Risk No: 1	High Standards	Date included:	01.10.19
Risk Title:	The Trust's clinical systems and processes may not consistently deliver harm free care.		
Risk Owner:	Director of Nursing, AHP and Quality	Date Last Reviewed:	15.10.20
Governance / review:	PSIG, Quality Forum, QAC / monthly review		

High Standards	Conseq-uence	Likeli-hood	Combined
Current Risk	4	4	16
Residual Risk	4	2	8
Risk Appetite / Target Risk score			8

Controls

Description:

- Staff Safety Huddles and Debrief
- Mandatory & Role Related Training available ; Clinical Supervision
- Thematic reviews of patient safety incidents and QI approach adopted by the Trust
- Infection Prevention & Control policies & the monitoring of
- Step up to Great Strategy High Standards work streams - Pressure ulcers, Falls, Deteriorating Patient, Positive and Safe, non fixed ligatures and Accreditation
- Step up to Great Strategy
- Patient Safety Plan - aligned to the National Patient Safety Plan / Patient Safety Improvement Group (PSIG)
- Nutrition & Pressure Ulcers Prevention Group (quarterly)
- High standards work stream 'Falls' including Falls Group – monitoring of incidents, themes, and national aligning to best practice
- Falls Group – monitoring of incidents, themes, and national aligning to best practice
- Suicide Reduction Plan in keeping with National Confidential Enquires Report
- Freedom to Speak Up Guardian and partners
- High Standards work stream –'Deteriorating Patient including sepsis' / 'Accreditation' including Accreditation Matron in post
- Deteriorating Patient Group
- Harm assessment process / Learning from Death and Suicide Prevention Clinician recruited 01/06/20
- Additional recruitment into patient safety and complaints teams
- Weekly meeting between patient safety and safeguarding teams

Gaps:

- Mandatory and role related training compliance across both substantive and bank staff – to be addressed by the recovery cell
- Availability of staff to investigate incidents and drive improvements forward.
- Some training suspended / All Leicester inquests suspended (until 30/09/20)
- Staff knowledge / ability to recognise and report poor behaviour towards patients from staff

Assurances

Internal:

- Quality Forum / Quality Assurance Committee / Strategic Workforce Committee
- All associated policies / Professional standards group
- Revised quality governance structure being embedded; Revalidation and registration process in place
- Associate Director of Nursing in place who leads on professional practice
- Mental Health Act Reviews / monthly MHA compliance census reported to LEG
- Mortality reviews & Learning from Deaths Process
- Trust wide Adult & Child Safeguarding
- Mandatory training reports ; Clinical supervision reports
- SUTG: High Standards Work streams reporting to Quality Forum and QAC
- Performance Report: Serious Incidents (number of)
- Deep dives at QAC
- Directorate risk registers

Evidence:

- Learning from deaths report to Trust Board
- Performance dashboard to FPC and Trust Board
- QAC assurance report to Board
- Update on progress of local Quality Accreditation
- Harm review paper
- SI reports
- Concerns / complaints
- Safer staffing
- Quality metrics

Assurance Rating Amber

External:

- Patient/family and staff FFT / PALS feedback
- CQC inspection / Professional Bodies e.g. NMC, GMC, HCPC
- Quality Contract and Monitoring with CCG & Specialised Commissioning
- Health watch Leicester / Coroner feedback / External reviews of quality governance
- LLR Transferring Care Safely Group/LPT engaged (acute/secondary provider feedback)

Evidence:

- Patient experience report to QAC
- CQC report and action plan to QAC

Assurance Rating Amber

Gaps:

- Fully implemented quality accreditation / Patient Safety Walk-rounds

Actions

Date:	Actions:	Action Owner:	Progress:	Status:
Jan 21	Develop and deliver plan for a coordinated approach to SI and complaint investigations	AS/SW/AK	Being discussed through exploring Governance	Amber

Risk No: 2	High Standards	Date included:	01.10.19
Risk Title:	The Trust's safeguarding systems do not fully safeguard patients and support frontline staff and services.		
Risk Owner:	Director of Nursing, AHP and Quality	Date Last Reviewed:	09/10/2020
Governance / Review:	Legislative Group, QAC / Monthly Review		

High Standards	Conseq-uence	Likeli-hood	Combined
Current Risk	4	3	12
Residual Risk	4	2	8
Risk Appetite	4	2	8

Controls

Description

- Safeguarding Team disseminate lessons learnt from investigations and reviews, Section 42 enquiries Care Act 2014) and through participation in multi-agency statutory reviews. processes (Child Safeguarding Practice Review [CSPR], Safeguarding Adult Review and Domestic Homicide Review .
- Legislative Committee oversight under new Quality Governance Framework.
- Identified Safeguarding Lead Nurses (Trust Lead, Child Lead, Adult Lead) and named Doctor for safeguarding children.
- Internal governance structure to manage safeguarding in place via Directorate oversight.
- Members of four local Safeguarding Boards, two Community Safety Partnerships and the Safeguarding Vulnerabilities
- Executive Committee.
- Adult and Children's Safeguarding Team in place.
- All vacant posts recruited to – full team complement in place

Gaps:

- Lack of consistent approach to how lessons are learnt and how they are disseminated across the Clinical Directorates through to front line staff.
- The number of Multi Agency Reviews (CSPR, SAR and DHR) across LLR is above the national average for the number of reviews commissioned within a locality area the size of LLR .
- The safeguarding training offer is not compliant with national standards and guidelines.
- Sufficient access to medical advice
- Lessons learned not being fully disseminated

Assurances

Internal:

Source:

- Legislative Committee
- Quality Forum provides oversight and challenge to the Legislative Committee.
- Quality Assurance Committee.
- Annual Quality Account.
- External review commissioned regarding safeguarding structures within LPT outlined 32 recommendations
- The identified Safeguarding Lead Nurses access safeguarding supervision external to the organisation.
- Annual Safeguarding Report.
- **SUTG:** High Standards Change Programme (at scoping stage)

Evidence:

- Safeguarding report presented to Trust Board upon request and there are regular updates from the DoN to QAC/TB
- Key Performance Indicators for the Legislative Committee.
- Progress and update reports regarding the external review action plan.
- Action plan
- Safeguarding new assurance reports for CCG, and the 4 safeguarding boards has been instigated to make the assurance meaningful and delivered in a timely , responsive manner.

Assurance Rating Amber

External:

Source:

- CQC inspections (contribution to CCG Safeguarding Inspections /direct LPT CQC Inspection)
- Commissioner meetings, including quarterly safeguarding assurance template (SAT) Membership of four Local Safeguarding Boards, including the Boards' respective sub-committees , i.e. Performance Group, Policy Group and Review Group
- External review completed and report accepted by the Trust.

Evidence:

- External review of safeguarding structures report
- CQC report
- Local Safeguarding Board reports and minutes

Assurance Rating Amber

Gaps:

- Training figures
- Full implementation of the external review recommendations

Key actions

Date:	Actions:	Action Owner:	Progress:	Status:
Dec20	Implement and embed the 32 recommendations from the external review.	Neil King	Action plan developed for all 32 recommendations - ongoing	Amber
Dec 20	Training capacity and offer to be reviewed	Neil King	Training deferred large scale deliveries not possible - Covid.	
Nov 20	Outline changing trend analysis throughout Covid period to highlight increasing work	Neil King	Safeguarding to become part of the recovery work in ICC	

Risk No: 3	High Standards	Date included:	01.10.19
Risk Title:	The Trust does not learn from incidents and events and does not effectively share that learning across the whole organisation.		
Risk Owner:	Director of Nursing, AHP and Quality	Date Last Reviewed:	15.10.20
Governance / Review:	Learning Lessons Exchange Group, Quality Forum, QAC / Monthly Review		

High Standards	Consequence	Likeli-hood	Combined
Current Risk	4	3	12
Residual Risk	4	2	8
Risk Appetite / Target Risk score			8

Controls

Description:

- Centralised process for identifying, processing, investigating, scrutiny and identifying Learning through the Serious Incident Process
- Complaints process and PALs team
- Patient and Staff Safety Incident review via triage and directorate responsibility
- Outcomes from Clinical Audit & service evaluation
- Working towards a robust Risk Management Process for identifying and manging risks to enhance learning
- Learning from Deaths Group using a human factors approach
- Learning lessons Exchange Group operating as a community of practice to embed a learning culture using a human factors approach
- Patient Safety Improvement Group aligning with national patient safety strategy using a human factors approach
- Appropriate groups for sharing learning in place and to follow up on progress against actions
- Centralised SI reporting and oversight process

Gaps:

- A robust Directorate level governance processes/systems
- Skilled SI investigators

Assurances

	Source:	Evidence:	Assurance Rating
Internal:	• Learning from deaths report • Patient safety quarterly report • Highlight report from Patient safety group • Highlight report from the Learning Lessons Exchange • Foundation for Great Patient Care • Escalation from Quality Forum to QAC • Incident review group meet weekly to review potential SI's and all COVID19 incidents and escalate to ICC • SUTG: High Standards Work streams • Performance Report: STEIS SI action plans completed within timescales.	• Monthly SI performance report for Quality Forum and QAC • Bi monthly patient safety report to Board • Highlight information and escalation processes • Reduction in harm and incidents • Reduction in concerns and complaints • Improved staff feedback • Performance Report	Amber
External:	• Feedback from patients/families • CQC statutory inspection framework • Quality and Serious Incident oversight by Commissioners & specialist commissioning • Coroner feedback • National Confidential Enquiries • Solicitor feedback learning points	• Patient experience report to QAC • CQC report	Green

Gaps:

- Triangulation with complaints and PALs

Key actions

Date:	Actions:	Action Owner:	Progress:	Status:
Oct 20	Plan a redesign of Directorate clinical governance structure	Anne Scott	Draft model developed through exploring governance COP	Amber
Oct 20	Exploration of trained investigator model to strengthen investigator process	Anne Scott	As above	

Risk No: 4	High Standards	Date included:	01.10.19
Risk Title:	Services are unable to meet 'safe staffing' requirements		
Risk Owner:	Director of HR / Director of Nursing	Date Last Reviewed:	14.10.20
Governance / Review:	Learning and OD Group, Quality Forum, QAC / Monthly Review		

High Standards

	Conseq-uence	Likeli-hood	Combined
Current Risk	4	3	12
Residual Risk	4	2	8
Risk Appetite / Target Risk score			8

Controls

Description:

- Monthly safe staffing reports with oversight and triangulation of fill rates, skill mix, temporary worker utilisation, vacancies, CHPPD, core clinical and mandatory training, patient experience feedback and Nurse Sensitive indicators
- 6 monthly establishment reviews include workforce planning, new and developing roles and recruitment and retention
- All reviews are in line with the NQB guidance for safe sustainable and productive staffing and the NHSI Developing Workforce Safeguards policy.
- Hot spot areas are escalated weekly to the Director of Nursing AHPs & Quality and monthly within the safe staffing report with actions to mitigate the risks.
- MHOST tool for review of patient acuity and dependency
- evidenced based tool for acuity and dependency measurement
- National safe staffing return recommenced
- Face to face training reviewed and roll out programme commencing from October 20 for Mappa and ILS and all other local skills training i.e. insulin administration currently being reviewed by the ICC education cell.

