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:	11.12.20
Governance / review:	PSIG, Quality Forum, QAC / Board - 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
- 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
- Patient Safety Plan - aligned to the National Patient Safety Strategy / 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
- Close linkage with 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
- Joint Director of HR/OD and Head of Patient Safety workshop to promote Just and Learning Culture

Gaps:

- Mandatory and role related training compliance across both substantive and bank staff
- Availability of staff to investigate incidents and drive improvements forward.
- Some training suspended / All Leicester inquests suspended
- Staff knowledge / ability to recognise and report poor behaviour towards patients from staff
- Model for governance

Assurances

Internal:

- QAC Chair attendance at Quality Forum
- Quality Forum / Quality Assurance Committee / Strategic Workforce Committee
- Quality Accreditation
- All associated policies / Professional standards group
- 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
- Triangulation with Claims, Safeguarding and Complaints

Evidence:

- QAC observations of Quality Forum
- QAC and Quality Forum annual committee reviews
- Learning from deaths report to Trust Board
- Performance dashboard to FPC and Trust Board
- QAC / Board assurance reporting
- Update on progress of local Quality Accreditation
- Harm review paper
- SI reports
- Concerns / complaints
- Quality metrics

Assurance Rating Green

External:

- NHFT Chief Nurse observation of Quality Forum
- Regular reporting of patient safety related information to the CQC under the TRA
- CQC attendance at events and CQC focus groups
- Patient/family and staff FFT / PALS feedback
- 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:

- NHFT Chief Nurse observations of Quality Forum
- Patient experience report to QAC
- CQC feedback – assurance report to QAC

Assurance Rating Green

Gaps:

Action

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 - ongoing	Amber
Jan 21	Development of reporting flow and oversight infrastructure including the embedding of SI assurance reporting to QAC / Board – in progress . Action plans written by 2/3 Directorates	TW		

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:	11/12/2020
Governance / Review:	Safeguarding Committee / Quality Forum / QAC / Board - 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

- 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
- New level 2 Safeguarding Committee

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.

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 Green

Gaps:

- Training figures
- Full implementation of the external review recommendations

Key actions

Date:	Actions:	Action Owner:	Progress:	Status:
Dec 20	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.	
Dec 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:	11.12.20
Governance / Review:	Learning Lessons Exchange Group, Quality Forum, QAC / Board - Monthly Review		

	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

Internal:

Source:	Evidence:	Assurance Rating
• 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. • Triangulation with Claims, Safeguarding, Complaints and F2SU Guardian	• 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 • Internal reviews of learning	Amber

External:

Source:	Evidence:	Assurance Rating
• 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 • Internal Audit report – Duty of Candour	• Patient experience report to QAC • CQC report / verbal feedback	Green

Gaps: Route for outputs from learning Lessons Exchange Group

Key actions

Date:	Actions:	Action Owner:	Progress:	Status:
Dec 20	Plan a redesign of Directorate clinical governance structure	Anne Scott	Draft model developed through exploring governance – plan being developed	Amber
Dec 20	Exploration of trained investigator model to strengthen investigator process and comply with patient safety strategy	Anne Scott		

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:	11.12.20
Governance / Review:	Learning and OD Group, Quality Forum, QAC / Board - 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 and review of acuity data.
- 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
- The roll our of the LLR COVID vaccination programme may impact on temporary workforce availability for ward/shift based work if staff prefer to work on this programme.

Assurances

Internal:

Source:

- 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
- Weekly inpatient safe staffing meetings chaired by Ass Nursing Director

Evidence:

- 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)

Assurance Rating Green

External:

Source:

- NHSE Safe staffing trends – monthly submission
- The Department of Health and Social Care's group annual governance statement - NHSI
- Single Oversight Framework

Evidence:

