Leeds and York Partnership
NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK

2016/17

Last updated March 2017

KEY TO TABLE HEADINGS

STRATEGIC OBJECTIVE	**The strategic objective the organisation is working towards achieving** • **Strategic Objective 1 -** We provide excellent quality, evidence based, safe care that involves people and promotes recovery and wellbeing • **Strategic Objective 2 -** We work with partners and local communities to improve health and lives • **Strategic Objective 3 -** We value and develop our workforce and those supporting us • **Strategic Objective 4 -** We provide efficient and sustainable services • **Strategic Objective 5 -** We govern our Trust effectively and meet out regulatory requirements
KEY RISK TO ACHIEVING THE OBJECTIVE	**The risks as shown on the Strategic Risk Register**
EXISTING KEY CONTROLS	**The systems, policies etc, people or structures are in place to ensure the risk is controlled and does not come to fruition, and ensures that the objective is achieved. The ones listed are the key high level controls rather than the day-to-day operational ones**
HOW DO WE KNOW THE CONTROLS ARE EFFECTIVE. WHAT POSITIVE ASSURANCES (I.E. EVIDENCE) IS THERE THAT CONTROLS ARE EFFECTIVE	**Who or what will provide evidence that the controls identified are effective and that reliance can be placed on them (this will come from (preferably) external i.e. independent sources and also from internal sources) – what are they saying about the current position with regard to the key controls (are they effective). Need to include actual performance targets and what our progress is against these.**
GAPS OR WEAKNESSES IN CONTROLS	**These are gaps that have actually occurred, not those that might occur in the future. Then list what other controls need to put in place, or how will existing controls be strengthened to address the gap.**
GAPS OR WEAKNESSES IN ASSURANCE	**These are gaps that have actually occurred, not those that might occur in the future. Then list what evidence from our assurance providers are we still waiting for to show that controls are effective (these can be internal and/or external – external assurances are better.**
ASSURANCE PROVIDER	**The executive director who has responsibility for assuring the Board**
BOARD / SUB-COMMITTEE TO RECEIVE THE ASSURANCE, WHEN AND NAME OF REPORT	**Those people and committees that have responsibility for oversight of the assurance on behalf of the Board**

STRATEGIC OBJECTIVE 1

We provide excellent quality, evidence based, safe care that involves people and promotes recovery and wellbeing

Principal risk	Existing Key Controls	How do we know the controls are effective? What positive assurances (i.e. evidence) is there that controls are effective	Gaps or weaknesses in controls	Gaps in or lack of assurance	Assurance provider	Board / sub-Committee to receive the assurance, when and name of report
(1.1) Failure to meet deadlines for the implementation of agreed procedures / systems and improvements for all compliance actions notified to the CQC (Risk No. 2 on the Strategic Risk Register)	An action plan has been developed and is being actively followed up through the CQC Fundamental Standards Group comprising executive directors which will monitor the action. The composition of the group represents all those who can assess the reported confirmation of completion of action.	The majority of actions have either been addressed or are on target to be addressed as reported to the CQC Fundamental Standards Group and the CQCFSG is assured on progress. Documentary evidence is being collected and actions cannot be classed as completed until evidence has been uploaded to the electronic tracker.	No gap in control	Not all actions have been completed and there will be some, such as the establishment of single sex accommodation which may not be fully completed at the time of the re-inspection.	Anthony Deery Director of Nursing Professions and Quality	**Quality Committee** CQC Action Plan update report (each meeting)
	An electronic action tracker has been implemented and action owners identified. Emails are regularly sent to action owners asking for an update	The system has only just been introduced awaiting assurance of its efficacy.	As yet it is not fully tested in a live environment.	This system is still in in its early phase and as such it is difficult to know if it is properly working and whether all action owners are getting the emails	Anthony Deery Director of Nursing Professions and Quality	**Quality Committee** CQC Action Plan update report (each meeting)
	All evidence of completion of an action goes through a governance group and the CQC Fundamental Standards Group will do a random check of the evidence.	The system has only just been introduced awaiting assurance of its efficacy.	As yet it is not fully tested in a live environment.	As yet it is not fully tested in a live environment.	Anthony Deery Director of Nursing Professions and Quality	**Quality Committee** CQC Action Plan update report (each meeting)
	Quality Reviews are being carried out using CQC Key Lines of Enquiry to assess services' compliance with fundamental standards	The system has been developed in conjunction with an experienced CQC inspector. The system was used up until the July inspection and this highlighted areas that needed addressing.	The system of quality reviews is to be re-started so there is an up-to-date statement in relation to compliance with the CQC fundamental standards	The system of quality reviews is to be re-started so there is an up-to-date statement in relation to compliance with the CQC fundamental standards	Anthony Deery Director of Nursing Professions and Quality	**Quality Committee** Quality Review update report (each meeting) **Note: this is a new report still to come to the committee**

