The point on a page – the Assurance Framework

The Board has three key roles in its leadership of AWP, as defined in the Foundation Trust Network's *The Foundations of Good Governance*:

- Formulating strategy;
- Shaping a positive culture for the Board and the organisation; and
- Ensuring accountability by holding the organisation to account for the delivery of strategy and **through seeking assurance that systems of control are robust and reliable**.

The Assurance Framework is a *dynamic* document which brings together three things:

- The Trust's purpose and priorities through its strategic objectives from its Integrated Business Plan (that includes Trust-wide strategies and Delivery Unit strategic priorities);
- A headline summary of all the issues (risks) that might get in the way of achieving those objectives;
- A headline summary of what we're doing about those issues, along with a concise description of how readers can be assured that what we're doing is working.

The Trust has defined its purpose as follows:

"We provide the highest quality mental healthcare to support recovery and hope".

To achieve this purpose the Trust has defined five priorities:

1. Deliver the best care
2. Support and develop staff
3. Continually improve what we do
4. Use our resources wisely
5. Be future focused

All NHS Trusts are required to use an Assurance Framework, not least because it's been proven good practice for many years in both healthcare and a whole range of complicated high-risk organisations. An Assurance Framework is a working document and you should be able to recognise in it all the principal risks you and your colleagues can see and are dealing with in helping to provide high-quality care for patients and service-users by identifying, removing, minimising and controlling all the things that can go wrong. In short, it is a list of the promises we've made and an assurance that we're going to deliver them despite all the problems we know we face on the way. It's a "live" document that changes over time, and in particular it picks up all the controls that we have in place to manage, minimise and/or remove the principal risks we've identified and points towards concise and comprehensive evidence that the controls are working.

The difference between "assurance" and "reassurance" is vital to make the Assurance Framework work:

- Reassurance is when someone tells you all's well;
- Assurance is when they tell you what's happening, show you the evidence, and you can judge for yourself if all's well – that's what the Assurance Framework is about.

The Assurance Framework and Risk Registers are complementary but not the same thing:

- The Assurance Framework identifies principal risks at quite a broad level over a full-year period – "what are the *sorts* of things that get in the way, what in general are we doing about it?" – the risks don't change much over a year, although the key controls and assurance elements probably will do;
- A Trust-wide, Directorate or local Risk Register identifies the precise day-to-day risks that make up those broad principal risks – "what *specifically is* getting in the way, what are we actually *doing* about it?", and those entries may stay relatively stable for the year or change day by day.

RAG Rating our Assurances

To provide the Board with an "at a glance" indication of how complete our assurances are against our strategic objectives a RAG rating is given. To RAG rate the objective the following guidance is given:

Green: Effective controls are definitely in place and the Board is satisfied that appropriate assurances are available.

Amber: Effective controls are thought to be in place but assurances are uncertain and/or possibly insufficient.

Red: Effective controls may not be in place and/or appropriate assurances are not available to the Board.

The Board must regularly review those RAG rated as green to ensure these remain current and satisfactory.

Further reading:

AWP Integrated Business Plan 2013/14 to 2017/18

"Board Assurance Frameworks: A *Simple Rules* Guide for the NHS, The Good Governance Institute, March 2009 and "Quality Governance: How does a board know that its organisation is working effectively to improve patient care? Guidance for NHS provider organisations", Monitor, April 2013

Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

Trust-wide Objectives and Assurances

Strategic Priority 1				*To deliver the best care*						
Lead director:				*Medical Director*						
Objective	**Associated risks** (and reference to risk registers)	**Risk Ref**	**Key controls in place to manage this risk**	**Current risk score**	**Positive assurances on controls**	**RAG status of assurance**	**Probable assurances on controls**	**Gaps in controls and/or assurance**	**Actions identified to close gaps**	**Completion date of actions**
To achieve a rating of 'good' from the Inspector of Hospitals										
	Gaps in quality governance system relating to ability to check and test effectiveness of processes in place, and challenges in capturing issues broader than specific compliance criteria, such as clinical environmental issues mean the Trust is not able to fully assure itself in all areas	CE5	Integrated Assurance Framework – the framework through which the Trust maintains oversight at management and Board level of performance across all areas. Use of IQ to record and monitor performance through regular review of data at Quality Huddle, Quality and Standards Committee and Board. 2 weekly check and challenge process reviewing progress against Trust-wide and locality action plans. Weekly locality walkabouts Monthly Executive walkabouts A review of the role of Professional Council is underway, with the aim of ensuring the group provides the required support and guidance within the Trust. The revised Supervision Policy	9	Positive trends in performance reported through IQ seen during 2013-14 Internal Audit report (Clinical Governance and Compliance) issued in Q3 of 2013/14 confirming accuracy of data recorded. PLACE audits and 15 steps inspections include service users and service to check environmental and other standards Completed actions from quality inspections are checked by LDU senior management and reviewed in locality governance meetings. Exceptions are reported by the CD		Clinical Audit will report on outcomes and issues throughout the year. Provision of Business Information, Data Quality and Incident Reporting Internal Audits to be undertaken in 2014/15 Clinical networks reflect service lines. Networks will compare and benchmark services against national standards and against each other, thus reducing variation in practice and outcomes. Soft roll out to take place from January 2015.	Comparison of Trust performance in relation to quality of services reported through IQ is limited in national comparators. IQ reporting requires further development to allow an “override” to apply a broader filter in areas of concern IQ domains are under review. The next iteration will ensure IQ reporting has less duplication and better reflects CQC quality domains and key lines of enquiry. Clearer links to be established for communication between the Academy and localities	A revised approach to Quality Improvement Visits will be implemented which will include a “Week in Focus” where localities will be subject to an inspection led by Trust subject experts on a chosen subject. IQ system to be revised in line with CQC domains, informed by intelligent monitoring Records Management requirements will be updated to reflect specific needs of teams	To commence February 2015 31 March 2015

Strategic Priority 1				*To deliver the best care*						
Lead director:				*Medical Director*						
Objective	**Associated risks** (and reference to risk registers)	**Risk Ref**	**Key controls in place to manage this risk**	**Current risk score**	**Positive assurances on controls**	**RAG status of assurance**	**Probable assurances on controls**	**Gaps in controls and/or assurance**	**Actions identified to close gaps**	**Completion date of actions**
			supports staff to discuss quality of services delivered with management, supported with mechanisms for future review and feedback. The revised quality inspection regime includes weekly quality walk-rounds by LDU senior management and others. Walk-rounds focus on environment, staff and service user experience and documentation. The inspections require action response within 24hrs. The QI regime also includes a 'Week in Focus', a detailed, operations-led compliance inspection based on CQC key lines of enquiry. This supports LDUs to remain 'inspection ready'. Quality Board meeting from January 2015 Accountability Framework now in use at Executive level and cascaded to localities for local implementation		to Q&S. Learning points from all sources, including from walk-rounds and Week in Focus, are reviewed and actioned through CIOG where they are collated into the Patient Safety Development plan. The senior nursing Inspection team undertake targeted assurance inspections to check compliance with regulation.					
	Suicide from ligature points - Never Event. A number of sites have been found to be in breach of Regulation 15. Completion of the Manchester Tool in this and previous years, has identified the need for a comprehensive programme of ant-ligature works.	CE4	All sites undertake annual Manchester environmental assessment, including internal & external environments, and all sites have undertaken fresh Manchester assessments since June 2014 Ligature risks were prioritised for immediate or planned action. Immediate risks are being addressed rapidly. Mitigating actions have been identified where ligature risk remains. An external review of ligature risk, policy & procedure was commissioned by the clinical executive.	15	Each LDU identified staff who have been trained to perform Manchester tool assessments. Manchester tool assessments are quality assured by H&S. Quality Improvement Plan delivery is overseen by Director of Operations. LDU senior leadership is held to account for completion of actions in fortnightly review.		Patient Safety and Quality (Regularity Reviews) Internal Audit Anti-ligature work now clinically led through suicide prevention group.	Work not yet complete to address all ligature issues, although all immediate actions have been taken.	External Reviewer developing 3 Trust-wide procedures and providing summary report on ligature points Mitigating actions are taken by each team to minimise risk. All risk assessments will be up to date and monitored by MM, assured through walk arounds and LDU governance. External review will be extended to identify step up and step down criteria in	31 January 2015