- Unify and Health roster data
- SOF / AGS

Assurance Rating Green

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:
Dec 20 Jun 21 Dec 20 Feb 21 Jan 21	• To develop a Trust wide safe staffing safeguards SOP • 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 • 6 monthly establishment review scheduled for Nov 20 • Registered nurse degree apprenticeships first cohort of 6 commences. • Commence Strand c preparation of international recruitment for 20 staff	Emma Wallis Amrik Singh Emma Wallis Alison O'Donnell	• The DRA off-framework staffing process and deployment has been reviewed and will feed into the SOP. • This has been delayed for a year due to a regional procurement exercise. • SOP development delayed due to Wave 2 demands	Amber

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:	14.12.20
Governance / Review:	Foundation for GPC, Quality Forum, QAC / Board - Monthly Review		

High Standards

	Consequence	Likelihood	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 COVID-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:

- Revised rating

Assurances

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
- Self assessment against all areas previously rated as inadequate

Evidence:

- Monthly assurance report to QAC / Board
- Monthly report to Strategic Exec Team
- Foundation for Great Patient Care highlight report to Quality Forum
- Deep dives at the Foundation for Great Patient Care

Assurance Rating Green

External:

- Proactive design of information flow to CQC to inform the TRA with ongoing feedback
- Ongoing focus groups, drop in sessions and invites for CQC to attend events
- CQC inspection and engagement meetings / discussions / Emergency Support Framework
- Third line assurance over compliance (outside of the CQC)
- CQRG – discussions with Commissioners
- Regulator inspections including HSE, NHSIPC
- KPMG value for money conclusion

Evidence:

- Inspection report
- Positive feedback from focus groups
- Minutes of CQC engagement meeting
- Regular phonecalls
- 3rd party assurance reports (HSE, IPC, NHFT buddy visits)
- External reports on governance and SI management

Assurance Rating Green

Gaps:

Key actions

Date:	Actions:	Action Owner:	Progress:	Status:
Dec 20	Support for areas identified as 'red' in the self assessment. Update to be provided to Ops Team 18 Dec 20	Julie Rubenzer Compliance Team	Managed by the FFGPC, reported to QF and QAC	Green
Jan 21	Responding to CQC requests for information under the TRA. Almost complete			

Risk No: 6	Transformation	Date included:	01.10.19		Conseq-uence	Likeli-hood	Combined
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.			Current Risk	4	3	12
Risk Owner:	Director MH	Date Last Reviewed:	14.12.20	Residual Risk	4	3	12
Governance / Review:	Transformation Committee, FPC / Board - Monthly Review			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
- Central access point
- East Midlands Clinical Senate – approved model
- Completion of a pre-consultation business case (incl. QIA risk assessment and workforce model)

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:
- 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

Evidence:
- Transformation Committee update papers
- SUTG project delivery dashboard
- Out of area improvement

Assurance Rating Amber

External:

Source:
- NHSE Strategic Direction
- 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 - approved

Evidence:
- External presentations
- CQC engagement minutes

Assurance Rating Green

Gaps:
- Management of change and associated EIA and QIA

Key actions

Date:	Actions: delayed due to COVID	Action Owner:	Progress:	Status:
Dec 20	Agree to consultation process with JHOSC	GK	Planning meeting in place to prepare for consultation	Amber
Dec 20	NHSE panel approval for going to consultation	GK		
May 21	Consultation process conclusion	GK		

Risk No: 8	Transformation	Date included:	01.10.19
Risk Title:	The transformation plan does not deliver improved outcomes for people with LD and/or autism.		
Risk Owner:	Divisional Director, FYPC and LD Services	Date Last Reviewed:	11.12.20
Governance / Review:	Transformation Committee, FPC / Board - Monthly Review		

Transformation

	Conseq-uence	Likeli-hood	Combined
Current Risk	4	4	16
Residual Risk	4	3	12
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 review and timely delivery of quality assurance
- 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. Additional funding for outreach service agreed.
- Forensics team strengthened and further recruitment underway (Community Transformation Fund) . ASD 14 to 25 service recruitment underway.
- 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. LPT Executive leadership of partnership/system response.

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. Recruitment to Case manager vacancies underway with CCG.
- Local LD rehab, ASD post diagnosis and forensics capacity
- Appropriate community placements in LLR including facility for 'unplanned care' response.
- 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. Outreach funding agreed.