Gaps:

- Trust wide safe staffing safeguards SOP
- Delay in 6 monthly establishment reviews

Assurances

	Source:	Evidence:	Assurance Rating
Internal:	• Workforce Planning capacity - funded establishments and 6 monthly reviews • Analysis of NSIs, outcomes and patient experience feedback • Analysis of CHPPD and fill rates • Analysis of temporary worker utilisation • Detailed reports on rostering effectiveness are provided to services each month to measure the impact of different initiatives and to help identify areas for improvement. • SUTG: High Standards Work streams • Performance Report: Safe Staffing	• Trust Workforce Plan • Monthly and 6 monthly safe staffing reviews • Analysis of the CHPPD has not identified variation at service level, indicating that staff are being deployed productively across services. • Analysis of NSIs has not identified correlation between staffing and impact to quality, safety and patient outcomes • Reports of staff sickness due to COVID • Static trend: KPI showing amber (Feb 2020)	Green
External:	• NHSE Safe staffing trends – monthly submission • The Department of Health and Social Care's group annual governance statement - NHSI • Single Oversight Framework	• Unify and Health roster data • SOF / AGS	Amber

Gaps:

- Evidence based acuity and dependency data for all in-patient areas
- Plan for more centralised recruitment

Key actions

Date:	Actions:	Action Owner:	Progress:	Status:
Nov 20	• To develop a Trust wide safe staffing safeguards SOP	Emma Wallis	• The DRA off-framework staffing process and deployment has been reviewed and will feed into the SOP.	Amber
Jun **21**	• To procure and implement Allocate SafeCare.to monitor actual patient demand at key points during the day and accurately align staffing to match. Delayed due to Covid but actually not going to be implemented until May 2021 as a system	Amrik Singh	• This has been delayed for a year due to a regional procurement exercise.	
Nov 20	• 6 monthly establishment review scheduled for November 2020	Emma Wallis		
Nov 20	• Plan to complete analysis of the acuity data collection for inpatient establishment reviews	Emma Wallis		

Risk No: 5	High Standards	Date included:	01.10.19
Risk Title:	Capacity and capability to deliver regulator standards		
Risk Owner:	Director of Nursing, AHP and Quality	Date Last Reviewed:	13.10.20
Governance / Review:	Foundation for GPC, Quality Forum, QAC / Monthly Review		

High Standards

	Conseq-uence	Likeli-hood	Combined
Current Risk	4	3	12
Residual Risk	4	2	8
Risk Appetite / Target Risk score			8

Controls

Description:

- Quality Improvement work programme / Quality accreditation
- Foundation for Great Patient Care with KLOEs driving the agenda / CQC project manager in post
- Quality Surveillance Tracker
- Core standards training / 3 phased methodology
- NHFT buddy programme / Revised Governance structure – plus COVID-19 governance arrangements
- Book of brilliance
- Step up to great strategy
- Senior Leadership and Extended Senior Leadership Team Meetings / Board development sessions – on hold
- Completed CQC action plan and ongoing improvement programmes
- IPC inspection and action plan
- Risk management strategy and ORR - plus additional RM arrangements for COVD-19
- Action cards
- Approval of new AMAT database CQC module
- Reading room available on MS Teams
- Time to shine sessions – with targeted and 1:1 training in some areas
- CQC inspection preparation checklist available in Time to Shine Booklet
- Feedback on Director interviews provided at CEB 3 July 2020
- Sight of the new key lines of enquiry emerging from the 2020 focus groups
- Ongoing fortnightly position statement against warning notice actions

Gaps:

- Full self assessment against areas previously rated as inadequate

Assurances

	Assurances	Evidence	Assurance Rating
Internal:	• Audit and Quality Accreditation programmes • Self assessment checklist • Quality surveillance tracker • Quality forum • AMAT tool • Foundation for Great Patient Care • SUTG: High Standards Work streams	• CQC update report to QAC • Weekly update report to Exec Team • Foundation for Great Patient Care highlight report to Quality Forum – demonstrating good attendance and engagement • Position statement against warning notice areas – paper to ops exec team • ORR reports • Deep dives at the Foundation for Great Patient Care	Green
External:	• CQC inspection and engagement meetings / discussions / Emergency Support Framework • CQC focus groups held • Regulator discussions (SIAM / informal discussions with NHSEI) – on hold • Third line assurance over compliance (outside of the CQC) • CQRG – discussions with Commissioners • Regulator inspections including HSE, NHSIPC • KPMG value for money conclusion • 360 Assurance internal audit	• Inspection report • Feedback from the July 2020 focus groups • Minutes of CQC engagement and SIAM meetings • 3rd party assurance reports (HSE, IPC, NHFT buddy visits) • External reports on governance and SI management	Green
Gaps:	Full accreditation programme Re rating from the CQC during the Transitional Regulatory Approach		

Key actions

Date:	Actions:	Action Owner:	Progress:	Status:
Nov 20	Self assessment for all areas previously rated as inadequate	Julie Rubenzer	Returns received from Bosworth Ward, CAMHS crisis/OP	Green
Nov 20	Re-design of information flow to the CQC to inform the TRA	Kate Dyer	Paper to Strategic Exec Nov 20 / discussions held with the CQC	

Risk No: 6	Transformation	Date included:	01.10.19
Risk Title:	The step up to great mental health strategy does not deliver improved mental health services that meet quality, safety and contractual requirements and are sustainable.		
Risk Owner:	Director MH	Date Last Reviewed:	15.10.20
Governance / Review:	Transformation Committee, FPC / Monthly Review		

Transformation

	Conseq-uence	Likeli-hood	Combined
Current Risk	4	4	16
Residual Risk	4	3	12
Risk Appetite / Target Risk score			8

Controls

Description:

- Step up to great system wide pathway redesign high level launch
- Developing delivery plan
- Resources identified to deliver plan
- Programme management in place with DMT oversight and a service reconfiguration steering group
- on-going engagement with staff, service users and carers
- Mental health urgent care hub - introduced in April 20
- central access point - live in April 20

Gaps:

- Quality and timeliness of engagement with external partners
- Effective balance of conflicting short term priorities, with the development of the longer term vision and plan
- System financial sustainability and mental health investment standard
- Leadership development
- Robust stakeholder management and engagement plan
- QIA risk assessment process

Assurances

Internal:

Source:	Evidence:	Assurance Rating
• Large scale co-production events • Project Initiation Document • LPT Trust Board quarterly updates • Directorate Management Team (DMT) • Implementation plan • SUTG: Step up to Great Mental Health	• Transformation Committee update papers • SUTG project delivery dashboard • Out of area improvement	Amber

External:

Source:	Evidence:	Assurance Rating
• Health and Wellbeing Board scrutiny • STP Better Care Together Plan – Mental Health work stream • System MH Partnership Board governance • City MH partnership Board scrutiny • MH Clinical Forum monthly updates • CPM monthly progress updates • MH collaborative • Clinical senate review of clinical model (Oct 2020)	• External presentations • CQC engagement minutes	Amber

Gaps:

- Consultation of new model
- Worked up workforce model
- Management of change and associated EIA and QIA
- Agreed internal governance pathways

Key actions

Date:	Actions: delayed due to COVID	Action Owner:	Progress:	Status:
Nov 20	Set up work streams for delivery plan	GK	Work streams have been set up	Amber
Nov 20	High level agreement on Mental Health investment plan across system	GK	System signed off submission to NHSEI 21st Sept	
Nov 20	Agree to consultation process with JHOSC	GK	Work streams set up	
Dec 20	Completion of a pre-consultation business case (incl. QIA risk assessment and workforce model)	GK	Outline case completed and groups set up to undertake further engagement and address gaps for business case	
Dec 20	NHSE panel approval for going to consultation	GK	Engagement with NHSEI planned in Nov to arrange process	
May 21	Consultation process conclusion	GK	Planning meeting in place to prepare for consultation	

Risk No: 8	Transformation	Date included:	01.10.19	Transformation	Conseq-uence	Likeli-hood	Combined
Risk Title:	The transformation plan does not deliver improved outcomes for people with LD and/or autism.			Current Risk	4	4	16
Risk Owner:	Divisional Director, FYPC and LD Services	Date Last Reviewed:	12.10.20	Residual Risk	4	3	12
Governance / Review:	Transformation Committee, FPC / Monthly Review			Risk Appetite / Target Risk score			12

Controls

Description:

- Clinical leadership and ownership
- Transforming care pre-admission process for people with LD and / or autism
- Risk of Admission Register (ROAR) and associated e-learning
- Full RCA for anyone that falls outside of the defined process for admission
- Care and Treatment Reviews
- SDIP for LD Rehab at the Agnes Unit
- LD Outreach team offer alternative to admission
- 12 point discharge plan is utilised and monitored via discharge planning meetings
- There is an Accountable Officer (LPT CEO), an SRO, an Exec Lead & an allocated Assistant Director
- LD forensic training package for health and social care staff
- System wide LeDeR reviews
- LD QI Programme redeveloping pathways, capacity and demand and workforce models
- Interim staff cover though use of redeployed short breaks staffing to strengthen outreach offer for risk stratified patients including bank holidays
- Forensics team strengthened and further recruitment underway (Community Transformation Fund) .
- AMH TCP Group established to lead admission avoidance improvement work in CMHTs and Wards - support provided by LD clinicians
- Increased LD Matron capacity to support transformation and TCP work programme
- LPT leadership of Integrated Admission Avoidance and Discharge Team

Gaps:

- Treatment and support for ASD only diagnosis (without LD) – recruitment underway for new 14 to 25yo ASD post diagnosis team (Community Transformation Fund).
- System wide workforce plan
- Local LD rehab, ASD post diagnosis and forensics capacity
- Appropriate community placements in LLR
- Increased Nos of people on Risk Of Admission Register due to escalating behaviours / reduced community support / placement breakdown / short breaks and day centre temporary closure
- Capacity to prioritise system improvement plan / Delayed discharges due to reduced provider resilience and staffing
- Rehab proposal funding not agreed due to contract slippage and Q1 roll-over of budgets. Forensics business case agreed through Stage 1 of Community Transformation Fund

Assurances

	Source:	Evidence:	Assurance Rating
Internal:	• SOP for in hours and out of hours CTRs and CETRs to reduce risk of admission • Risk of admission register • Root Cause Analysis for all admissions • Transformation Committee • Improvement plan for AMH team	• List of people at risk of admission • Learning from RCAs to reduce risk of future admissions • Report into transformation committee • Admissions recorded without a CTR or LEAP • LD QI programme plan and progress reports	Amber
External:	• Adult Case Managers (CCGs / Specialised Commissioning) • External input into Root Cause Analysis on all admissions • CCG and LAs engagement in LD QI Programme Board • System LD and Autism Executive	• Learning from RCAs to reduce future admissions • Minutes of the TCP Executive Board • System Performance against TCP inpatient trajectory, LeDeR and Health checks (NHSEI escalated).	Amber

Gaps:

- LPT Action Plan in response to Annual LeDeR review report
- CCG Case Managers for children – recruitment underway Oct 2020 (CCG Led)
- System based support for effective discharge of Ministry Of Justice cases into the community (escalated to NHSEI for support)

Key actions

Date:	Actions:	Action Owner:	Progress:	Status:
Dec 20	Deliver LD Rehab SDIP within agreed timescales	HT	Links to rehab proposal awaiting CCG approval	Amber
Dec 20	Recruitment into Forensics and Post Diagnosis 14-25yo ASD services	HT	Recruitment underway. Awaiting funding confirmation.	
Nov 20	Sustain AD leadership of LD QI programme and TCP response	HT	Governance arrangements in place. Reporting to DMT, TCP Executive and Transformation Committee.	