Principal risk	Existing Key Controls	How do we know the controls are effective? What positive assurances (i.e. evidence) is there that controls are effective	Gaps or weaknesses in controls	Gaps in or lack of assurance	Assurance provider	Board / sub-Committee to receive the assurance, when and name of report
(1.2) High number of vacancies in care services (Risk No. 58 on the Strategic Risk Register)	ET has agreed a detailed recruitment plan for staff in care services which will include targeted recruitment fares and assessment centres. The Trust has in place a 'Bank' of staff who can be called upon to fill vacancies on a short-term basis. This is controlled through e-Rostering which will show what staff are available to ensure there is the ability to have the right staff with the right skills in the right place. Bank staff have to meet the Trust's standards for training and development therefore the Trust has more control over the quality of the 'Bank' staff over agency staff.	The Board has received assurance that wards have safe levels of staffing. The Finance and Business Committee has also received assurance that the Trust is a low user of agency staff in comparison to other NHS organisations.	The Trust continues with a programme of recruitment to the 'Bank' to ensure there are sufficient staff available to meet demand. The Board still needs to agree the Workforce Plan.	There continues to be an ongoing issue in the area of recruitment and retention in some service delivery areas. Whilst the wards are staffed to a safe level these do not always allow the right level of therapeutic care.	Lynn Parkinson Interim Chief Operating Officer	**Board of Directors** Integrated Quality and Performance Report (quarterly)
(1.3) Problems with recruiting and retaining staff working within Clifton House which may lead to staff currently working at the unit suffering stress and service user activities being limited due to reduced staffing. (Risk No.488 on the Strategic Risk Register)	The situation is being monitored regularly within the LD and Specialist Care Group management meetings there is a plan in place to recruit staff to the ward to enable this to be opened in early 2017/18. There has been a recruitment drive in the York area to attract staff to the vacant posts. There are regular update reports received at ET and the Board of Directors to monitor the situation on an ongoing basis.	There is limited evidence that the controls are effective.	There has been limited success in attracting staff to the service.	There is currently no assurance that there are sufficient levels of staff at Clifton House and there is the potential for more staff to leave.	Lynn Parkinson Interim Chief Operating Officer	**Board of Directors** Update reports on the progress at Clifton House (currently each meeting)