Assurances

Internal:

Source:	Evidence:	Assurance Rating
• 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 report • 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:

Source:	Evidence:	Assurance Rating
• 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). NHSEI intensive support in place.	Amber

Gaps:

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

Key

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.	
Dec 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:	10.12.20
Governance / Review:	IPCC, QAC and FPC / Board - Monthly Review		

Environments / High Standards	Consequence	Likelihood	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. Daily SitRep received from UHL
- 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
- Daily SitRep reports received from UHL

Assurance Rating Green

Gaps:

Key actions

Date:	Actions:	Action Owner:	Progress:	Status:
Jan 21	LPT participation in NHSE cleaning with confidence (CwC) campaign. Applies to all Trust staff. Not intended as a specific action just for cleaning staff. Shows staff responsibilities.	H Walton / IPC	Webinar and elearing complete. Reported to IPC. Action to align to staff training. IPC to lead in future.	Green
Dec 20	Complete review of shared cleaning and food delivery staff roles (only in event of outbreak situation)	H Walton	On outbreak wards staff aligned to task for whole shift. System in operation and working.	

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:	10.12.20
Governance / Review:	Estates Committee, FPC / Board - Monthly Review		

	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
- UHL 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

Internal:

Source:

- 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

Evidence:

- 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

Assurance Rating Amber

External:

Source:

- NHSI / CQC / HSE / Fire service
- 360 Assurance internal audit of estates maintenance - Limited Assurance

Evidence:

- Audits and reports
- PLACE scores

Assurance Rating 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 PAM	R Brown	E&F to procure specialist resources.	Amber
Feb 21	FBC to Board for final decision to transform FM services	RB	Resources appointed to support FBC. Delay in UHL response to LPT technical and financial requests. Info expected Jan21. Possible impact to FBC date.	
Dec 20	KPIs to be agreed as part of the 20/21 SLA	RB	Action with Dir Estates UHL to sign Collaboration Agreement – escalated.	
Dec 20	FM Transformation plan and FBC.	RB	Progress regularly reported to EMEC, FPC and Transformation Cttee. Project Board to be established. LPT resources acquired and progress good with compliance and FBC development. On track.	

Risk No: 11	Environment	Date included:	01.10.19
Risk Title:	The current estate configuration does not allow for the delivery of high quality healthcare		
Risk Owner:	Director of Finance, Business & Estates and Deputy Chief Executive	Date Last Reviewed:	11.12.20
Governance / Review:	Estates Committee, FPC / Board - 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:

- 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 (complete) • 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.	Green

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:
Dec 20	Re start Estates Workshops and Strategic Property Group.	R Brown	Strategy workshops to align with other LPT Strategies, eg Clinical, Quality, Finance, Workforce, IMT. Discussed at Transform Cttee. New Strategic Property Group established and operational.	Amber
Dec 20	Recruit a new Head of Capital Projects & Property (done)	RB	Offer made. HR to issue contract. On track.	
Dec 20	Dormitory decant accommodation at The Willows (on track)	RB	Scope and costs agreed. Project on delayed as Willows used as RED ward for a period. Revised completion agreed 2/2021. On track	
Jan 21	Implementation of plan for the dormitories (20/21 to 22/23)	RB	Project Launch mtg 2/12/2020. Still await NHSE/I approvals. Architect Design meeting and visit commenced 7/12/2020. On track.	

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:	15.12.20
Governance / Review:	Transformation Committee , FPC / Board - Monthly Review		

G Well-governed

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

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

Internal:

Source:
- 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.