Strategic Priority 1				*To deliver the best care*						
Lead director:				*Medical Director*						
Objective	**Associated risks** (and reference to risk registers)	**Risk Ref**	**Key controls in place to manage this risk**	**Current risk score**	**Positive assurances on controls**	**RAG status of assurance**	**Probable assurances on controls**	**Gaps in controls and/or assurance**	**Actions identified to close gaps**	**Completion date of actions**
			Planned actions will result in 'safer' rooms in each ward. Service users' risk assessments will identify those most in need of 'safer' rooms. Master classes for WM and Matron on environmental risk assessment		Quality walk-rounds identify risk in the environment and check delivery. Compliance inspections check regulatory compliance.				relation to service user risk.	

Strategic Priority 2				*To support our staff*						
Lead director:				*Rachel Clark, Director of Organisational Development*						
Objective	**Associated risks** (and reference to risk registers)	**Risk Ref**	**Key controls in place to manage this risk**	**Current risk score**	**Positive assurances on controls**	**RAG status of assurance**	**Probable assurances on controls**	**Gaps in controls and/or assurance**	**Actions identified to close gaps**	**Completion date of actions**
To implement Friends and Family for staff	No risks currently identified in relation to this objective.	None.	Bespoke information prepared for each delivery unit to encourage responses and to make information more locally relevant Locality/Delivery Unit leadership actively promoting staff engagement Localities to communicate local results, providing response to local issues and encouraging staff to engage in regular surveys Trust wide communication of overarching results and actions in response	None.	Successful implementation of test across the Trust, measured through response rates Data published on NHS England website Established reporting to Board and Senior Management Team. Employee Strategy and Engagement Committee scrutinises scores, Trust wide and local actions and monitors progress.		Reporting will evidence value of measure. Performance reviews with Local/ Specialist Delivery Leadership teams to focus on staff engagement	Improved Communication strategy required to improve mechanisms for feedback to staff – Trust wide and local feedback needed	Develop the Communication Strategy	28 February 2015
To enable every team to receive Team Development in the coming two years	Lack of ownership of Team Development by localities	OD1	Appointed Organisational Development Lead to implement Team Development programmes OD Project coordinator appointed Access to specialist Team Development expertise via collaboration with Aston OD.	None	Pilot phase complete Launch of Team based Working (TbW) – 14 January 2015 TbW commencing with senior teams		Stage gate reviews will take place throughout pilot and wider implementation, which will be reported on to ESEC			31 January 2015
	Logistical challenges of releasing staff, especially in inpatient services	OD2		9						
	Failure to relieve work related stress resulting from	OD3		9						