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(1.4) Inability to agree long term Estates Plan and optimum use of estate Resulting in the use of estate being constrained by the lack of a clear Clinical Services Development Plan for some services. (Risk No. 128 on the Strategic Risk Register)	In order to support the development of a long term Estates Plan a Clinical Services Development Plan is being developed.	Awaiting the Clinical Services Development Plan being finalised.	The Clinical Services Development Plan is not yet finalised and is expected to be completed June 2017	There is currently limited assurance in place that the optimum use of estate can be evidenced, the Clinical Services Development Plan will provide the information required for the Estates Plan to be developed from.	Lynn Parkinson Interim Chief Operating Officer	**Board of Directors** Clinical Services Development Plan (June 2017)
	Commissioner discussions progressing specifically with regard to learning disabilities aligned with the Transforming care agenda (TCA) with the expected outcome that the number of assessment and treatment beds will reduce and specification for facilities to repatriate people in out of area placements will be identified and therefore the impact on our estate utilisation can be planned.	There is a good working relationship with the commissioner and we are working with them as members of the Transforming Care Agenda Programme Board, estates utilisation is one of the work streams that we are participating in.	Work is ongoing to develop the Clinical Services Development Plan which will define and agree clinical priorities aligned to commissioner intent and this will be complete in June 2017.	Whilst timescales and milestones are explicit in the TCA programme, service models are not yet specified and therefore we cannot be clear about interdependencies with other aspects of our clinical strategy and therefore our estates utilisation plans.	Lynn Parkinson Interim Chief Operating Officer	**Finance and Business Committee** Estates Strategy Update Report (each meeting)
	Partnership arrangements are being developed regarding Child and Adolescent Mental Health Services (CAHMS) with Leeds Community Health (LCH).		Outcome of the discussions with LCH are awaited	There is currently no assurance in place that the partnership arrangements will address the optimum use of estate can be evidenced as they are still being developed.	Lynn Parkinson Interim Chief Operating Officer	**Finance and Business Committee** Estates Strategy Update Report (each meeting)

STRATEGIC OBJECTIVE 2

We work with partners and local communities to improve health and lives

Principal risk	Key Controls	How do we know the controls are effective? What positive assurances (i.e. evidence) is there that controls are effective	Gaps or weaknesses in controls	Gaps in or lack of assurance	Assurance provider	Board / sub-Committee to receive the assurance, when and name of report
(2.1) Providing services from premises that are not in direct ownership of the Trust Resulting in the risk of unacceptable delays in executing identified environmental changes and a lack of responsiveness to maintenance requests (Risk No. 9 in the Strategic Risk Register)	Health and safety inspections and ligature anchor point audits supported by risk assessments with clinical environments group overseeing risk assessments to determine works required in terms of ligature anchor points and the care environment. A list and programme of environmental changes pertaining to managing ligature risks was agreed and prioritised by the Clinical Environment Group. This programme is ongoing in nature and is reported monthly to the Environmental Group. New ligature risks are reported to the Environment Group, discussed and actions agreed. If the works are of such a nature that capital funding is required these are reported to the Estates Strategy Steering Group.	The Clinical Environments Group reviews all audits and make recommendations as to the changes that are needed. These included changing radiator covers, handrails, magnetic backing plates to soap/towel dispensers, anti-ligature furniture, anti - ligature curtains and blinds. From the findings of all ligature risk assessments, completed for all clinical areas as part of CQC inspection, risks were either identified as manageable by clinical intervention/observation or by required environmental changes.	Disconnect between local risk registers and the estates risk register Lack of understanding at a local level of how escalation operates. There is work underway to map these processes and review structures and roles	Assessment of ligature anchor points and their remedy is ongoing and as such assurance is always being sought.	Dawn Hanwell Chief Financial Officer	**Finance and Business Committee** Estates Strategy Update Report (each meeting)
	Responsive maintenance process managed by monthly meetings with third party suppliers (PFI provider, NHS Property Services) Rolling scheduled backlog maintenance programmes agreed and monitored on monthly basis	Estates are working closely with the third parties to ensure the contracts are being managed correctly and that the maintenance programme is being addressed in a timely manner. Monthly meetings take place with our PFI partners and care services. KPIs and financial penalties are in place. Currently, weekly meetings are in place with NHS PS and Mitie. A new SLA is currently being reviewed and will include accountability, KPIs, penalties and a schedule of planned preventative maintenance.	Formal contract arrangements need to confirmed with NHS Property Services (currently still operating under BTA – draft agreements to change to market rent have been developed). Ongoing delays have been escalated to the Chief Executive at NHS PS. Draft SLA is currently being reviewed. Heads of Terms approved (22 March) and solicitors instructed in terms of finalising the lease. This work should be complete in April 2017.	Once the formal contract arrangements are in place with NHS PS assurance can be gained that the contract is being managed in accordance with that	Dawn Hanwell Chief Financial Officer	**Finance and Business Committee** Estates Strategy Update Report (each meeting)