Evidence:
- Minutes from Executive meetings, Board sub-committees, Trust Board and SLT meetings

Assurance Rating Green

External:

Source:
- 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

Evidence:
- 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

Assurance Rating Amber

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. System response and actions to become an ICS by April 21 completed in November 20	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:	11.12.20
Governance / Review:	FPC / Board - Monthly Review		

Well-governed	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
- SUTG 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, sickness absence of Acting Head of Information
- Level 2 committee dashboards – implementation delayed due to COVID

Assurances

	Source:	Evidence:	Assurance Rating
Internal:	• FPC / QAC • Bi monthly Performance review meeting routine established • DMT meetings • Trust Board • Revised business rhythm for level 1 committees	• Simple Dashboards to FPC / QAC of KPIs / Simplified Board report • Performance report update on quality metrics / KPIs . Agreement by QAC/FPC on the set of KPIs for the Board • Month 7 reviews were scheduled, but cancelled as part of the wave 2 covid response • Performance report review workshop reviewed performance framework meetings & agreed actions, including to reprioritise the agenda • Evaluation of performance review meetings & performance report & level 2 dashboard implementation	Amber
External:	• 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:
Dec 20	Demonstration of consistent period of review (6 months)	DC		Amber
Dec 20	Consideration of avoidable harm measures including impact of partial or full COVID related closures	AS/ A Scott		
Mar 21	Work with FPC & QAC to scope level 2 dashboard requirements for 21/22 implementation	SM/KD		
Dec 20	Develop work plan for revised Board performance report implementation	SM	Outline workplan in place for month 8 & 9 reporting	
Jun 21	Consider ORR links to performance report	SM/KD		

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:	11.12.20
Governance / Review:	IM&T Delivery Group / Transformation committee / FPC / Board - Monthly Review		

	Conseq-uence	Likeli-hood	Combined
Current Risk	4	1	4
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
- Go Live complete, evaluation and further system exploitation under way

Gaps: Agreed plan for formal evaluation

Assurances

Internal:

Source:
- 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
- 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:

Key actions

Date:	Actions:	Action Owner:	Progress:	Status:
Dec 20	Review of initial roll-over at the single EPR meeting	Jon Hames	In progress with colleagues in LPT	Green
Dec 20	Agreed plan for formal evaluation	Jon Hames	24December	

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:	11.12.20
Governance / Review:	SWC, QAC / Board - 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
- Embeddedness

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 Green

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 Green

Gaps:

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	
Dec 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			
Dec 20	Anti – Racism strategy co production with NHFT - progress	HA		

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:	11.12.20
Governance / Review:	SWC, QAC / Board - Monthly Review		

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

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

Internal:

Source	Evidence	Assurance Rating
• 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:

Source	Evidence	Assurance Rating
• 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 Actions

Date:	Actions:	Action Owner:	Progress:	Status:
Dec 20	Leadership development programme linked to leadership behaviours - ongoing	SW	Staff survey closed Step up to great conference 27th Nov CUBE feedback model launched	Green
Feb 21	Analysis of staff survey results	SW		

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:	11.12.20
Governance / Review:	SWC, QAC / Board - 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:

- 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)

Evidence:

- 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

Assurance Rating
Amber

External:

Source:

- National NHS people plan
- NHS retention support and benchmarking data
- Benchmarking reports
- LLR People Board

Evidence:

- Engagement with development of NHS people plan

Assurance Rating
Green

Gaps:

Key

Date:	Actions:	Action Owner:	Progress:	Status:
Dec 20 Jan 21	• Transformation programme on centralised recruitment – paused due to covid • Ageing well programme	Sarah Willis	• Centralised recruitment agreed as a transformation committee programme being developed	Amber

Risk No: 27	Equality, Leadership, Culture	Date included:	01.10.19
Risk Title:	The health and well being of our staff is not maintained and improved		
Risk Owner:	Director of HR & OD	Date Last Reviewed:	11.12.20
Governance / Review:	SWC, QAC / Board - Monthly Review		

Equality, Leadership, Culture	Conseq-uence	Likeli-hood	Combined
Current Risk	3	3	9
Residual Risk	3	2	6
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

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

Evidence:

- 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

Assurance Rating Green

External:

Source:

- NHSI reporting

Evidence:

- NHSI benchmarking reports
- Attendance at external NHSI wellbeing workshops

Assurance Rating Green

Gaps:

Key actions

Date:	Actions:	Action Owner:
Dec 20	Review of progress against the health and wellbeing approach and action plan	Kathryn Burt
Dec 20	System wide virtual health and wellbeing week – end of October	SW
Dec 20	Refreshed health and wellbeing approach for 2020 ongoing review at senior leaders forum	SW
Dec 20	System level support for post incident psychological support for staff	sw
Dec 20	System mental health HWB hub	
Dec 20	Working from home LIA	

Progress:

- NHS long terms people plan well being event attending in Nov
- LPT health and wellbeing system conference in 29 oct
- Developing the offer
- Working from home LIA 8th Dec

Status: Amber

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:	15.12.20
Governance /	Waiting List and Harm Prevention Committee, FPC and QAC / Board - Monthly Review		

Access to Services	Conseq-uence	Likeli-hood	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:
Dec 20	Implement revised Access Policy	WTHR Comm	Revised Access Policy drafted	Amber
Dec 20	Agree services to be prioritised for deep dive waiting list review at FPC	WTHR Comm	Directorates reviewing priority using risk-based approach	
Dec 20	Agree priorities for MHIS and growth with commissioners	MH Partnership	Delay in 20/21 contract, business cases drafted for MHIS.	
Dec 20	Agree a process to triangulate evidence of harm with Trust wide data	Directorates	Review of enabling data and potential application commenced	
Dec 20	Agree suite of indicators to evidence consistent approach to harm review processes	Directorates	QI approach being developed	
Dec 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
Risk Title:	Insufficient executive capacity (including Shared Chief Executive role) to cover demand and impacts on LPT ability to achieve it's strategic aims		
Risk Owner:	Director of HR & OD/Chief Executive	Date Last Reviewed:	11.12.20
Governance / Review:	Strategic Exec Board / Board - Monthly Review		

Well-governed

	Conseq-uence	Likeli-hood	Combined
Current Risk	4	3	12
Residual Risk	4	2	8
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:

- 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

Evidence:

- 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
- Appointment of Director of Nursing AHP & Quality

Assurance Rating Green

External:

Source:

- 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

Evidence:

- Regular contact and positive feedback from NHSI
- Positive feedback at assessment
- CQC inspection

Assurance Rating Green

Gaps:

Actions

Date:	Actions:	Action Owner:	Progress:	Status:
Dec 20	• Interviews for Director of CHS and Deputy CEO	SW/CEO		Green

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:	10.12.20
Governance / Review:	FPC / Board - 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

Internal:

Source:

- 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

Evidence:

- Quarterly DQIP report to FPC (last one 17.03.20) closed previous DQIP actions
- DSPT regular updates for FPC (last one August 20)

Assurance Rating Amber

External:

Source:

- 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

Evidence:

- Data quality framework 19/20 – Significant assurance rating over compliance with policy
- DSPT 19/20 – Significant assurance

Assurance Rating Green

Gaps:

- Data quality group hasn't met during Covid 19 response

Key actions

Date:	Actions:	Action Owner:	Progress:	Status:
Jan 21	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		

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:	06/12/2020
Governance / Review:	ICC / Strategic Exec Board / Board - Monthly		

High Standards	Consequence	Likelihood	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
- Final step down proposals for redeployment with System Partners agreed

Gaps:

- Restoration pipeline not yet complete
- Staffing challenges to support 36 surge beds in the event of level 5 Escalation in LLR (mitigation agreed within the system)
- Joint UHL/LPT Operating Model for COVID19 Staff Immunisation not yet agreed
- LPT Workforce Bureau not yet fully operational
- The roll our of the LLR COVID vaccination programme may impact on temporary workforce availability for ward/shift based work if staff prefer to work on this programme.