Risk No: 9	Environment	Date included:	01.10.19
Risk Title:	Inability to maintain the level of cleanliness required within the Hygiene Standards		
Risk Owner:	Director of Finance, Business & Estates and Deputy Chief Executive / Director of Nursing	Date Last Reviewed:	15.10.20
Governance / Review:	IPCC, QAC and FPC / Monthly Review		

Environments	Consequence	Likeli-hood	Combined
Current Risk	4	2	8
Residual Risk	4	2	8
Risk Appetite / Target Risk score			8

Controls

Description:

- PLACE Audits
- Contract management with NHSPS for provision of soft facilities management (including cleaning standards)
- Collaborative agreement in place with UHL for provision of soft facilities management (including cleaning standards)
- Use of the Hygiene standards
- Appropriately trained estates team in place
- Backlog maintenance controls
- Hygiene Code gap analysis undertaken – Aug 2019
- Estates rep sits on/reports into IPC Group (cleaning/water/waste/decontamination)
- Infection control team / IPC quarterly report and annual report
- PLACE Audit action plan
- SOPs in place to describe key responsibilities
- Audit programme includes Cleaners rooms and trolleys
- Clear and agreed reporting mechanism against the Hygiene code
- 20/21 FM SLA and performance KPIs
- Revised cleaning spec/scope (zoned wards) and allocation of cleaning responsibilities (FM staff/Ward staff)

Gaps:

Assurances

Internal:

Source:

- Cleaning report to the Estates Committee
- UHL and NHSPS contractual cleaning audits and confirmation that cleaning specifications meet covid IPC requirements.
- PLACE audit action plan
- Finance and Performance Committee
- IPC Group to QAC
- Bi-monthly contractual cleaning forum (estates/IPC/NHS PS/UHL) - this goes to estates committee and FPC.
- Reporting against the delivery of the Estates Strategy
- Regular cleaning audits and KPI score monitoring
- Regular assurance information from UHL
- IPC Bi-Annual report to Trust Board

DMTs

- Monthly reports to FPC (Estates) and QAC - (IPC)
- PLACE scores and report for 2019
- Contractual cleaning audit findings – showing majority green reporting
- Regular performance reports against hygiene standards and regular review at IPC

Assurance Rating Green

External:

Source:

- NHSI IPC audit
- CQC inspections
- PLACE audits

Evidence:

- PLACE audit / NHSI audit received
- National Guidance on cleaning for COVID-19
- Premises Assurance Model
- CQC IPC summary inspection report

Assurance Rating Green

Gaps:

Key actions

Date:	Actions:	Action Owner:	Progress:	Status:
Oct 20	• Maintain high cleaning standards. Review in October to verify continued good progress.	R Brown	• Audits satisfactory	Green

Risk No: 10	Environment	Date included:	01.10.19
Risk Title:	The Trust does not implement planned and reactive maintenance of the estate leading to an unacceptable environment for patients to be treated in		
Risk Owner:	Director of Finance, Business & Estates and Deputy Chief Executive	Date Last Reviewed:	15.10.20
Governance / Review:	Estates Committee, FPC / Monthly Review		

Environments

	Conseq-uence	Likeli-hood	Combined
Current Risk	4	4	16
Residual Risk	4	3	12
Risk Appetite / Target Risk score			12

Controls

Description:

- Contract management with NHSPS for provision of facilities management
- Collaborative agreement with UHL for provision of facilities management
- Appropriately trained estates team in place
- Health and Safety Reviews
- Backlog maintenance controls
- P22 partner in place
- Revenue and capital budget setting process in place
- Condition survey for the inpatient estate completed 2018
- Approved Estates Strategy
- Planned and preventative maintenance plan held by UHL
- FM Transformation Board (Jan 2020 onwards)
- PPM schedules (12 month forward view) received from UHL Dec 2019 and assessed as adequate

Gaps:

- Lack of systematic process for identify high risk areas requiring maintenance
- Not complying with the KPIs
- Maintenance and repairs are not always undertaken in a timely manner – UHL aware
- Clarity over the arrangements for managing risk with FM until transfer completed

Assurances

	Source	Evidence	Assurance Rating
Internal:	• Estates committee / FPC • Initial review to identify high risk areas of the estate that require maintenance completed Reporting of FM KPIs to FPC • Estates risk register • Audit action plan – track via FM Oversight Group • Self assessment on premises assurance model • Foundation for Great Patient Care quality surveillance tracker, deep dives and escalation process • FM Oversight Group currently on hold (COVID) – reinstated starting October 2020	• Report to the Estates Committee, and then to FPC which details performance • PPM performance report • Reports demonstrating implementation of the Estate Strategy to the Estates Committee	Amber
External:	• NHSI / CQC / HSE / Fire service • 360 Assurance internal audit of estates maintenance - Limited Assurance	• Audits and reports • PLACE scores	Amber

Gaps:

- Lack of assurance on information received from UHL due to inconsistent audits
- Assurance information not being received from NHSPS
- Poor performance against set KPI resulting in lack of assurance

Key actions

Date:	Actions:	Action Owner:	Progress:	Status:
Jan 21	Procure specialist estate resources to support Premises Assurance Model	R Brown	E&F to procure specialist resources.	Amber
		RB	Reassess current data by Dir E&F to create recommendation.	
Feb 21	FBC to Board for final decision to transform FM services	RB	UHL to sign Co-operation Agreement.	
Oct 20	KPIs to be agreed as part of the 20/21 SLA	RB	FM Transition Board remains paused. To be reinstated Alongside FM Oversight Group, to assist progressing the project work.	
Oct 20	FM transformation plan to enable greater control.	RB		

Risk No: 11	Environment	Date included:	01.10.19		Consequence	Likelihood	Combined
Risk Title:	The current estate configuration does not allow for the delivery of high quality healthcare			Current Risk	4	4	16
Risk Owner:	Director of Finance, Business & Estates and Deputy Chief Executive	Date Last Reviewed:	15.10.20	Residual Risk	4	3	12
Governance / Review:	Estates Committee, FPC / Monthly Review			Risk Appetite / Target Risk score			12

Controls

Description:

- A dedicated estates team in place
- Estates Strategy approved by the Trust Board in Oct 2019.
- Capital resource prioritisation framework
- Condition surveys have been completed in priority areas (in-patient estate)
- The mental health inpatient re-provision SOC.
- Health and Safety Risk Assessments in place
- Clinical risk assessment to mitigate re privacy and dignity
- Business case for interim dormitory solution approved by the Board Jan 20
- Approved Strategic plan for the elimination of dormitory accommodation
- Clinical model for Beacon Project approved by SEB in June 2020

Gaps:

- Lack of derogation process to the Board
- Premises Assurance Model to be updated
- Challenges around availability of capital funding

Assurances

	Source	Evidence	Assurance Rating
Internal:	• Monthly report to FPC on progress against the Estate Strategy • Health and Safety Reports and confirmation of compliance with actions • The SOC was signed off by the Board in October 2019 • Strategic Estates and Medical Equipment Committee • Finance and Performance Committee • Health and Safety Committee • Directorate Health and Safety Action Groups • Building of new CAMHS Unit • Annual PLACE inspections • 3 year plan to eliminate dormitory accommodation (AMH/MHSOP) agreed by Trust Board	• Monthly report to FPC on progress against the Estate Strategy • Health and Safety Reports and confirmation of compliance with actions • The SOC was signed off by the Board in October 2019 • PLACE report for 2019	Amber
External:	• PLACE audits complete and actions in hand by Property Officers • NHSI • CQC • HSE • Fire service • KPMG audit of financial and quality accounts • In-patient reconfiguration to eliminate dormitories. Phase 1 OBC approved by Exec	• CQC report • 360 audit • Exec approval to OBC fee request.	Amber

Gaps:

- LPT does not have Premises Assurance Model (PAM)
- LPT to revisit Estates Return Information Collection (ERIC) data set

Key actions

Date:	Actions:	Action Owner:	Progress:	Status:
Oct 20	Re start Estates Workshops with clinical teams.	R Brown	Workshops to be reinstated at strategic level to align with other LPT Strategies, eg Clinical, Quality, Finance, Workforce, IMT.	Amber
Dec 20	Recruit a new Head of Capital Projects & property	RB	Scope agreed. Interserve currently costing the scheme.	
Dec 20	Decant dormitory accom at The Willows, target completion 12/2020	RB	NHSE/I approval to first scheme (£4m). Design to commence.	
Jan 21	Implementation of plan for the dormitories (20/21 to 22/23)	RB	Handover to LPT target 12/10/20 (+2 weeks).	
Nov 20	Completion of CAMHS construction.	RB		

Risk No: 12	Patient Involvement	Date included:	01.10.19
Risk Title:	Service users, carers and families do not have a positive experience of care, do not feel able to participate effectively and share their experiences.		
Risk Owner:	Director of Nursing, AHP and Quality	Date Last Reviewed:	15.10.20
Governance / Review:	Patient and Carer Experience Group, Quality Forum, QAC / Monthly Review		

Patient Involvement

	Consequence	Likelihood	Combined
Current Risk	3	2	6
Residual Risk	3	2	6
Risk Appetite / Target Risk score			6

Controls

Description:

- Step up to Great patient involvement programme
- Patient Involvement Experience Strategy and Team
- Patient surveys / Friends and Family Test
- Envoy Patient Experience portal
- Equality and diversity work
- Care planning audit programme
- Three year patient experience and involvement delivery plan 2019/2022
- Collaborative care programme
- Recovery café programme
- Patient Involvement Co-Design Group in place
- New Friends and Family Test Automated system now in place May 2020
- Three year Patient Experience and Involvement Delivery Plan in place for 2019-2022
- Patient and Carer Leadership Programme commenced in September 2020
- People's Council membership recruitment completed, welcome and introduction event taking place on 16/09/2020
- Executive sponsor for Carers now identified and will be Director of Nursing, AHPs and Quality
- Operational lead for Carers now identified and will be Head of Patient Experience and Involvement

Gaps:

- Lack of use of carer assessments to develop better understanding of the link between incidents and concerns when introducing new pathways
- Friends and Family Test automated system implementation due to be completed July 2020 (delayed to September 2020

Assurances

Internal:

Source:
- Patient and Carer Experience Group established
- Equality Diversity and Inclusion Patient Experience and Involvement Group established
- Complaints Review Group established
- Quarterly Patient Experience and Involvement Reports
- Quality Forum
- Quality Assurance Committee

Evidence:
- Monthly Highlight Reports from PCEG to Quality Forum
- Three year patient experience and involvement delivery plan in place
- Service User Involvement Group established
- Friends and Family Test feedback
- Compliments, concerns and complaints feedback received

Assurance Rating: Green

External:

Source:
- Community Mental Health Survey
- CQC inspections
- MHA visits
- Joint Strategic Needs Assessment
- Healthwatch

Evidence:
- Community Mental Health Survey Report and supporting improvement plan
- CQC Reports
- Ward Accreditation programme being progressed
- Step up to Great monthly reports

Assurance Rating: Green

Gaps:

- Implementation of FFT system delayed due to delays on reconfiguration of iPads . Implementation for inpatient services now planned to be completed by end of September 2020. Community services planned to come on line during October and November. Plans are in line with the national recommencement of FFT collection which will commence with feedback collection commencing in December 2020 and the first data reporting requirements in January 2021.

Key actions

Date:	Actions:	Action Owner:	Progress:	Status:
Nov 20	Launch Patient Experience survey	Alison Kirk	Implementation plan in place to have inpatient wards operational by end of September 2020 and community services by mid November 2020, in line with national timelines and requirements	Amber
Nov 20	Re-launch FFT	AK	Draft policy to be discussed at Patient and Carer Experience Group for sign off	
Dec 20	Approve and adopt the Trust wide reward and recognition policy	AK	Programme and training and development established to support directorates with implementation of the policy. Aim to establish Complaint Peer Review Programme by Q3.	
Dec 20	Deliver the complaints improvement programme	AK/MS		

Risk No: 16	Well - Governed	Date included:	01.10.19
Risk Title:	The Leicester/Leicestershire / Rutland system is unable to deliver the agreed plan for Integrated Care Systems		
Risk Owner:	Director of Strategy and Business Development	Date Last Reviewed:	14.10.20
Governance / Review:	Transformation Committee , FPC / Monthly Review		

Well-governed

	Conseq-uence	Likeli-hood	Combined
Current Risk	4	3	12
Residual Risk	3	2	6
Risk Appetite / Target Risk score			4

Controls

Description:

- LPT will play our role in system meetings and the development of the ICS proposal, through honest and trusting discussions.
- A consistent agreed objective and system narrative that is used and tested in all system meetings, with all partners.
- Regular discussion and engagement with our Senior Leadership Team.
- Chief officers meeting fortnightly
- Chief officers have signed up to working together to resolve and deliver system issues and transformation
- Shared purpose agreed with chief officers
- Senior system staff (CEO, DoF & DoS for all organisations meet monthly)
- Risk sharing agreement
- System leader agreed conversations on new behaviours and agreement to a system control total now in place,
- will be formalised during the contractual process.
- System wide vision known as the 10 expectations developed and agreed

Gaps:

- Ensuring individual organisations maintain commitment to the agreed priorities for the ICS
- The system is introducing a governance process for the partnership board, which will include, shared purpose, risk sharing and how a provider alliance system will operate
- We are introducing a governance process for the 2 way flow of information and engagement between our senor leadership team and our Directors.
- Clear agreed transformation plan
- Clear strategy for bed based services within community hospitals

Assurances

	Source:	Evidence:	Assurance Rating
Internal:	• Formal updates from system meetings to Executive meetings, Board sub-committees and Trust Board. • Regular discussion at executive meetings and with senior leaders. • Work in progress to develop greater partnership working between organisations which enable the provider alliance concept to be tested.	• Minutes from Executive meetings, Board sub-committees, Trust Board and SLT meetings	Green
External:	• System assessment against the ICS maturity matrix • NHS E & I assessment of system maturity • System meetings and system performance dashboards • Assessment of the System's Long Term Plan Submission • LLR Strategic Executive system meetings	• Joint shared document of our system assessment • Summary of NHS E/I assessment of the system • Papers and minutes from system meetings • Formal feedback on our LTP from NHS E/I	Green

Gaps:

- No national blue-print
- Agreement with NHSEI on forward plan
- Confirm local authorities role in the ICS

Key actions

Date:	Actions:	Action Owner:	Progress:	Status:
Dec 20	• Implement with system partners agreed joint ways of working	DW, DC & AH	LPT is an integral part of the LLR recovery cell and there is regular attendance at the HETCG (Health Economy Tactical Group), HESCG (strategic coordinating group), SAGE (Technical advice) and Recovery Cell. Recovery cell now stood down and system expectation delivery being mobilised. Focus on delivery of the ICS by April 21	Green

Risk No: 20	Well - Governed	Date included:	01.10.19
Risk Title:	Performance management framework is not fit for purpose		
Risk Owner:	Director of Finance, Business & Estates and Deputy Chief Executive	Date Last Reviewed:	12.10.20
Governance / Review:	FPC / Monthly Review		

	Conseq-uence	Likeli-hood	Combined
Current Risk	4	2	8
Residual Risk	4	1	4
Risk Appetite / Target Risk score			4

Controls

Description:

- Information asset owners in place
- SIRO in place
- Clinical system training in place
- Board approved Performance management framework
- Board level performance dashboard
- Revised governance framework
- STUG plan
- SOP in place
- 360 data quality audits
- Nationally submitted data
- Information team in place
- Simplified board reporting and an agreed set of KPIs for the Board
- Committee dashboards with KPIs owned by QAC/FPC
- Performance review meetings
- Highlight reporting for escalated items
- Annual committee reviews undertaken and 6 month interim reviews scheduled in work plans

Gaps:

- Avoidable harm measures
- Capacity of the information team due to demands from national sitrep reporting & changes to information team members
- Level 2 committee dashboards – implementation delayed due to COVID

Assurances

Internal:

Source:	Evidence:	Assurance Rating
• FPC / QAC • Performance review meetings • DMT meetings • Trust Board • Revised business rhythm for level 1 committees	• Simple Dashboards to Finance and Performance Committee / QAC of KPIs that the committees own • Simplified Board report • ORR reports • Performance report update on quality metrics / KPIs . Agreement by QAC/FPC on the set of KPIs for the Board • Month 5 reviews reviewed services' performance trajectories & targets based on services' assessment of service restoration status	Amber

External:

Source:	Evidence:	Assurance Rating
• Contract monitoring of quality indicators by Commissioners • Finance, Technical and Performance monitoring of contracted performance indicators • NHSI / CQC inspections SIAM • External and internal audit	• Internal audit of performance scheduled for 2020/21	Amber

Gaps:

- Fully embedded system (demonstrated once level 2 dashboards are fully implemented)
- External Quality Account audit – no data testing due to COVID
- Trust wide approach to reporting planned post covid performance & capacity

Key actions

Date:	Actions:	Action Owner:	Progress:	Status:
Nov 20	• Demonstration of consistent period of review (6 months)	DC	• Evaluation of performance review meetings & performance report & level 2 dashboard implementation – meeting on 30/10/20	Amber
Nov 20	• Consideration of avoidable harm measures including impact of partial or full COVID related closures	AS/ A Scott		

Risk No: 23	Single Patient Record	Date included:	01.10.19
Risk Title:	Failure to deliver the EPR system and demonstrate the benefits of the system		
Risk Owner:	Director of Strategy and Business Development	Date Last Reviewed:	14.10..20
Governance / Review:	IM&T Delivery Group / Transformation committee / FPC / Monthly Review		

	Conseq-uence	Likeli-hood	Combined
Current Risk	4	2	8
Residual Risk	4	1	4
Risk Appetite / Target Risk score			4

Controls

Description:

- SEPR Project Board
- Training plan for EPR implementation
- Data migration plan (7 cycles of Data Checking)
- Reporting and monitoring arrangements
- Implementation plan
- Communication plan
- Benefits
- New training methods to offer a more blended learning approach
- Go/No Go criteria, including break point dates determined
- End User Training being rolled out
- contract extension with Servelec for current RiO EPR

Gaps:

- Completion of final stage of data migration

Assurances

Internal:

Source:

- Training plan involving Learning and Development and Nursing
- Monitoring trajectory of training delivery
- Significant progress on data migration and cleansing work
- EPR Project Board in place and will continue for at least 6 months post full transfer to support ongoing data improvement.
- **SUTG:** Single EPR Programme Plan

Evidence:

- Delivery reports to Finance and Performance & QAC
- Monthly meetings of the EPR restarted from June 2020
- Training plan compliance figures report
- EPR project board papers
- Discussions at Combined Executive Board

Assurance Rating Green

External:

Source:

- 360 Assurance internal audit – patient records EPR
- SystmOne benchmarking inform project
- Company providing SystmOne has track record of implementation and delivery
- SystmOne is a market leader

Evidence:

360 Assurance internal audit

Assurance Rating Green

Gaps:

- Accuracy of reporting function
- Contingencies not formalised with clear go / no go criteria defined
- Agreed plan for formal evaluation

Key actions

Date:	Actions:	Action Owner:	Progress:	Status:
Oct 20	Commence Super User Training	Jon Hames	Competed training build	Green
Oct 20	Develop a plan for formal project evaluation	Jon Hames	Continuation of work to support services with data correction work	
Oct 20	Final Data Cut and sign off data	Jon Hames		
Oct 20	Complete Configuration Build	Jon Hames		

Risk No: 24	Equality, Leadership, Culture
Date included:	01.10.19
Risk Title:	Failure to deliver workforce equality, diversity and inclusion
Risk Owner:	Director of HR & OD
Date Last Reviewed:	14.10.20
Governance / Review:	SWC, QAC / Monthly Review

Equality, Leadership, Culture

	Consequence	Likelihood	Combined
Current Risk	3	4	12
Residual Risk	3	3	9
Risk Appetite / Target Risk score			9

Controls

Description:

- The Trust has embarked on a programme of work to improve the experience of BAME staff
- Independent focus groups run and led by national WRES team
- Delivery of key actions from focus group
- Electronic system controls to support identification of staff who want to progress in their careers
- Staff survey results
- WRES /WDES data and action plans
- CEO sent letter to all BAME staff
- Risk assessments for BAME Staff and protected characteristics
- Staff support groups / bame staff listening sessions
- Annual Report on WRES
- Appraisal
- Continued listening events with staff
- Reverse mentoring cohorts
- Cultural ambassadors
- Equality and Diversity Inclusion Group
- Our Future Our Way / Leadership behaviours
- EDI Group / CEO letter to all BAME STAFF
- Virtual Staff support groups meeting via M Teams ongoing

Gaps:

- Delivery against outcome measures / WRES and diversity metrics
- Staff survey performance
- Limited representation of BAME staff at senior levels
- Lack of career development for BAME staff at all levels

Assurances

Internal:

Source:
- Response to National Workforce Equalities letter from NHSEI reviewed by EDI Group
- WRES action plan
- Diversity workforce dashboard
- Trust board equalities report
- Annual Equalities Action Plan
- Staff support groups
- Equality Programme plan

Evidence:
- Progress reports on WRES action plan
- Staff survey report Trust Board
- EDI Bi annual report to EDI committee
- EDI group
- Annual meeting schedule across the year
- WRES/WDES DATA published action plan to QAC/swc

Assurance Rating Amber

External:

Source:
- Staff survey 2019
- National WRES metrics and report
- Engagement with national WRES team

Evidence:
- Trust Board reports on national WRES programme

Assurance Rating Amber

Gaps: Embeddedness

Key actions

Date:	Actions:	Action Owner:	Progress:	Status:
Aug 21	WRES Delivery action plan	Haseeb Ahmed	Newly formed EDI group	Amber
Jan 21	WRES cultural pilot programme plan developed and agreed launch August 20 delayed by wres team to early 2021	Kathryn Burt SW	Continue to recruit BAME interview panel members	
Nov 20	Programme of WeNuture OD sessions - moving to virtual sessions (in development)	SW	BAME Risk Assessments in progress	
Aug 21	EDI system conference – cancelled due to covid			
Oct 20	Anti – Racism strategy co production with NHFT - progress	HA	3rd meeting 28th Oct	

Risk No: 25	Equality, Leadership, Culture	Date included:	01.10.19
Risk Title:	Staff do not fully engage and embrace the Trusts culture and collective leadership		
Risk Owner:	Director of HR & OD	Date Last Reviewed:	14.10.20
Governance / Review:	SWC, QAC / Monthly Review		

	Conseq-uence	Likeli-hood	Combined
Current Risk	4	2	8
Residual Risk	4	2	8
Risk Appetite / Target Risk score			6

Controls

Description:

- Our Future Our Way is LPT's Culture, Inclusion and Leadership programme.
- Change champions in place, facilitating sessions where possible
- Training provided to all change champions
- SWC / Exec team
- Line Management pathway
- Leadership and Team development programme
- Learning and development annual plan
- Communications strategy in place supporting engagement with staff
- Vision co designed and live
- 9 priorities identified and communicated as part of the Our Future Our Way
- Leadership behaviours Workshops
- Virtual Leadership Forum M teams
- OD delivery plan
- E-learning training programme commenced
- Appraisal system aligned with leadership behaviours framework – new appraisal programme launched
- Senior leadership monthly meetings

Gaps:

- Leadership conferences – paused because of covid.

