vulnerabilities .	Jan-23
SR6	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 was be conducted by an independent accredited organisation (SEC-1 LTD) Nov 2022. 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 The ICT infrastructure has firewalls, intrusion prevention, virus protection software and e-mail protection systems that are continually updated to prevent attack. A Phishing exercise was conducted in November 2022 and a further Phishing exercise is planned in April 2023. 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. This reports into Information Governance Group (IGG). 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. Data security and protection toolkit audit Cyber security audit IG Toolkit in particular information security which includes patching	Feb-23
SR6	Data security and protection toolkit audit	Internal audit of data security and protection toolkit provided moderate risk rating but high assurance. The Penn tesk has now been completed and this rating has been rivised upwards. The DSP toolkit for 2023 will also take account of this.	Feb-23
SR6	Cyber Security audit	DSP ToolKit audit on data security and protection provided significant assurance in August 2022	Aug-22
SR6	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.	Nov-22
SR6	IG Toolkit in particular Information security which includes patching, updating of systems, malware, cyber security etc.	DSP ToolKit audit on data security and protection provided significant assurance in August 2022	Aug-22
SR6	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.	Feb-23

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*
SR6	Cultural and staff ability and aptitude was preventing optimum and appropriate use of technology	Work with staff through Digital Change Team and Thrive by Design and OD team to understand the barriers to using technology and provide the necessary help and support. Thrive by Design implementation of digital inclusion programme through 2022.	Sep-23
SR6	Requirement to improve knowledge of staff of the dangers of a cyber attack on the Trust	Conduct Phishing exercises across the Trust to expose the dangers of opening suspicious e-mails with follow up programme.	Oct-23

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
SR7. (Risk 1110) If we fail to achieve solutions for PFI provision we will incur quality and financial risks for the organisation.		Current Risk Score	16	Executive lead	Dawn Hanwell (Chief Finance Officer)

Assurance rating (quarterly) (limited, partial, significant)	Q1 (end June 2022)	Q2 (end September 2022)	Q3 (end December 2022)	Q4 (end March 2023)
	N/A New	Partial	Partial	Partial

Contributory risks from the directorate risk register				Risk Score			
Datix Ref	Description	Lead / responsible director	Overseeing group	Q1 (end June 2022)	Q2 (end September 2022)	Q3 (end December 2022)	Q4 (end March 2023)
1006	demise of PFI in 2028	Dawn Hanwell	Estates Steering Group	16	16	16	16
1010	Condition of property	Dawn Hanwell	Estates Steering Group	12	12	9	9
125	Using sub optimal premises	Dawn Hanwell	Estates Steering Group	9	9	6	6

Key controls in place		Assurance that controls are effective	Date
Ref	*The main controls/systems in place to manage principal risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*
SR7	Healthcare planning exercise	Work with our healthcare planners PWC has concluded. We now have a Board approved Care Services Strategic Plan which outlines our future clinical strategy and requirements for bed base.	Nov 2021 - Sept 2022
SR7	Development of Strategic Outline Case	Draft version of the SOC presented to the Board in December 2022. Final version incorporating a revised financial case to be approved by Board in March 2023.	Mar-23
SR7	Discussions with Treasury, NHSE, ICB	Awareness at National and Regional Level around the pending issues with the PFI demise	Sep-22
SR7	Lifecycle Maintenance	Ongoing Lifecycle maintenance of properties - both PFI and lease and owned	Feb-23
SR7	Stakeholder engagement	Continuing to engage with stakeholders across the WYICS concerning the Trust's PFI scenario. Support received from WYICS CE. Log of engagement in place.	Mar-23
SR7	Care Services Strategic Plan	Board of Directors ratified the Care Services Strategic Plan	Sep-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*
SR7	Long term Estates Plans concerning the PFI Estate	Development and approval of the SOC for submission to NHSE. Continue to refine the SOC shortlist in preparation for compilation of the Outline Business Case (OBC).	Sep-23

SR7	IPA (Infrastructure & Projects Authority) PFI expiry checklist	Complete a table top review of the Trust's level of compliance with the PFI expiry checklist ahead of our next review in July 2023.	Jul-23
SR7	Development of governance and assurance framework to establish, manage and monitor PFI expiry strategy	Developing an internal governance group associated with preparing for the ceasation of the PFI concession.	ongoing
SR7	Stakeholder engagement / communication strategy	Development of communication and lobbying campaign concerning the Trust's PFI concession expiry. Continue to engage with DHSC / IPA / NHSE to seek support and guidance	Ongoing