Strategic Priority 2				*To support our staff*						
Lead director:				*Rachel Clark, Director of Organisational Development*						
Objective	**Associated risks** (and reference to risk registers)	**Risk Ref**	**Key controls in place to manage this risk**	**Current risk score**	**Positive assurances on controls**	**RAG status of assurance**	**Probable assurances on controls**	**Gaps in controls and/or assurance**	**Actions identified to close gaps**	**Completion date of actions**
	workload		Collaboration with Quality Academy to enable rapid implementation Facilitation training in place to resource Team Development Full programme roll-out is supported by an implementation plan							
	Insufficient resources to support of Team Development (LDUs and central resource)	OD4		9						
To see 10% of questions on the annual staff survey improve on 2013 results	Failure to implement the Trust response to the 2013 staff survey.	OD5	Targeted programmes addressing issues highlighted in 2013 survey (6 improvement priorities) – activity monitored by ESEC. Wrote to all members of staff describing improvement priorities and reinforcing commitment to staff Staff Engagement Framework introduced Enabling Excellence Programme Reinstated Learning and Development portfolio Bursary panel re-launch Effective working with Staff side Acute Care Pathway review programme Workforce Planning and capacity management	None	Staff Friends and Family test results Completion rates of appraisal and appraisal feedback Compliance with Statutory and Mandatory training requirements Organisational Health Index Staff survey 2014: • 51.2% response rate • 8% scores improved • 15% scored declined • 77% score remained same		Cultural Audit	Better coordination of staff engagement and support opportunities Greater visibility of Trust commitment to support and develop our staff Effective internal communication plan	An innovative communication and engagement plan is being developed to build a high degree of awareness with Trust purpose and priorities. Workforce Development Management Group set up. Launch of ‘Development ‘Hive – January 2015 Bespoke locality workforce development plans Detailed review of 2014 staff survey feedback to identify local and trust wide actions.	31 March 2015
	Failure to effectively communicate response to 2013 staff survey	OD6		9						
	Continued low morale and lack of engagement across staff groups due to on going redesign and skill mix reviews, large scale change projects Trust-wide and work pressures.	OD7		9						
	Continued low morale and lack of engagement across staff groups due to ongoing redesign and skill mix reviews, large scale change projects Trust-wide and work pressures.	OD7		9						

Strategic Priority 3				*To continually improve what we do*						
Lead director:				*Alan Metherall, Acting Director of Nursing*						
Objective	**Associated risks** (and reference to risk registers)	**Risk Ref**	**Key controls in place to manage this risk**	**Current risk score**	**Positive assurances on controls**	**RAG status of assurance**	**Probable assurances on controls**	**Gaps in controls and/or assurance**	**Actions identified to close gaps**	**Completion date of actions**
To fully establish the Quality Academy				*None.*				The decision has been taken to disband the Quality Academy following a review of the arrangements. The Trust is working to implement increased levels of inspection and audit, and has set up a Quality Board to advise the Trust and oversee the operation of quality networks.		
To achieve a 20% reduction in the use of restrictive practices	*No risks currently identified in relation to this objective.*	*None.*	Conflict Resolution Training PMVA Training amended to include a focus on the preventative interventions identified in Safe Wards Safer Staffing Numbers Violence Reduction Group leading the implementation of Safe Wards PERT Training. Training needs for bank staff being identified. In the absence of national guidance the Trust recently approved local definitions of restraint.	*None.*	Wards to have access to incident data on restraint data. Work plan for Violence Reduction Group CIOG reviews incidents and cascades lessons learned Mental Health Legislation Group reviews practice and learning. Quality and Standards Committee reports. Lead Nurse for PMVA now based in N&Q Directorate.		Q4 Audit Monthly incident reporting (commence Aug 2014) Adoption of preferred model of physical interventions	No nationally recognised model or ‘Kite Mark’ for models of PMVA Numbers of bank staff trained.	Options appraisal commencing July 2014 led by VRG Work is underway to identify a point of access for a PMVA team at each site Safer Staffing numbers will ensure appropriate staffing levels.	31 March 2015