STRATEGIC OBJECTIVE 3

We value and develop our workforce and those supporting us

Principal risk	Key Controls	How do we know the controls are effective? What positive assurances (i.e. evidence) is there that controls are effective	Gaps or weaknesses in controls	Gaps in or lack of assurance	Assurance provider	Board / sub-Committee to receive the assurance, when and name of report
(3.1) Workforce not equipped or sufficiently engaged to deliver new models of care. Resulting in the quality of care being sub-optimal; decreased workforce morale and productivity; and increased sickness absence with associated pay costs. (Risk No. 5 in the Strategic Risk Register)	There is an annual Staff Survey in place. Within this is a measure of feedback on overall levels of staff engagement Key issues arising from the staff survey and other engagement activities continue to be addressed through Trust wide and service level activity and communicated through Chief Executive led listening events and communications.	2016 staff survey results indicate that levels of staff engagement are improving and have increased year on year since 2014. The 2016 survey achieved a response rate of 53%, this is the highest ever response rate achieved and is 3% higher than the national average. Therefore we are assured that levels of staff engagement are improving.	Trust communication channels require further development in order to effectively support engagement plans and campaigns. These channels impact on overall levels of engagement.	2015 Staff Survey – response rate did not increase in comparison to the 2014 survey. This indicates that levels of overall engagement are static and there is no assurance of any increased level of engagement or participation in the survey. The 2016 survey is awaited to see if there is an increased level of engagement.	Susan Tyler Director of Workforce Development	**Board of Directors** Report on the outcome of the Annual Staff Survey (annually)

	From April 2017 an agreed Trust engagement plan will be implemented, this will include a number of elements, including consistent senior management engagement activity. The Trust has committed to longer term use of the Your Voice Counts digital crowdsourcing platform as a key enabler to improving levels of staff engagement, including addressing key areas from the 2016 staff survey and also supporting local staff engagement.	Feedback from the 2016 senior manager engagement activities has been used to respond to specific concerns raised by staff and considered alongside other feedback received from the staff survey and staff Friends and Family Test. Feedback from staff who have used the digital platform so far indicates that confidence and participation rates are growing.	Response is voluntary and it will take time to build the confidence and motivation of staff to respond and provide feedback in this way. The Trust is currently developing internal capacity to continue to utilise the Your Voice Counts digital platform. This will be developed support wider staff engagement across the Trust and locally in teams.	From September 2016, the Crowdsourcing platform will provide an alternative platform collecting staff feedback and identify levels of staff engagement. It is hoped once this is embedded, participation levels will increase significantly and this will become an assurance of staff engagement. There is also a gap in target setting and progress reporting. This is being reviewed.	Susan Tyler Director of Workforce Development	Senior Management Group Report on CEO/director led engagement activity (quarterly)