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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
SR8. (Risk 1111) There is a risk we fail to understand, plan and deliver services that meet the health needs of the population we serve.			Current Risk Score	12	Executive lead: Joanna Forster Adams (Chief Operating Officer)
Assurance rating (quarterly) (limited, partial, significant)	Q1 (end June 2022)	Q2 (end September 2022)	Q3 (end December 2022)	Q4 (end March 2023)	
		Partial	Partial	Partial	

Contributory risks from the directorate risk register				Risk Score			
Datix Ref	Description	Lead / responsible director	Overseeing group	Q1 (end June 2022)	Q2 (end September 2022)	Q3 (end December 2022)	Q4 (end March 2023)
TBC	There a number of services which have long waits to access assessment and treatment, delaying diagnosis and treatment and not meeting a number of populations groups health needs. Services include Gender, ADHD, LADS, CFS, MAS	Mark Dodd:Deputy Director of Service Delivery	Operational Delivery and Performance group	16	16	16	16
TBC	Lack of (or inadequate use of) public health intelligence to inform resource allocation.	Carl Money (Head of Performance) and Alison Kenyon (Deputy Director of Service Development)		N/A	12	12	12
TBC	Community Transformation Programme is not realised within timescales	Josef Faulkener (Head of Operations)		N/A	9	9	9
TBC	There are a number of services who due to workforce challenges (vacancies and absence) are not able to deliver the expected capcaity or quality of care impacting on recovery rates and clinical outcomes for service users. These include CMHT's, Forensics, LD Psychology	Mark Dodd:Deputy Director of Service Delivery	Operational Delivery and Performance group	16	16	16	16
TBC	People who have an SMI are more likely to smoke, be overweight, abuse addictive substances, be unable to work, be in the lower socioeconomic groups and die earlier than the general population.	Joanna Forster Adams (Chief Operating Officer)/Cathy Woffendin (Director of Nursing and Professions)	Service Development Group	N/A	16	16	16

Key controls in place		Assurance that controls are effective	Date
Ref	*The main controls/systems in place to manage principal risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*
SR8	Robust performance monitoring and actions to address waiting times	QDAP Reports at Operational Delivery Group with summarised perfromance reporting through Chief Operating Officer Report.	Jan-23
SR8	People Plan implemntation	Workforce Committee Performance reports and updates on delivery of the People Plan	Feb-23
SR8	Monitoring of the ethinic mix of detained patients. Reduction in Restrictive Practices inequalities work led by Wendy Tangen. Engagement with the Synergi programme, WREN, health inequalities	MHL committee and Service Development Group	Jan-23

SR8	Paritcpate as partners in the Population Health Boards of the Leeds Office of the ICB to influence the prioritisation of the mental wellbeing of the population and improve the health inequalities and disadvatages people with an SMI expereince	Addressing Health Inequalities through Service Delivery Group	Jan-23
SR8	Community Transformation Programme instrastucture established with Executive level involvement and oversight/progress reports to Trust Board.	Updates provided to the Board each month through the Chrief Operating Officers report. Routine oversight through the LYPFT Service Development Group	Jan-23
SR8	Annual Service Quality Reports	Quality Committee	Jan-23

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*
SR8	Analytics regularly reviewed in Service Deveopment Group in relation to population health needs,	Establishment of a set of data and information which informs decision making in respect of service development	Jul-23
SR8	Systematised ways of working at Service level to understand their populations and measure performance of acgieving health care needs,	Head of Peformance and Deputy Director of Service Delivery to enhance the format of QDAPprocess to ensure that this is development and embedded as business as usual.	Jul-23
SR8	Care Service Strategic Plan implementation programme under development with measures to be established to measure compiance.	Service Development Group	Jul-23
SR8	There is an annual plan relating to Addressing Health Inequalities through Services Delivery - this needs to be developed into a startegy for the Orgnaistion which steers progress.	Chief Operating Officer to develop the infrasture to enable this.	Jul-23