Strategic Priority 4				*Use our resources wisely*						
Lead director:				*Sue Hall, Director of Resources*						
Objective	**Associated risks** (and reference to risk registers)	**Risk Ref**	**Key controls in place to manage this risk**	**Current risk score**	**Positive assurances on controls**	**RAG status of assurance**	**Probable assurances on controls**	**Gaps in controls and/or assurance**	**Actions identified to close gaps**	**Completion date of actions**
To establish the Resources Directorate	*Directorate has been established, but work is ongoing to ensure this directorate is able to be flexible to respond quickly to LDU needs and those of the Trust, and encompasses the required skills and competencies.*	*None.*	Enabling Excellence programme, supporting cultural change and embedding Trust intentions, priorities and goals Future Focus Finance national initiative launched in November 2015 to ensure teams are sited and working towards changing needs of NHS finance.	*None.*	Performance reported in relation to localities through IQ, as evidence of strong leadership through triumvirate management structure		Feedback will be gathered via the Staff Survey during the year A successful continuation of the FT journey tests the effectiveness of our support services as well as our care services, therefore this will be an assurance that the directorate is operating effectively Internal and External Audit reviews of finance and workforce management and controls	Directorate is established but evaluation is ongoing.	Resources staff included in Ops SMT and attend, where required, locality meetings to understand their business Weekly Resources "huddle" to identify issues to be resolved and highlight any that cross functions. Benchmarking exercise undertaken through SBS to test efficiency in both financial and process terms.	28 February 2015
To achieve our CIP Programme	Failure to identify, agree and implement and systematically deliver CIPs (Cost Improvement Plans) at Trust and locality level.	TW6	Corporate restructure undertaken to provide better support to front line services and review all practices to minimise bureaucracy Induction and leadership development programme in place for new Clinical Directors to enable them to support change and new working practice. Local ownership provides relevant opportunities to review working practices and develop new approaches Business planning process from which Cost Improvement Plans are identified, developed and agreed is in place. IQ System provides an accessible focus on quality and drives continuous improvement. Programme Management Office (PMO) managing CIPs through: - Weekly CIP assurance process	9	Reporting on delivery to Finance and Planning Committee and Board on a monthly basis. Monthly monitoring via PMO & Ops of CIP delivery against budgets Internal and External Audit reviews of financial management and controls		IQ development to include financial performance Business Development – Contracting and Commissioning Response Internal Audit to be undertaken during 2014/15	Access to shared good practice to inform CIP development	Further development of the Trust's workforce strategy which will ensure the Trust's staff align to the needs of service users and carers in a sustainable way Further development of the Trusts Organisational Development strategy which will include work-streams that ensure the Trust has the culture and tools to eliminate waste in the delivery of services.	31 March 2015

Strategic Priority 4				*Use our resources wisely*						
Lead director:				*Sue Hall, Director of Resources*						
Objective	**Associated risks** (and reference to risk registers)	**Risk Ref**	**Key controls in place to manage this risk**	**Current risk score**	**Positive assurances on controls**	**RAG status of assurance**	**Probable assurances on controls**	**Gaps in controls and/or assurance**	**Actions identified to close gaps**	**Completion date of actions**
			in place - Weekly recruitment panel in place - Coordinating CIP development process for 14/15 and 15/16 with detailed PIDs, QIAs and defined delivery plans & leads. - Monthly monitoring via PMO & Ops of CIP delivery against budgets. QIA process for CIPs has ensured clinical buy-in to CIPs, supported by a bi-annual review of locality performance. The Quality and Standards Committee has oversight of QIAs, ensuring that CIPs do not adversely impact on quality and finally. The resources restructure introduced a business intelligence team which will support streamlined reporting and accurate information.							

Strategic Priority 5				*Be future focused*						
Lead director:				*Executive Team*						
Objective	**Associated risks** (and reference to risk registers)	**Risk Ref**	**Key controls in place to manage this risk**	**Current risk score**	**Positive assurances on controls**	**RAG status of assurance**	**Probable assurances on controls**	**Gaps in controls and/or assurance**	**Actions identified to close gaps**	**Completion date of actions**
To become authorised as a Foundation Trust	Failure to match demand with capacity would lead to pressure on existing resources and a requirement to use out-of-area beds for adult, PICU and older adults, potentially compromising patient care.	TW2	Trust wide escalation to red against current escalation policy Discussions held with commissioners Consideration given to black escalation discussed with commissioners On-going discussions with local authorities regarding DTOC both locally and Trust wide Acute Care Pathway review underway Consideration on whether to block purchase private beds Action plan developed and agreed System wide Capacity Group	12	Progress to implement actions identified recorded and reported Review completed of all current DTOCs Register of all patients ready for discharge prepared Close working with Commissioners System wide ownership Admission of adult acute patients to home locality underway Daily bed state in place Warning notices issued by CQC in September 2014 have been lifted		Patient Safety and Quality (Regularity Reviews) Internal Audit to be undertaken in July/August 2014 reviewing practice in selected operational teams	Currently the Trust is experiencing significant pressures and action needs to be taken before this is effectively controlled and assurance can be provided over this.	Work with commissioners to identify capacity Work across system to improve capacity planning Bulk purchase of external beds with Priory, Bristol	31 March 2015 31 January 2015
	It is recognised that the following risks also directly relate to the achievement of this objective as they have the potential to impact directly upon quality of services provided. These have been captured above and therefore not reiterated in full here. • **TW2 –** Failure to manage capacity leading to further pressure on existing resources and a requirement to use out-of-area beds for adult, PICU and older adults, potentially compromising patient care and creating significant pressures on beds across the Trust. • **CE4 –** Suicide from ligature points - Never Event. A number of sites have been found to be in breach of Regulation 15. Completion of the Manchester Tool in this and previous years, has identified the need for a comprehensive programme of ant-ligature works. • **CE5 –** Gaps in quality governance system relating to ability to check and test effectiveness of processes in place, and challenges in capturing issues broader than specific compliance criteria, such as clinical environmental issues mean the Trust is not able to fully assure itself in all areas									