Assurances

	Source	Evidence	Assurance Rating
Internal:	• Staff survey results • Board approval of change champion programme • Programme plan in place and approved by Trust Board • 92 change champions engaged • Focus groups • Strategic workforce group • Attendance at virtual SLT • Board development	Staff survey report to Board 3rd March Board update on leadership behaviours progress Jan 20 Virtual SLT monthly Reports to SWC quarterly meetings continuing – papers include leadership behaviours update, appraisal framework, OD plan for bitesize sessions LPT people plan mapped to national and OFOW Board Development session 6th Oct	Green
External:	• Staff survey / Staff Friends and family test • External recognition of initiatives • NHSI Well led external review • CQC Well Led review • NHSI Support on the culture and leadership programme • WRES programme • People Plan	SIAM feedback CQC engagement meeting feedback	Green
Gaps:	• Staff survey report due March 21		

Key

Date:	Actions:	Action Owner:	Progress:	Status:
Dec 20	• Leadership development programme linked to leadership behaviours - ongoing	SW	- Progressing. Programme in place – further work around behaviours. Was paused due to covid, now reinstated	Green
Dec 20	• Staff Survey engagement – ongoing	SW	- Staff survey launches at end of Sept, out until December	
Nov 20	• Developing CUBE behaviours feedback model	SW	- Elearning in development	

Risk No: 26	Equality, Leadership, Culture	Date included:	01.10.19
Risk Title:	Insufficient staffing levels to meet capacity and demand and provide quality services		
Risk Owner:	Director of HR & OD	Date Last Reviewed:	14.10.20
Governance / Review:	SWC, QAC / Monthly Review		

Equality, Leadership, Culture

	Conseq-uence	Likeli-hood	Combined
Current Risk	4	4	16
Residual Risk	4	3	12
Risk Appetite / Target Risk score			12

Controls

Description:

- E rostering in place across inpatient services
- Auto planner within CHS
- Safer staffing reports with oversight of staff levels
- Centralised temporary staff service
- Regular recruitment conferences and schedule of events
- Recruitment and retention schemes in place
- Growing our own workforce
- LLR System and LWAB working together on system initiatives
- Flexible working guidance launched
- Proposal for super enhancing recruitment and attraction campaign and Bespoke plan for integrated Ageing Well recruitment campaign
- Significant Covid related recruitment activity taken place to support Surge capacity - Bring back staff/Retirees
- Aging well started
- Recruitment team moving to business as usual recruitment
- Camhs Recruitment Plan
- Community Service Redesign Aging well recruitment

Gaps:

- Workforce Planning capacity
- Community Service Redesign Aging well
- National workforce nursing supply challenges
- National medical workforce challenges within CAMHS
- Full utilisation rostering
- Medical consultant capacity concerns in AMH/CAMHS
- A centralised trust wide approach to recruitment

Assurances

Internal:

Source:	Evidence:	Assurance Rating
• Third cohort of nurse associate roles • Further development of other roles • Reengineering of clinical roles • SWC , Directorate Workforce groups , retention working group • Workforce and Wellbeing Board • Transformation committee • HR Team • Electronic recruitment system • Staff staffing report • **SUTG:** Workforce Transformation Programme Plan • **Performance Report:** Targets x 2 for sufficient staffing (Turnover and Vacancy)	• Progress reports to SWC Jan 16th • Performance dashboard monthly • Workforce reports monthly • Deep Dive review CAMHS staffing Sep QAC • International Recruitment Plan to exec team 16 oct	Amber

External:

Source:	Evidence:	Assurance Rating
• National NHS people plan • NHS retention support and benchmarking data • Benchmarking reports • LLR People Board	• Engagement with development of NHS people plan	Amber

Gaps:

Key actions

Date:	Actions:	Action Owner:	Progress:	Status:
Dec 20	• Transformation programme on centralised recruitment – paused due to covid	Sarah Willis	• Centralised recruitment agreed as a transformation committee programme being developed	Amber

Risk No: 27	Equality, Leadership, Culture	Date included:	01.10.19	**Conseq-uence**	**Likeli-hood**	**Combined**
Risk Title:	The health and well being of our staff is not maintained and improved					
Risk Owner:	Director of HR & OD	Date Last Reviewed:	14.10.20			
Current Risk				3	3	9
Residual Risk				3	2	6
Governance / Review:	SWC, QAC / Monthly Review					
Risk Appetite / Target Risk score						6

Controls

Description:

- Occupational health service wellbeing strategy and implementation plan
- Workforce and wellbeing group
- Wellbeing calendar – including a range of wellbeing events
- Counselling service
- 1:1s, Supervision, Appraisal
- Focus on wellbeing, sickness management policy
- Anti bullying harassment and advice service
- Bullying and harassment sub group
- Annual Health and Wellbeing event / Health and Wellbeing Approach and bulletin launched
- Health and wellbeing champions / Virtual exercise classes / Wobble Rooms
- Staff Physiotherapy scheme
- MH first aid training
- Mindfulness programmes / Psychological support offer for staff
- Leadership Behaviours Framework
- Weekly OD bite size virtual sessions now underway
- NHS People Plan national support
- Daily Sickness absence monitoring
- Appraisals linked to Leadership Behaviours Framework (see action on risk 26)
- All staff risk assessments in place supporting health and wellbeing - part of supervision and appraisal conversations

Gaps:

- Embedding of culture and leadership plan
- Embedding of WRES plan
- post incident psychological support for staff
- Embedding of National People Plan

Assurances

	Source	Evidence	Assurance Rating
Internal:	• Monitoring sickness reports workforce reports • Sickness reviews within divisions • Wellbeing element of appraisal / Wellbeing conferences • Occupational health department / Staff reps / Amica • Risk assessments / stress indicator	• Performance management report monthly • Staff side and management meetings monthly • SWC reports / Occupational Health annual report • Referrals to Amica • Review of hwb offer at strategic gold	Green
External:	• NHSI reporting	• NHSI benchmarking reports • Attendance at external NHSI wellbeing workshops	Green
Gaps:			

Key actions

Date:	Actions:	Action Owner:	Progress:	Status:
Nov 20	• Review of progress against the health and wellbeing approach and action plan	Kathryn Burt	• NHS long terms people plan well being event attending in Nov	Amber
Nov 20	• System wide virtual health and wellbeing week – end of October	SW		
Nov 20	• Refreshed health and wellbeing approach for 2020 ongoing review at senior leaders forum	SW	• LPT health and wellbeing system conference in 29 oct	
Nov 20	• System level support for post incident psychological support for staff	SW/Amica	• Developed a business case to support mental health referrals for employees approved and now commencing implementation. Paused due to covid	
Dec 20	• Appointment of a psychologist for staff referral support			
Nov 20	• System mental health HWB hub	TBC	• Developing the offer	

Risk No: 28	Access to Services	Date included:	01.10.19
Risk Title:	Delayed access to assessment and treatment impacts on patient safety and outcomes		
Risk Owner:	Divisional Directors / Medical Director	Date Last Reviewed:	15.10.20
Governance /	Waiting List and Harm Prevention Committee, FPC and QAC / Monthly Review		

Access to Services

	Consequence	Likelihood	Combined
Current Risk	4	4	16
Residual Risk	4	3	12
Risk Appetite / Target Risk score			12

Controls

Description:

- Strategic risk based approach to waiting time management approved by Trust Board
- Weekly patient tracking list sessions operational in all prioritised services
- Caseloads at service level have been risk stratified to enable a proactive risk management approach
- Improvement plans in place for priority services / Joint waiting times and harm review group in operation
- System planning (design groups) established to manage patient flow and investment
- Business cases to address high risk areas / Outsourcing arrangements where appropriate (e.g. HEALIOS and St Andrew's)
- Staff productivity and efficiency programmes in place via service transformation
- Winter planning/OPEL framework/daily escalation tool/calls in place
- Revised performance report with narrative
- Recovery Co-ordinating Group and CRG established to drive the restoration and recovery of services using the likelihood of harm as a denominator for prioritisation
- Directorate level performance and accountability reviews in place

Gaps:

- Robust access policy
- Consistency in harm review processes and visibility of evidence
- LLR financial sustainability plan
- Contract roll-over resulting in shortfall of funds to match growth of population / prevalence / demand
- The outcomes for CYP, adults and older people may be adversely impacted as a result of temporary service suspensions or prioritisation of clinical service delivery
- Identification of patients clinical needs may be delayed
- Post Covid19 demand and capacity modelling in light of digital first, reduced face to face capacity and non-availability of group work
- Evaluation and efficacy of telephone and video contacts

Assurances

Internal:

Source:

- Directorate performance reports
- Waiting time performance reported to Finance and Performance Committee monthly
- Internal strategic waiting times approach
- Daily OPEL escalation template
- Waiting times and harm review programme plan
- Plan on a Page, recovery action cards and QIAs for each service

Evidence:

- Performance management dashboard
- Dashboards to DMTs
- Reports into waiting times and harm review group
- Harm review process update to QAC 17.03.20 and FPC 21 July 2020
- Recovery Co-ordinating Group and CRG action logs
- Plan on Page and QIA for each service

Assurance Rating Amber

External:

Source:

- Collaborative contracting forum with commissioners with escalation route
- NHS Improvement Support Team review of CAMHs
- CQC inspection process
- Contract performance monitoring
- NHSI Regional Escalation oversight of 4 hr performance
- 360 Assurance internal audit of waiting times
- National benchmarking data

Evidence:

- Audit reports
- CQC report
- Contract Performance Report

Assurance Rating Amber

Gaps:

- Triangulation of evidence of harm with Trust wide data connecting incidents, SI's and complaints with people waiting
- Sharing the learning

Key actions

Date:	Actions:	Action Owner:	Progress:	Status:
Oct 20	Implement revised Access Policy	WTHR Comm	Revised Access Policy drafted	Amber
Oct 20	Agree services to be prioritised for deep dive waiting list review at FPC	WTHR Comm	Directorates reviewing priority using risk-based approach	
Oct 20	Agree priorities for MHIS and growth with commissioners	MH Partnership	Delay in 20/21 contract, business cases drafted for MHIS.	
Oct 20	Agree a process to triangulate evidence of harm with Trust wide data	Directorates	Review of enabling data and potential application commenced	
Nov 20	Agree suite of indicators to evidence consistent approach to harm review processes	Directorates	QI approach being developed	
Nov 20	Develop Covid sensitive trajectories for waiting time improvement of priority services	Directorates	Awaiting NHSE/I Covid demand and capacity tool	
Dec 20	Deliver agreed actions from 360 internal audit of waiting times	WTHR Comm	Action plan in place to be implemented Sept – Dec 2020	

Risk No: 33	Well - Governed	Date included:	01.10.19		Conseq-uence	Likeli-hood	Combined
Risk Title:	Insufficient executive capacity (including Shared Chief Executive role) to cover demand and impacts on LPT ability to achieve it's strategic aims			Current Risk	4	3	12
Risk Owner:	Director of HR & OD/Chief Executive	Date Last Reviewed:	14.10.20	Residual Risk	4	2	8
Governance / Review:	Strategic Exec Board, Trust Board / Monthly Review			Risk Appetite / Target Risk score			8

Controls

Description:

- Shared Chief Executive appointed with NHFT (NHFT rated outstanding overall and outstanding for well led domain)
- Overall Well-led inadequate rating from CQC
- No Vacant Executive team posts / Additional temporary supernumerary support from external sources
- Buddy arrangements with NHFT / Supportive oversight from NHSI/E
- Deputy Chief Executive position created strengthening executive capacity for LPT
- Business manager /LPT Programme Lead role for NHFT working closely with the Chief Executive across both organisations
- Lead LPT Director for the Buddying Programme – DoN
- Resources identified to support buddy programme via NHFT directors
- Set days/working pattern for CEO role allowing shared resource time spent each week to be auditable with exceptions according to needs
- Regular review of buddy work programme and impacts
- Discussion at Board of Directors Nominations and Remunerations Committee
- MOU between LPT and stakeholders (NHFT, NHSEI) setting out the capacity and resource requirements for each organisation for the buddying programme
- Agreed funding with NHSEI and NHFT
- Shared Director posts with NHFT from January 2020 – Governance & Strategy
- Deputy CEO in place
- Recruitment of substantive Director of Adult Mental Health
- Substantive Appointment of deputy CEO
- Appointment of interim Director of Nursing, AHPS and Quality
- Appointment of a substantive Medical Director

Gaps:

- Retirement of CHS Director
- Director of Finance - leaving

Assurances

Internal:

Source:	Evidence:	Assurance Rating Green
• New governance process • Organisational risk register • Review at SEB and Exec. boards • Review at Performance Committee/ Rem comm • Regular monitoring of LPT KPI's/ strategic priorities • Review at Trust Board • 1:1's CEO with Directors to monitor impact • 1:1's Directors with direct reports to monitor impact • DMT's/Corporate management team meetings • Positive outcomes/benefits from exec. involvement with NHFT including innovations from joint learning and development of directors and deputies through inclusion in programme • Well Led action plan • ICC CEO call with LPT/NHFT • Phase 2 Gold Command – weekly	• Remcom paper on exec capacity • Buddy programme meeting minutes • SUTG update report • New governance process agreed • Leadership presentations to Board and senior management team • SLT meetings • Ceo proposals to remcom 6th Oct 2020	

External:

Source:	Evidence:	Assurance Rating Green
• Support from NHSI/E • Buddying support from NHFT / Ongoing support from NHSI / Engagement meetings CQC • Perspectives on CQC/NHSI support of shared role • Regional and national recognition of effective joint working across the Trusts	• Regular contact and positive feedback from NHSI • Positive feedback at assessment • CQC inspection	

Gaps:

Actio

Date:	Actions:	Action Owner:	Progress:	Status:
Oct 20	• Interim CHS director recruitment underway	SW/CEO	30th Oct 2020	Green
Nov 20	• Director of Nursing AHP & Quality substantive recruitment underway	SW/CEO	23/24 Nov 20	

Risk No: 35	Well Governed	Date included:	01.10.19
Risk Title:	The quality and availability of data reporting is not sufficiently mature to inform quality decision making		
Risk Owner:	Director of Finance, Business & Estates and Deputy Chief Executive	Date Last Reviewed:	15.10.20
Governance / Review:	FPC / Monthly Review		

Well-governed	Conseq-uence	Likeli-hood	Combined
Current Risk	4	3	12
Residual Risk	4	3	12
Risk Appetite / Target Risk score			12

Controls

Description:

- Executive senior information risk officer (SIRO) sponsorship
- Performance management framework (which includes the 6 dimensions of data quality)
- Performance review meetings include Directorate level metrics
- Data quality policy and procedure
- Regular reporting of data quality maturity index in board reports
- Annual benchmark reporting against peers
- Experienced subject matter experts in the corporate information team
- National guidance
- Electronic patient records (EPR)
- EPR data migration validation exercise
- Dedicated resource which supports Directorate reporting requirements
- Ongoing work programme to improve ensure appropriate configuration of systems managed through the IM&T Committee

Gaps:

- Incomplete data quality reports for local and national data sets
- Insufficient monitoring of data quality incidents does not allow for learning opportunities
- Configuration of systems to support requirements of information standards and NHS data models
- Robust technical infrastructure to support timely and accessible use of data

Assurances

	Source	Evidence	Assurance Rating
Internal:	FPC / Trust Board Clinical audit Annual record keeping audit Data quality flag for priority KPIs Data security and protection toolkit self assessment Board development session – validation of data in readiness for migration Regular oversight reports from the IM&T Committee	Quarterly DQIP report to FPC (last one 17.03.20) DSPT regular updates for FPC (last one August 20)	Amber
External:	Internal audit programme for data quality and reporting Internal audit review of our data security and protection toolkit (DSPT) External Account (quality account indicators) Not undertaken for 19/20 Commissioner scrutiny	Data quality framework 19/20 – Significant assurance rating over compliance with policy DSPT 19/20 – Significant assurance	Green
Gaps:	Late DQUIP reporting to FPC		

Key actions

Date:	Actions:	Action Owner:	Progress:	Status:
Dec 20	Create a formal data quality group (as a sub set of data privacy committee) – paper to SEB	Dani Cecchini	Paper to be drafted by SK and SM	Amber
Jan 21	Output from data quality group (including framework for delivery of reporting)	Sharon M		
Nov 20	DQUIP report to FPC in November	Sharon M		

Risk No: 40	High standards	Date included:	11.03.20
Risk Title:	The ability of the Trust to deliver high quality care may be affected during a Coronavirus COVID-19 pandemic		
Risk Owner:	Director of Finance, Business & Estates and Deputy Chief Executive	Date Last Reviewed:	16.10.20
Governance / Review:	Strategic Exec Board Monthly		

High Standards	Conseq-uence	Likeli-hood	Combined
Current Risk	5	3	15
Residual Risk	5	2	10
Risk Appetite / Target Risk score			10

Controls

Description:

- NHS level 3 major incident led by COBR with national, regional and local resilience structures and policies in place
- COVID-19 Incident Management Team and Control Centre open 8 – 8 7days per week / Single point contact 24/7 email and dedicated phone
- LPT Gold, Silver and Bronze chain of command with role specific cells to support the ICC
- ICC arrangements updated in readiness for second surge to ensure sustainability
- Restoration Coordination Group in place with the majority of services restored within the limitations of IPC
- Policy controls and action cards in place for IPC, major incident, Flu pandemic, brexit, management of isolation and reporting / Agile home working policy / Occupational Health dedicated phone lines etc
- Participation in national and LLR health resilience forums
- Ongoing Webinars / Communications for COVID-19 both internally and externally
- National guidance on workforce / National and system updates including modelling on the development of the pandemic
- Procurement hub with PPE planning and distribution, and systems and processes in place to respond to PPE shortages including mutual aid arrangements
- Established covid surge and winter capacity in line with system requirements
- LLR and LPT established alert system to identify and respond to any local and Trust surges
- Exercise Rapid Response 2 - scenario planning exercise 13.10.20 to set work programme for ICC

Gaps:

- Restoration pipeline not yet complete
- Full preparedness for second peak

Assurances

Internal:

- Fortnightly flash report to Board
- Communications structures to staff
- Maintenance of the action, risk and decision log (ICC)
- Daily National PPE SitReps
- Daily national NHSE/I patient related SitRep also provided to the LLR system
- Health Economy Tactical Coordinating Group (HETCG) SitRep (2 times a week)
- Daily staffing SitRep
- CEO sitrep

Evidence:

- Fortnightly Flash report to Board
- Regular COVID staff briefing (3x week)
- Monthly risk report to level one committees
- Situation Reports (SitReps) (CEO, Directorate, PPE etc)
- Regular staff and stakeholder briefings
- ICC decision log
- Revised ICC arrangement agreed at Exec Team 16.10.20

Assurance Rating Green

External:

- Department of health / Public Health England / NHSEI / COBR / Chief Medical Officer
- LLR system advice and planning / Joint CEO exec daily (Mon-Fri) reporting structure
- Gov.uk COVID-19 information email alerts / National webinars
- Buddy relationship with NHFT

Evidence:

- Records of strategic gold coordinating group meetings
- Records of health economy SCG and TCG
- National intervention at the LLR Incident Management Team

Assurance Rating Green

Gaps:

	Actions:	Action Owner:	Progress:	Status:
Mar 21	Ongoing restoration of services	Dani Cecchini	RCG continues to meet to progress.	Amber
Nov 20	Complete all second surge preparation activities	Dani Cecchini	Embedding new ICC arrangements	

Risk 41	Equality, Leadership and Culture / High Standards	Date Included on ORR	27.05.20
Risk Title	The Trust may not appropriately manage the health and well-being of our BAME staff , and staff with key protected characteristics given the disproportionate impact of COVID-19		
Risk Owner:	Director of HR & OD	Date Last Reviewed:	14.10.20
Governance / Review	Strategic Exec Board Monthly		

E Equality, Leadership, Culture / S High Standards	Conseq-uence	Likeli-hood	Combined
Current Risk	5	3	15
Residual Risk	5	2	10
Risk Appetite / Target Risk score			10

Controls

Description:

- National level 4 major incident led by COBR with national, regional and local resilience structures and policies in place
- Participation in national and LLR health resilience forums
- COVID-19 Incident Management Team and Control Centre
- LPT Gold, Silver and Bronze chain of command with role specific cells to support the ICC
- National weekly Webinars / Communications for COVID-19 both internally and externally
- Collaboration with NHFT and Sussex Partnership NHS Trust
- Communication of information – staffnet and daily emails
- Staff guidance on Management of isolation and reporting / Agile home working policy / Occupational Health dedicated phone lines
- Procurement cell with PPE planning and distribution
- Virtual network meetings / Listening Group meeting for BAME colleagues
- Re-deployment exercise / Swabbing and testing availability for all staff immediately upon reporting of symptoms
- Service user feedback / Bank staff feedback
- Government and NHS Employers, NHS Confederation guidance and briefing papers
- LPT action cards to provide advice i.e. around pregnancy, death notification etc.
- Risk assessment tool in place for vulnerable / shielding staff completed 100 % BAME Staff assessed / 97% total at risk groups

Gaps: ..

Assurances

Internal:

Source:
- Regular data analysis with narrative
- Communications structures to staff
- 7-day per week COVID related National Guidance reviewed daily
- Monitoring of unintended consequences of rapid and high pressured decision making

Evidence:
Data report to ICC - plan for weekly update
Daily communications, e.g. 28.04.20 reference to pregnancy
All staff risk assessments and HWB conversations

Assurance Rating Amber

External:

Source:
- Department of health / Public Health England / NHSEI / Cobra / Chief Medical Officer
- Government and LLR system advice and planning / Joint CEO exec daily
- Gov.uk COVID-19 information email alerts / National webinars
- Buddy relationship with NHFT
- CQC updated Reg 15 death notification form (incl info on protected characteristics).

Evidence:
- Records of Joint CEO daily conference calls
- NHSEI weekly data of deaths by ethnicity

Assurance Rating Green

Gaps:

- NHSEI/PHE review of the impact of coronavirus on BAME communities yet to be undertaken
- NHS Employers inquiry on the impact of Covid-19 on people with protected characteristics under the Equality Act; age, disability, sex, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sexual orientation and gender reassignment – to be completed.
- Data from CQC reg 15 death notification forms – to be shared with system partners.

Actions

Date:	Actions:	Action Owner:	Progress	Status:
Nov 20	Anti Racism collaboration work with NHFT	SW/HA		Green
Sept 20	Compassionate conversations workshops	SW	Listening events underway letter to all staff	
Jan 2021	WRES Culture pilot to commence – delayed by the WRES team	SW	Rolling programme underway	

Risk 42	High Standards	Date Included on ORR	27.05.20
Risk Title	The Trust may not appropriately manage its patients with LD and Autism given the known disproportionate adverse impact of COVID-19 on this patient group		
Risk Owner:	Assistant Director FYPC&LD	Date Last Reviewed:	12.10.20
Governance / Review	Strategic Exec Board Monthly		

High Standards	Conseq-uence	Likeli-hood	Combined
Current Risk	4	3	12
Residual Risk	4	2	8
Risk Appetite / Target Risk score			8

Controls

Description:

- Active engagement in bi-weekly multiagency LD & Autism Sub-cell to inform and coordinate response
- Monitoring of changes to care needs from multiagency LD & Autism Sub-cell
- Covid-19 LD National Guidance
- Creation of isolation Pod at the Agnes Unit for suspected C19 patients and new admissions
- Closure of Short Breaks facility with increase outreach support
- LLR multi-agency LD and Autism response service contribution
- Refreshed care plans and risk assessments
- Use of digital technology for undertaking assessments and clinical discussions
- Virtual weekly discharge meetings
- Virtual Care and Treatment Reviews
- Risk stratified caseload of people who used short breaks; shared information with social care teams and agreed bespoke wrap-around support packages
- Re-deployed short breaks staff to: increase outreach teams reach and intensity and provide BH cover; staff up Agnes Unit
- Regular telephone contact with people on caseload and easy read information on Covid-19 distributed
- Visits continuing where families / carers comfortable
- COVID-19 Incident Management Team and Control Centre
- LPT Gold, Silver and Bronze chain of command with role specific cells to support the ICC
- Service user feedback
- LPT action cards to provide advice
- Action plan in place to avoid unnecessary admissions to AMH wards of service users with LD and/or Autism
- Quality impact assessments for all service closures
- ASD E-learning pack for AMH staff published on Ulearn
- Active engagement of care providers/placements through discharge management forums supporting Covid 19 related decision making

Gaps:

- Knowledge of reduction in staff with specialist learning disabilities/autism training as a result of COVID-19
- Re-mobilisation plan for Shortbreaks service under development
- Increased LD Matron capacity wef Oct 2020 to enhance leadership & clinical support to COVID-19 response

Assurances

	Source	Evidence	Assurance Rating
Internal:	Source: • Daily SitRep which records COVID-19 deaths with LD / Autism condition • Communications structures to staff • 7-day per week COVID related National Guidance reviewed daily • Monitoring of unintended consequences of rapid and high pressured decision making	Evidence: SitRep data – daily Staff communications	Assurance Rating Amber
External:	Source: • Department of health / Public Health England / NHSEI / Cobra / Chief Medical Officer • Government and LLR system advice and planning / Joint CEO exec daily • Gov.uk COVID-19 information email alerts / National webinars • Buddy relationship with NHFT	Evidence: • Records of Joint CEO daily conference calls • NHSEI weekly data of deaths which includes those who have been treated for a mental health condition or have a learning disability and/or autism	Assurance Rating Green
Gaps:	• Shor tbreaks remobilisation plan and timeline under development		