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
- Revised COVID19 governance arrangements from 4 December 2020

Evidence:

- Weekly 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
Dec 20	Finalise Operating Model for Joint COVID Staff Vaccination - including long term plan for staff vaccination	Dani Cecchini Avinash Hiremath	Initial staff vaccination is jointly delivered led by UHL at LGH hospital hub.	
Dec 20	Full Implementation of LLR Workforce Bureau arrangements (21 Dec)	DC/ASc	All staff operating the bureau have been recruited.	
Jan 21	Deliver pods at mass vaccination centre (Peepul's Centre)	SW/DW/DC	FYPC supporting operational delivery	

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:	11.12.20
Governance / Review	ICC / Strategic Exec Board / 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

	Source	Evidence	Assurance Rating
Internal:	• 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	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:	• 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).	• Records of Joint CEO daily conference calls • NHSEI weekly data of deaths by ethnicity	Assurance Rating Amber

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:
Dec 20	Anti Racism collaboration work with NHFT	SW/HA		Green
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:	11.12.20
Governance / Review	ICC / Strategic Exec Board / 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
- 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 - Visits continuing where families / carers comfortable
- 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
- COVID-19 Incident Management Team and Control Centre with Gold, Silver and Bronze chain of command with role specific cells
- 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
- Increased LD Matron capacity wef Oct 2020 to enhance leadership & clinical support to COVID-19 response

Gaps:

- Knowledge of reduction in staff with specialist learning disabilities/autism training as a result of COVID-19
- Re-mobilisation plan to be reviewed for Short breaks service in January

Assurances

	Source:	Evidence:	Assurance Rating
Internal:	• 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	SitRep data – daily Staff communications	Amber
External:	• 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 • System response - LD&A sub cell (moving to LD&A Design Group)	• 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 • Benchmarking against National Advisory Group for people with learning disabilities and autistic people standards	Green

Gaps:

- Short breaks remobilisation plan shared with CRG – timelines being refined to ensure safe transition of Agnes Unit staffing changes – review in January.

Actions

Date:	Action	Action Owner:	Progress:	Status:
Jan 21	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 Short breaks facility for limited service offer – review in January.	Green

Risk 43	High Standards	Date Included on ORR	27.05.20
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.		
Risk Owner:	Medical Director	Date Last Reviewed:	11.12.20
Governance / Review	ICC / Strategic Exec Board / 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:

- 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) resumed
- 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
- Section 12 Task and Finish Group established under Associate MD.

Gaps:

- Remote MHA Assessments at the point of detention remain subject to discussion

Assurances

	Source	Evidence	Assurance Rating
Internal:	• Revised LEG ToR with targeted focus on MHA/MCA now level 2 committee reporting directly into QAC from December 2020 • QAC Chair observation planned for LEG • 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	Section 12 audit submitted to LEG in October 2020 Bi monthly report to LEG (end of year dashboard in June) MHA Role specific training data to LEG	Assurance Rating Amber
External:	• Mental Health Act focussed reviewer visits from CQC – remote in response to COVID-19 • Regular reporting of MHA related information to the CQC under the TRA • CQC attendance at events and CQC focus groups • Ad hoc IMHA service feedback • Tribunal Service Mental Health	CQC MHA reviewer reports / internal action plans CQC feedback provided to LEG	Assurance Rating Green

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:
Dec 20	Remote Mental Health Act assessments being developed with LA / Process Flow Chart with LA (response to latest national guidance)	Alison Wheelton Saquib Muhammad	CCG have commissioned Section 12 Solutions who presented to LLR on 09/12/20. Implementation will start with Phase One, the core model which is the S12 Doctor App, expected implementation 02'20. Phase Two will consider electronic statutory paperwork which will include considerations of work and testing undertaken within LPT in respect of remote MHA assessments.	Green

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:	14.12.20
Governance / Review	ICC / Strategic Exec Board / Board – Monthly		