Strategic Priority 5				*Be future focused*						
Lead director:				*Executive Team*						
Objective	**Associated risks** (and reference to risk registers)	**Risk Ref**	**Key controls in place to manage this risk**	**Current risk score**	**Positive assurances on controls**	**RAG status of assurance**	**Probable assurances on controls**	**Gaps in controls and/or assurance**	**Actions identified to close gaps**	**Completion date of actions**
To implement the Bristol Tender and provide Mental Health Services as part of Mental Health Bristol	*No risks currently identified.* **Proposed risks:** Service User experience deteriorates Trust is not able to meet contractual requirements New ways of working are not embedded leading to recruitment difficulties	*None.*	The key control is to inspire confidence in AWP as the existing contract holder, by ensuring that our services are responsive, locally-focussed, effective, and demonstrate value for money, and so establishing AWP as a provider that CCGs need to engage with. Controls already in place to meet those objectives include: – AWP's revised management structure prioritises clinical leadership – Locality structure enables services to be matched to local priorities, to experiment and innovate, and to respond quickly to changing needs – An open and transparent culture encourages dialogue with CCGs and between AWP staff – The "Back to the Floor" programme and Quality Improvement Visits allow Executive Directors to be aware of issues and opportunities apparent at localities. – Sharing of IQ information with commissioners – Service User and Carer involvement at all levels of the organisation Greater transparency of financial positions and costs. Integrated Business Plan for 2014/15 – 2018/19	*None.*	Effective service delivery is being monitored through the contract performance framework Locality has regular performance meetings with CCGs Regular reporting to the Executive Team via fortnightly NED/Executive phone call Robust programme management infrastructure and governance. Exception reporting to Board.		Additional streamlined reporting when Business Intelligence Team is configured. Contracts finalised and signed.	Appropriate skills and capacity to support the transition process. The capacity of the Trust for cultural change may still limit the progression of the Trust's bid as historic issues could still be affecting current delivery of services. The practical challenge of implementing partnership working and strong governance in a new system. Difficulty in recruiting to key positions.	Work is ongoing to positively shape culture. CEO/Chair to have regular meetings with CCGs 360 degree feedback being set up from CCGs Organisational Development programme to address the gaps in staff skills to ensure the Trust is fit for purpose Clinical Engagement being harnessed through Bristol Medical meetings and development of Clinical Networks via System Leadership Creation of Business Development and Information function to support localities Learning from tender experience in other areas Skilled and experienced programme management support. Clear governance and contractual frameworks. System Leader	31 January 2015

Strategic Priority 5				*Be future focused*						
Lead director:				*Executive Team*						
Objective	**Associated risks** (and reference to risk registers)	**Risk Ref**	**Key controls in place to manage this risk**	**Current risk score**	**Positive assurances on controls**	**RAG status of assurance**	**Probable assurances on controls**	**Gaps in controls and/or assurance**	**Actions identified to close gaps**	**Completion date of actions**
									interim arrangements to be put in place	