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(3.1) CONT	Staff receive appraisals which will ensure they have the right skills in place to meet the needs of the new models of care to support this process there are enhanced fortnightly reports being sent to all appraisers and overall percentage by care group/team sent to senior managers and an updated appraisal procedure and paperwork in place. Compliance with appraisals is being monitored through the CQC Fundamental Standards Group	The Trust has achieved a compliance rate of 83.11% against a target of 85% so there is some assurance that appraisals are taking place.	During the second phase of implementation of iLearn we will extend its remit to staff appraisal to help make monitoring appraisals easier.	There is limited assurance that the target for appraisals has been achieved.	Susan Tyler Director of Workforce Development	**Board of Directors** Integrated Quality and Performance Report (quarterly) **Quality Committee** Workforce Performance Report (quarterly)
	An Employee and Managing Attendance Procedure is in place with formal stages of attendance management outlined in this. Reports for the Board of Directors and its sub-committees are generated from ESR data in respect of attendance. Sickness reporting system (First Care) implemented in November 2014 provides improved management information and the ability to monitor absence management performance. Management information on absence is provided by HR on a monthly basis to the care groups Sickness action plans are developed in care groups; and Proactive physiotherapy service using early intervention and referral system to reduce MSK absences HR sickness absence group formed to focus on high areas of sickness. A Health and Well-being plan reflects national Health and Wellbeing CQUIN targets with emphasis on mental health and physical activity. Actions arising out of the H&WB plan being developed and reviewed through the Health and Well-being Group. Resilience training is being offered to staff and teams to support change management from April 2016.	In the last year sickness rates have remained well above target, however we are seeing a slight downwards trend with figures at September (4.9%) going below 5% for the first time since January 2015 and figures at February 2017 (4.97%) keeping below the 5% mark . The First Care system is slowly becoming more embedded and HR business partners are engaging more with managers about using the MI to support managing attendance more proactively. We are, seeing an improvement in MSK absence month on month from the highest point in 2015 of 26% of all absence to February 2017 17.4% of all absence which demonstrates that the interventions and actions are working. This service receives very positive feedback from staff and managers and is highly valued. A full review and evaluation of the First Care system has taken place and a decision is has been taken to extend the system until September 2017 with some improvements implemented in March 2016 to enable more evaluation about its benefits to the Trust.	Rapid change and uncertainty have impacted on resilience of workforce demonstrated through high levels of absence (4.97% February 2017) Resilience training to improve employee well-being needs to be more systematic	Reporting system introduced to support reduction in absence has not delivered expected results as quickly as anticipated, improvements to the system and easier reporting implemented from March 2016 have still not achieved expected results .	Susan Tyler Director of Workforce Development	**Quality Committee** Quarterly Workforce Development Performance Reports (quarterly) **Board of Directors** Integrated Quality and Performance Report (quarterly)

STRATEGIC OBJECTIVE 4

We provide efficient and sustainable services

Principal risk	Key Controls	How do we know the controls are effective? What positive assurances (i.e. evidence) is there that controls are effective	Gaps or weaknesses in controls	Gaps in or lack of assurance	Assurance provider	Board / sub-Committee to receive the assurance, when and name of report
(4.1) Deterioration in financial standing and potential loss of contract income when services are tendered Resulting in an inability to maintain a strong financial position in the context of increasing demand, uncertainty of potential tender processes, commissioner and local authority funding positions and capability to deliver further ongoing efficiencies. (Risk No. 3 in the Strategic Risk Register)	Integrated Quality and Performance Report which assures on the surplus planned, actual and projected and also on the current NHS Improvement assessment.	The IQP shows that the Trust's financial position is currently ahead of plan and there is confidence that the finance and use of resource theme will be at least a 2 for the remainder of the financial year.	None	None	Dawn Hanwell Chief Financial Officer	**Finance and Business** Financial Performance Report and out-turn (each meeting) **Board of Directors** Financial Report presented as part of the IQP (quarterly)
	Clinical income risks are reviewed on a monthly basis and strategies formulated to avoid or mitigate risks through the Clinical Income Management Group (CIMG).Tender opportunities are reviewed by CIMG on a case by case basis along with considerations of whether to bid or not bid on any given tender using agreed growth strategy principles. The Finance and Business Committee receive clinical income reports demonstrating performance and status of contracts, including material risks and threats. Longer term planning documents reported to Board and NHS Improvement includes further analysis to identify threats to contract income at the earliest opportunity. Partnership working arrangements in Leeds, 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).	The IQP shows that the Trust's financial position is currently ahead of plan and there is confidence that the finance and use of resource theme will be at least a 2 for the remainder of the financial year. External audit have looked at income as part of their statutory work and reported no significant findings	None	None	Dawn Hanwell Chief Financial Officer	**Finance and Business** Clinical Income update report (each meeting) **Board of Directors** Financial Report presented as part of the IQP (quarterly)