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

	Source:	Evidence:	
Internal:	• Notes of the East Midlands Alliance are shared with the Exec Board meeting • Regular updates on the LLR / Northants system approach • LPT Waiting Times and Harm Review Committee /programme plan • Regular reports to FPC and QAC on waiting times, management of harm and service restoration/ recovery • Daily OPEL escalation template • Directorate performance reports • Plan on a Page, recovery action cards and QIAs for each service	East Midlands Alliance meeting notes Notes and action log of committee Notes and action log for QAC/FPC Harm review process update to QAC 17.03.20 and FPC 21 July 2020 Plan on Page and QIA for each service	Assurance Rating Amber
External:	• Quality / Contract Monitoring with CCG & Specialised Commissioning with escalation route • LLR Transferring Care Safely Group/LPT engaged (acute/secondary provider feedback) • System oversight by NHSEI • System-wide Clinical Forums for mental health, community services and children and young people. • CQC inspection process • 360 Assurance internal audit of waiting times • National benchmarking data	Contract monitoring reports Oversight reports to NHSEI Meeting notes and feedback CQC Reports /focus groups	Assurance Rating Amber
Gaps:	• Outputs from EM demand and capacity modelling • Outputs from joint LLR/Northants demand and capacity work		

Acti

Date:	Actions	Action Owner:	Status:
Dec 20	Joint East Midlands wide Mental Health demand and capacity modelling	DW/AS	Amber
Dec 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:	13.12.20
Governance / Review	ICC / Strategic Exec Board / 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
- Riddor reporting
- Learning lessons exchange group including Legal, Patient Safety and Complaints Teams.

Gaps:

- Robust documentation of patient specific care decisions in relation to COVID (for example remote assessment) and any signposting provided.
- Robust documentation of the consideration of COVID upon discharge (e.g. was it safe to discharge in current climate)

Assurances

Internal:

- New Learning lessons exchange with patient safety and complaints
- 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

- Claims reporting
- Notes from learning lessons exchange with patient safety and complaints teams
- 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
- Monthly risk report to level one committees
- 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:
Regular benchmarking / information reports from Legal firm

Assurance Rating Green

Gaps:

Actions

Date:	Actions	Action Owner:	Progress	Status:
Dec 20	Regular reporting of any claims and inquests related to covid to Exec Team (first claim being reported to Ops 18 Dec 20).	KD		Amber
Dec 20	Ongoing discussion with directorates around standard of documentation with a view to identifying any improvement action.	NP / Directorates		
Dec 20	Meeting with Solicitors (Weightmans and Browne Jacobson) for benchmarking and horizon scanning	NP/KD		

Risk 46 CLOSE	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:	15.12.20
Governance / Review	ICC / Strategic Exec Board / Board - Monthly		

Well-governed	Consequence	Likelihood	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:

Assurances

	Source	Evidence	Assurance Rating
Internal:	• 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	Assurance Rating Green
External:	• 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	Assurance Rating Green
Gaps:			

Actions

Date:	Actions	Action Owner:	Progress	Status:

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:	15.12.20
Governance / Review	ICC / Strategic Exec Board / 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 Green
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:
Dec 20	Consideration being given to 'attend anywhere' remote consultation product.	David Williams		Amber

Risk 48	Well Governed	Date Included on ORR	24.06.20
Risk Title	We are unable to contain 2020/21 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:	11.12.20
Governance / Review	FPC / Board monthly		

G Well-governed	Conseq-uence	Likeli-hood	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.
- Phase 3 financial plan based on directorate level forecast baseline & additional investment costs.
- Phase 3 financial plan has been approved by Trust Board
- Statutory I & E break even duty delivery over 3 years, taking one year with another.
- Budget and financial target re-setting completed
- Month end financial position review undertaken with finance leads & Deputy DoF before position and forecast is finalised

Gaps:

- 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
- At month 8, some income is starting to flow, which if sustained into month 9 could support the forecast outturn to be revised.