Action

Date:	Action	Action Owner:	Progress:	Status:
Nov 20	Short breaks remobilisation plan implementation	Mark Roberts / Recovery Cell	LD Service Manager collaborating with multiagency colleagues through LD&A sub-cell to progress actions Clinical review undertaken. Planning underway for use of Shortbreaks facility for limited service offer.	Green

					Conseq-uence	Likeli-hood	Combined
Risk 43	High Standards	Date Included on ORR	27.05.20	**Current Risk**	5	3	15
Risk Title	The Trust response to COVID-19 may negatively impact on the safety and well-being of vulnerable patients detained under the Mental Health Act.			**Residual Risk**	5	2	10
Risk Owner:	Medical Director	Date Last Reviewed:	03.08.20	**Risk Appetite / Target Risk score**			10
Governance / Review	Strategic Exec Board Monthly						

Controls

Description:

- Guidance from NHSEI
- Emergency Coronavirus Act 2020 - MHA legislation and associated Code of Practice (remains the same)
- MHA Service support (Weightmans solicitors) for advice through Legal Dept
- Legal input into Action Cards (includes MHA) kept up to date.
- MHA Policy and procedure – MHA Policy Database
- Documentation Policies within operational services (MHA content specific guidance)
- COVID-19 Incident Management Team and Control Centre / LPT Gold, Silver and Bronze chain of command with role specific cells to support the ICC
- MHA Service Continuity Plans
- Communication of information through ICC submission of continuity plans
- Clinical Lead / interim Medical Director
- Managers Panel Members (Hospital Mangers)
- MHA training (role specific training)
- Independent Mental Health Advocacy service (POhWER) commissioned by LA
- Review and response to NHSEI guidance (issued 19th May)
- Processes in place to continue to hold panel hearings
- Managers Panel Members continue to work remotely

Gaps:

- Remote MHA Assessments at the point of detention remain subject to discussion but not agreement

Assurances

	Source	Evidence	Assurance Rating
Internal:	• Regular dashboard (MHA activity) to LEG including number of tribunal applications • MHA census at point of care – monthly (measures minimum standards at point of care) • Incident reporting • Mental health act training data	Bi monthly report to LEG (end of year dashboard in June) MHA training data – on the agenda for discussion August LEG	Amber
External:	• Mental Health Act focussed reviewer visits from CQC – remote in response to COVID-19 • Ad hoc IMHA service feedback • Tribunal Service Mental Health	Process in place as part of continuity planning should notification be received Service development to meet National Directions to include legal support to patients accessing service	Amber

Gaps:

- Trend analysis and escalation of incidents, restrictive interventions etc for patients detained under the MHA (considering the impact of changes during COVID)
- Data from POhWER to demonstrate uptake – possible concern over access by patient's lacking capacity due to the nature of remote assessment

Actions

Date:	Actions:	Action Owner:	Progress	Status:
Sept 20	• Remote Mental Health Act assessments being developed with LA / Process Flow Chart with LA (response to latest national guidance)	Alison Wheelton and Associate MD	• Protocol remains in draft as different options/providers are considered. A section 12 audit is currently underway until mid-August.	Amber
Sept 20	• LPT led multi agency audit July 20 – S12 doctor availability to support joint agency working	Alison Wheelton	• Being undertaken as part of remote MHA assessments project – audit due to end mid Aug 2020	

Risk 44	Access to Services and High Standards	Date Included on ORR	27.05.20
Risk Title	A post COVID-19 surge in referrals would have a detrimental impact on waiting times and patient harm if the Trust is unable to increase capacity		
Risk Owner:	Director of Strategy and Business Development	Date Last Reviewed:	14.10.20
Governance / Review	Combined Exec Board / Fortnightly		

Access to Services / High Standards	Conseq-uence	Likeli-hood	Combined
Current Risk	4	4	16
Residual Risk	4	3	12
Risk Appetite / Target Risk score			12

Controls

Description:

- **Impact of this is managed through Risk 28 'Delayed access to assessment and treatment impacts on patient safety and outcomes'.**
- NHSI demand and capacity management training complete
- Step up to Great MH transformation programme
- Phase 3 planning including winter planning and impact of referral surge (not yet visible)
- OPEL framework/daily escalation tool/calls in place
- East Midlands MH alliance working with NHSEI to develop MH capacity planning model
- Agreed joint working approach between LLR and Northants system to undertake demand and capacity modelling

Gaps:

- Outputs of capacity planning not yet finalised
- Formal contracting arrangements are suspended until 31 March 21
- Robust access policy
- Consistency in harm review processes and visibility of evidence
- LLR financial sustainability plan
- Contract roll-over resulting in shortfall of funds to match growth of population / prevalence / demand
- The outcomes for CYP, adults and older people may be adversely impacted as a result of temporary service suspensions or prioritisation of clinical service delivery
- Identification of patients clinical needs may be delayed
- Post Covid19 demand and capacity modelling in light of digital first, reduced face to face capacity and non-availability of group work
- Evaluation and efficacy of telephone and video contacts

Assurances

Internal:

Source:	Evidence:	Assurance Rating
Notes of the East Midlands Alliance are shared with the Exec Board meeting	East Midlands Alliance meeting notes	Amber
Regular updates on the LLR / Northants system approach		
LPT Waiting Times and Harm Review Committee /programme plan	Notes and action log of committee	
Regular reports to FPC and QAC on waiting times, management of harm and service restoration/ recovery	Notes and action log for QAC/FPC Harm review process update to QAC 17.03.20 and FPC 21 July 2020	
Daily OPEL escalation template		
Directorate performance reports		
Plan on a Page, recovery action cards and QIAs for each service	Plan on Page and QIA for each service	

External:

Source:	Evidence	Assurance Rating
Quality / Contract Monitoring with CCG & Specialised Commissioning with escalation route	Contract monitoring reports	Amber
LLR Transferring Care Safely Group/LPT engaged (acute/secondary provider feedback)		
System oversight by NHSEI	Oversight reports to NHSEI	
System-wide Clinical Forums for mental health, community services and children and young people.	Meeting notes and feedback	
CQC inspection process	CQC Reports /focus groups	
360 Assurance internal audit of waiting times		
National benchmarking data		

Gaps:

- Outputs from EM demand and capacity modelling
- Outputs from joint LLR/Northants demand and capacity work

Acti

Date:	Actions	Action Owner:		Status:
Oct 20	Joint East Midlands wide Mental Health demand and capacity modelling	DW/AS	The work is now due for submission at the end of October, the NECSU are completing this work	Amber
Oct 20	Clarifying the programme of work to respond to the modelling	DW/AS		

Risk 45	Well Governed	Date Included on ORR	27.05.20
Risk Title	A post COVID-19 surge in legal challenge would have a detrimental impact on our reputation and financial position.		
Risk Owner:	Shared Director of Corporate Governance and Risk	Date Last Reviewed:	19.10.20
Governance / Review	Strategic Exec Board Monthly		

Well-governed	Conseq-uence	Likeli-hood	Combined
Current Risk	3	3	9
Residual Risk	3	2	6
Risk Appetite / Target Risk score			6

Controls

Description:

- Guidance provided by Public Health England, Chief Coroner, NHSI, HSE and DOH
- Coronavirus Act 2020 enacted to ease the burden on front line and adult Social care. CV Act 2020 reviewed by Legal Team.
- LPT Legal Team / Panel firms (Weightmans Solicitors) for Claims and Inquest Support
- LPT Claims Management Policy and in-house procedure currently in place
- Extra patient controls documentation e.g. temperature control
- Internal inquest process – reviewed in light of COVID and witnesses and Services update as to the current status of Inquests
- Legal input into Action Cards (includes MHA, DoLs, Restraint etc.) to Medical Director and ICC for authorisation thereafter.
- Documentation Policies within Services (GMC / NMC Codes of Practice, Trust Policy)
- Legal Briefing to ICC Clinical Senate re prospective prosecution and outcome / Prompt Sheet to assist clinicians with comprehensive documentation of patient care to
- COVID-19 Incident Management Team and Control Centre / LPT Gold, Silver and Bronze chain of command with role specific cells to support the ICC
- Approved, interim governance and risk management arrangements with focus on action, risk and decision logs

Gaps:

- Robust documentation of patient specific care decisions in relation to COVID (for example remote assessment) and any signposting provided . To include consideration of any limitations of patient assessments, information provided in terms of follow up etc.
- Robust documentation of the consideration of COVID upon discharge (e.g. was it safe to discharge in current climate)

Assurances

Internal:

- Report of high value claims and high profile inquests to ET /Inquest spreadsheet
- Weekly flash report to Board if required
- Communications structures to staff
- 7-day per week COVID-19 major incident meetings / COVID related National Guidance reviewed daily
- Monitoring of unintended consequences of rapid and high pressured decision making
- Daily National PPE SitReps / Daily staffing swabbing SitRep / CEO daily SitRep

- Fortnightly inquest spreadsheet to Service and Governance Leads
- Weekly Flash report to Board if required / ICC decision log
- Monthly claims and inquests report to ET
- Daily staff COVID-19 briefing
- Monthly risk report to level one committees / Directorate highlight reports
- Situation Reports (SitReps) / Regular staff and stakeholder briefings

Assurance Rating Green

External:

- Virtual legal forums / Peers trusts including UHL legal team / NHLSA / weekly Coroner feedback
- Department of health / Public Health England / NHSEI / COBR / Chief Medical Officer
- Gov.uk COVID-19 information email alerts / National webinars
- Buddy Trust

Evidence:

Assurance Rating Green

Gaps:

- Riddor reporting

Actions

Date:	Actions	Action Owner:	Progress	Status:
Nov 20	- Prompt card for clinicians to support robust record keeping	Legal Team / MCS	Drafted and with Divisional Directors for review On-going	Amber

Risk 46	Well Governed	Date Included on ORR	27.05.20
Risk Title	We are unable to restore or recover our services, impacting on our ability to deliver against national requirements and commissioned activity.		
Risk Owner:	Director of Finance, Business & Estates	Date Last Reviewed:	05.10.20
Governance / Review	Strategic Exec Board Monthly		

Well-governed

	Conseq-uence	Likeli-hood	Combined
Current Risk	4	3	12
Residual Risk	4	3	12
Risk Appetite / Target Risk score			12

Controls

Description:

- COVID-19 Incident Management Team and Control Centre with LPT Gold, Silver and Bronze chain of command
- Recovery cell to plan the restoration of services and enable recovery, linking in with all ICC specialist cells
- Approved, interim governance and risk management arrangements with focus on action, risk and decision logs
- Prioritisation of critical services and maintenance of business continuity plans
- Participation in national and LLR health resilience forums
- National weekly Webinars / Communications for COVID-19 both internally and externally
- Communication of information – Staff Room and daily Email
- National guidance on workforce / National and system updates including modelling on the development of the pandemic
- Impact of COVD-19 on existing ORR and local / Directorate risk registers
- High level restoration plans shared with regulators and agreed across LLR
- Detailed plans for restoration and recovery at service level
- Guidance around safe environments and cohorting in place
- Phase 3 planning guidance in place
- LPT Board development session on learning from COVID
- LLR lessons learned exercise taken place

Gaps:

- Residual performance and wait times issues captured in risk 44 and 28

Assurances

Internal:

Source:	Evidence:	Assurance Rating
• Fortnightly flash report to Board • Communications structures to staff • 7-day per week COVID-19 major incident meetings • COVID related National Guidance reviewed daily • Monitoring of unintended consequences of rapid and high pressured decision making • Daily National PPE SitReps • Daily staffing swabbing SitRep / CEO daily SitRep	• Fortnightly Flash report to Board • Exec Team regular reports on restoration • 1 Sept Board – restoration and recovery • Daily staff COVID-19 briefing • Monthly risk report to level one committees • Directorate highlight reports • Situation Reports (SitReps) • Regular staff and stakeholder briefings • ICC decision log • Oversight and performance report for restoration & Recovery	Green

External:

Source:	Evidence:	Assurance Rating
• Virtual legal forums • Department of health / Public Health England / NHSEI / COBR / Chief Medical Officer • Gov.uk COVID-19 information email alerts / National webinars • Buddy relationship with NHFT	Submitted plans to NHSEI	Green

Gaps:

Actions

Date:	Actions	Action Owner:	Progress	Status:
				Green

Risk 47	Well Governed / High Standards	Date Included on ORR	27.05.20
Risk Title	We are unable to provide a COVID-19 safe environment for our staff and patients		
Risk Owner:	Shared Director of Governance and Risk	Date Last Reviewed:	19.10.20
Governance / Review	Strategic Exec Board Monthly		

Well-governed / High Standards	Conseq-uence	Likeli-hood	Combined
Current Risk	5	3	15
Residual Risk	5	2	10
Risk Appetite / Target Risk score			10

Controls

Description:

- National guidelines set out in 'Operating framework for urgent and planned services in hospital settings'
- PHE 'COVID-19 Infection prevention and Control guidelines'
- National guidelines set out in 'COVID-19 prioritisation within community health services'
- COVID-19 Incident Management Team and Control Centre with LPT Gold, Silver and Bronze chain of command
- Recovery cell to plan the restoration of services and enable recovery, linking in with all ICC specialist cells
- Clinical Reference Group overview of service recovery and restoration plans
- Approved, interim governance and risk management arrangements with focus on action, risk and decision logs
- Risk assessment for all redeployed staff where vulnerable or shielding
- All staff who were able to work from home i.e. the work can be done at home have moved to working from home
- Silver command re-deployment of staff from services that had been stood down and deployed to services where extra surge was required
- Staff side involvement with process for bringing redeployed staff back into the services
- Agreed zoning and social distancing for the training centres
- Active participation in the Bring Back Staff (BBS) national scheme
- Liaison with third party organisations to explore surplus workforce e.g. LOROS, DMU etc
- Set up NHS Professionals as a source of supply
- Signed up to LLR system workforce sharing agreement
- Work with HEE to identify paid placements for third year nursing students as aspirant nurses
- Policy controls are in place for IPC, major incident place, Flu pandemic
- Participation in national and LLR health resilience forums
- Communication of information – Staff Room and daily Email
- Staff guidance on Management of isolation and reporting / Agile home working policy / Occupational Health dedicated phone lines
- Wellbeing support for staff
- National guidance on workforce / National and system updates including modelling on the development of the pandemic
- Procurement hub with PPE planning and distribution
- Increased swab capacity. Local testing stations set up for swabbing for primary mental health, community and care home staff. Swabbing centres established
- risk assessments for all bame and staff with high risk protected characteristics
- critical training undertaken including mask fit testing
- Directorate zoning proposal paper approved by Strategic Exec 12/6/20

Gaps:

- Impact of a surge in non covid referrals and acuity requiring face to face contact and an increase in workload

Assurances

	Source	Evidence	Assurance Rating
Internal:	• Flash reports to Board • Communications structures to staff • 7-day per week COVID-19 major incident meetings • COVID related National Guidance reviewed daily • Monitoring of unintended consequences of rapid and high pressured decision making • Daily National PPE SitReps / Daily national NHSE/I patient related SitRep also provided to the LLR system	• Staff COVID-19 briefing • Monthly risk report to level one committees • Directorate highlight reports • Situation Reports (SitReps) • Regular staff and stakeholder briefings	Assurance Rating Amber
External:	• Buddy relationship with NHFT • Department of health / Public Health England / NHSEI / COBR / Chief Medical Officer • LLR system advice and planning / Joint CEO exec daily (Mon-Fri) reporting structure		Assurance Rating Green
Gaps:			

Actions

Date:	Actions	Action Owner:	Progress	Status:
Oct 20	H&S team undertaking environmental risk assessments across all estate	Bernadette Keavney	The action is been monitored through the RCG and the Health and Safety Committee.	Amber
Oct 20	Consideration being given to 'attend anywhere' remote consultation product.	David Williams		

Risk 48	Well Governed	Date Included on ORR	24.06.20
Risk Title	We are unable to contain expenditure, or to recover income in line with the limits imposed by NHSEI under the Phase 3 financial regime.		
Risk Owner:	Director of Finance, Business & Estates and Deputy Chief Executive	Date Last Reviewed:	12.10.20
Governance / Review	FPC / monthly		

Well-governed	Consequence	Likelihood	Combined
Current Risk	5	3	15
Residual Risk	5	2	10
Risk Appetite / Target Risk score			10

Controls

Description:

- Block payment was in place 01/04/20 – 31/10/20
- Top up payment ensured Trust broke even each month to month 6
- All covid related costs month 1-6 were reimbursed each month
- Transformation committee oversight of CIPs
- Operational oversight & management of costs through Directorate Management Teams
- Financial governance and control framework in place through Standing Financial Instructions with reporting to the Audit Committee
- Capital Management Committee's oversight of capital planning and agreed governance processes; Capital Financing strategy
- Treasury management policy , cash flow forecasting and management
- Underlying cost run rate is reported to FPC, to manage & understand the underlying position
- Underlying cost run rate has been compared to 20/21 block income to identify any gaps
- Financial plan process for 01/10/20 – 31/03/21 follows NHSE/I financial plan guidance.
- Draft phase 3 financial plan based on directorate level forecast baseline & additional investment costs.
- Draft phase 3 financial plan has been approved by Trust Board in principle; final plan will be approved before submission to NHSE/I on 22/10/20.
- Statutory I & E break even duty delivery over 3 years, taking one year with another.

Gaps:

- Draft phase 3 financial plan delivers a deficit.
- In year statutory break even delivery may not be achieved (subject to 0.5% materiality application)
- Fixed covid & top up funding has been allocated to the Trust for month 7-12; spend will need to be contained within these values
- Lack of clarity on income flows under phase 3 guidance has introduced higher income risk in to the financial plan than usual.
- Investments/service changes could be progressed which are reimbursed via assumed income, which doesn't flow as expected
- Ledger budgets are based on old contract values & could confuse 20/21 variance reporting. Budgets will be reset in month 7 to match phase 3 financial plan.
- CIP development & approval of QIA s

Assurances

	Source:	Evidence:	Assurance Rating
Internal:	• Finance and Performance Committee report includes I & E, cash & capital reporting • Audit Committee • Transformation Committee oversight of CIP & QIA development • CCG/LPT process to agree approach to investment funding in 20/21 • Capital management committee review & agreement of capital bids, in year plan delivery & annual development of capital plans	• Formal I & E, cash & capital monitoring • Standing Financial instructions • Transformation committee papers • Highlight report • Monthly Director of Finance report	Assurance Rating Amber
External:	• KPMG audit of 20/21 annual accounts and value for money conclusion • Internal Audit Plan 2020/21: Integrity of the General Ledger and Financial Reporting Q3/4; Financial Systems Q3/4	• 2019/20 annual accounts unqualified opinion • Significant assurance IA opinions issued 2019/20	Assurance Rating Amber
Gaps:	NHSEI agreed plan in place		

Actions

Date:	Actions	Action Owner:	Progress	Status:
October 20	Budget and financial target re-setting	Sharon Murphy	On target – will be matched to submitted financial plan	Amber
Nov 20	Agree investment process with CCG leads	Sharon Murphy	Cost based plan will be submitted 22/10/20.	
October 20	Board approval of phase 3 financial plan	Sharon Murphy	Provisional board approval gained 05/10/20; final approval delegated to Chief Executive & Chair by board.	

Risk No: 50	Transformation			Transformation	Consequence	Likeli-hood	Combined
Risk Title:	The Long Term Plan/Ageing Well Urgent Community Response national targets may not be met , leading to delay in the timely assessment of patients and reputational impact			Current Risk	3	3	9
Risk Owner:	Director of CHS (Transformation Committee)	Date Last Reviewed:	02/10/20	Residual Risk	3	2	6
Governance / Review :	Transformation Committee / FPC / 3 monthly			Risk Appetite/Target Risk			6

Controls

Description:

- National Ageing Well team support offer and quarterly assurance meetings
- Written confirmation of 20/21 LLR Ageing Well n/r accelerator funding
- LLR Primary and Community Board oversight
- LLR Programme Board in place
- CHS Programme Board in place
- Highlight report to Transformation Committee monthly for exec/trust board oversight
- Community Service Resign model of care implemented Dec 2019
- LLR Ageing ell recruitment plan designed and funded
- System support to recruit into the planned CCG CSR investment (943k) and risk manage the posts

Gaps:

- No formal contractual agreement in place for 20/21
- Publication of the national CSDS technical specification has been delayed due to Covid-19
- The TPP SystmOne electronic patient record is not currently configured in a way that easily enables reporting of urgent response standards

Assurances

	Source	Evidence	Assurance Rating
Internal:	Source: • Transformation Committee • CHS Ageing Well Programme Board	Evidence: • Highlight report to Trust Board • Highlight report to Transformation Committee • Paper to raise awareness and seek way forward to SOG in lieu of CPM • Follow up paper to SOG seeking system support to risk share costs and commence recruitment	Assurance Rating: Amber
External:	Source: • LLR STP governance structure • System Operational Group (SOG) • LLR Transformation Group • LLR Primary and Community Design and Delivery Group	Evidence: • Minutes of meeting • Minutes of meeting • Minutes of meeting	Assurance Rating: Amber
Gaps: ..			

Key actions

Date:	Actions:	Action Owner:	Progress:	Status:
Oct 20	Proposal to CHS Programme Board setting out options for system configuration once national technical specification is available	C Purves		Amber
Oct 20	Ensure that costs are accurately & transparently reflected in LPT/system 20/21 financial plan	Sharon Murphy		
Dec 20	Primary and Community Design group to find recurrent funding solution for CSR investment (943k)	R Bilsborough		

Risk 51	High Standards, Equality, Leadership and Culture	Date Included on ORR	DRAFT
Risk Title	If staff are not vaccinated for flu they pose a risk to the health and wellbeing of themselves, colleagues, patients and the wider community. This would adversely impact on Public Health, potentially leading to increased hospitalisation, increased staff sickness levels and a risk to those who are vulnerable and shielding.		
Risk Owner:	Director of Nursing, AHPs and Quality	Date Last Reviewed:	25.09.20
Governance / Review	Strategic Flu and Covid-19 Group / Quality Forum / QAC / fortnightly review		

Well-governed / High Standards	Conseq-uence	Likeli-hood	Combined
Current Risk	5	4	20
Residual Risk	5	2	10
Risk Appetite / Target Risk score			10

Controls

Description:

- Strategic Flu and Covid-19 Group
- Electronic vaccine booking system and system for real time uptake reporting
- Mixed delivery model of flexible localised peer vaccinators and clinic delivery with capacity for 5440 appointments
- Implemented the national best practice vaccination programme principles including flexible access, board endorsement, publicity and comms and staff incentives
- Communications plan
- High level action plan which aligns with national and LLR plans and uptake ambitions

Gaps ..

- National vaccine shortage / LPT shortage of supply (1000 doses in stock, 3000 doses ordered against requirement of 5329) .
- Availability of peer vaccinators. We have 42 trained peer vaccinators – issues with rota and release for each to cover two clinic shifts in an 8 week period

Assurances

	Source	Evidence	Assurance Rating
Internal:	Source: Fortnightly review at the Strategic Flu and Covid-19 Group with reporting to level 1 and 2 committees Update reporting from Cinnamon digital system for booking and administration	Evidence: Paper to SEB / QF and QAC Reports from Cinnamon to Strategic Flu and Covid-19 Group	Assurance Rating Green
External:	Source: Feed into the situation reports for the LLR Flu and Covid-19 Board	Evidence: Sitrep	Assurance Rating Green
Gaps ..			

Actions

Date:	Actions	Action Owner:	Progress	Status:
Oct 20 – Feb 21	Quality improvement project around vaccine hesitancy - collaborative conversations with leaders and peer vaccinators throughout the Flu season.	Lyn Williams	Started Sept 20	Amber
Oct 20 – Feb 21	Implementation of the Flu action plan (oversight by Strategic Flu Group)	Emma Wallis	Started Sept 20	