Principal risk	Key Controls	How do we know the controls are effective? What positive assurances (i.e. evidence) is there that controls are effective	Gaps or weaknesses in controls	Gaps in or lack of assurance	Assurance provider	Board / sub-Committee to receive the assurance, when and name of report
(4.2) The danger of a cyber-attack to the Trust's UCT systems through malicious hacking or system virus infection Resulting in a potential business continuity issues. (Risk No. 105 on the Strategic Risk Register)	The ICT infrastructure has firewalls, virus protection software and email protection systems that are continually updated to prevent attack. The role of chief information security officer is encompassed in the role of the Chief Information Officer, and the team structure reconfigured to provide further support.	Our virus protection (Sophos) system evidences virus protection to all devices on the Trust network and has a reporting tool which has stated no breaches to date Firewall logs evidence the monitoring of network traffic and intrusion prevention systems automatically detect and prevent access. The system continually logs activity and no breaches to date NHS mail, which is an external service, has protection services which has evidenced protection is in place.	None	Penetration testing of network security is planned annually and is next scheduled for January 2017. Once completed we will be able to assess our level of assurance about our security arrangements Internal audit will carry out an audit in November 2016 will report its findings to management and t the audit committee. The outcome of this audit is awaited. .	Dawn Hanwell Chief Financial Officer	**Finance and Business Committee** Information Systems Strategy Update Paper. (each meeting)
	There is a cyber security programme in place and changes have been made to our network infrastructure including updating the Trust's Internet Web Filtering system and tracking assets that connect to the IT network.	Some assurance has been achieved through the cyber security programme.	The cyber security programme which will improve our awareness and response to threats is still ongoing. Further protection is now planned for the desktop and laptop estate and a software product has been identified for procurement to achieve this.	Awaiting completion of the cyber security programme in order to gain a high level of assurance	Dawn Hanwell Chief Financial Officer	**Finance and Business Committee** Information Systems Strategy Update Paper. (each meeting)

STRATEGIC OBJECTIVE 5

We govern our Trust effectively and meet out regulatory requirements

Principal risk	Key Controls	How do we know the controls are effective? What positive assurances (i.e. evidence) is there that controls are effective	Gaps or weaknesses in controls	Gaps in or lack of assurance	Assurance provider	Board / sub-Committee to receive the assurance, when and name of report
(5.1) The Trust is not achieving its target for compulsory training as specified in its Compulsory Training procedure with the risk that the Trust cannot evidence that staff have the right skills and training to carry out their role. (Risk No. 156 in the Strategic Risk Register)	There is a ratified Compulsory Training procedure in place that articulates the required training for every role in the Trust. Implementation of new iLearn Learning management system has provided; easier access and navigation for staff to book onto and complete training; easier compliance monitoring for line managers; automatic prompts given to staff when compliance is due to expire; and More regular and enhanced reporting on CT compliance. A compulsory training programme is in place with sufficient capacity for all staff to be trained and remain in date and compliant. Compulsory training is recorded centrally and is performance reported at a Trust, Care Group, Service Area and individual level though iLearn. Continually working with CT trainers and teams to ensure the compulsory training programme meets training and local delivery requirements	On aggregate the Trust has achieved a compliance rate of 88.2% against a target of 85%; however, not all services in the Trust have met the target. Internal audit carried out an audit of compulsory training in November 2015 which provided 'significant assurance' on the processes and content of the compulsory training system	None	The target for compulsory training is not being met in all areas of the Trust	Susan Tyler Director of Workforce Development	**Board of Directors** Integrated Quality and Performance Report (quarterly)