Assurances

	Source	Evidence	Assurance Rating
Internal:	Source: • Finance and Performance Committee report includes I & E, cash & capital reporting • Audit Committee • 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	Evidence: • Formal I & E, cash & capital monitoring • Standing Financial instructions • Highlight report • Monthly Director of Finance report	Assurance Rating Green
External:	Source: • 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	Evidence: • 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:
Mar 21	Ongoing monitoring and reporting of financial delivery	Sharon Murphy	Ongoing	Green

Risk No: 50 DE-ESCALATE	Transformation		
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		
Risk Owner:	Director of CHS (Transformation Committee)	Date Last Reviewed:	11/12/20
Governance / Review :	Transformation Committee and FPC / Board 3 monthly		

	Consequence	Likeli-hood	Combined
Current Risk	3	2	6
Residual Risk	3	2	6
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
- Publication of the national CSDS technical specification
- Options appraisal undertaken for the TPP SystmOne electronic patient record configuration
- Costs are accurately & transparently reflected in LPT/system 20/21 financial plan
- Recurrent funding solution for CSR investment (943k)
- Appointed to data quality and transformation roles x 3wte to support changes to front line inputting and DQ improvement

Gaps:

Assurances

Internal:

Source:	Evidence:	Assurance Rating:
• Transformation Committee • CHS Ageing Well Programme Board • Primary and Community Design Group	• 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	Green

External:

Source:	Evidence:	Assurance Rating:
• LLR STP governance structure • System Operational Group (SOG) • LLR Transformation Group • LLR Primary and Community Design and Delivery Group	• Minutes of meeting • Minutes of meeting • Minutes of meeting	Green

Gaps:

Key actions

Date:	Actions:	Action Owner:	Progress:	Status:
				Green

Risk 51	High Standards, Equality, Leadership and Culture	Date Included on ORR	27.10.20
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:	02.12.20
Governance / Review	Strategic Flu and Covid-19 Group / Quality Forum and QAC / Board – monthly review		

S High Standards / E Equality, Leadership, Culture	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 national best practice vaccination programme principles incl.flexible access, board endorsement, publicity and comms and staff incentives
- High level action plan which aligns with national and LLR plans and uptake ambitions
- 47 Trained peer vaccinators to cover all clinic shifts
- Flu QI project learning set and membership
- Introduced a super prize draw for December 20 (vaccine incentive programme)
- Re-imbursement process for staff accessing vaccine outside of the trust
- Vaccine hesitancy training
- Task and finish group for to address needle phobia
- Tailored communications for engaging bank workers
- Text messaging for flu booking
- Bank lead for vaccine hesitancy

Gaps:

- National vaccine shortage / LPT shortage of supply

Assurances

	Source	Evidence	Assurance Rating
Internal:	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 QI project delivery reports Reviewed performance plan against high performing trust plans Facebook survey to evaluate vaccine hesitancy Reflective diaries to understand vaccine hesitancy	Paper to SEB / QF and QAC Reports from Cinnamon to Strategic Flu and Covid-19 Group QI project delivery update in highlight reports to the Quality Forum	Green
External:	Feed into the situation reports for the LLR Flu and Covid-19 Board	Sitrep	Green

Gaps:

Actions

Date:	Actions	Action Owner:	Progress	Status:
Dec 20	Daily updates of flu figures to the Executive Team and Heads of Nursing to identify low uptake teams	Emma Wallis		Amber
Dec 20	Roving drop in clinics until 6 Dec including wkends targeting low uptake sites	Emma Wallis		
Dec 20	Thank you letters for peer vaccinators			
Dec 20	Escalation of lack of vaccine supply to the LLR Flu Board	Anne Scott		
Feb 21	Delivery of the Flu recovery plan	Emma Wallis	Started Sept 20	
Feb 21	Quality improvement project around vaccine hesitancy.	Lyn Williams	Started Sept 20	

Risk 52	High Standards, Equality, Leadership and Culture	Date Included on ORR	11.11.20
Risk Title	Without sufficient student placement capacity, the health and social care system will have a shortfall in the availability of a qualified workforce		
Risk Owner:	Director of Nursing, AHPs and Quality / Medical Director	Date Last Reviewed:	24.11.20
Governance / Review	ICC / SWC and QAC / Board - monthly review		

High Standards	Equality, Leadership, Culture	Conseq-uence	Likeli-hood	Combined
Current Risk		5	4	20
Residual Risk		5	3	15
Risk Appetite / Target Risk score				10

Controls

Description:

- Group placements, pathways and use of technology
- Supervisors and assessors development training
- Participation in clinical expansion programme for AHPs led by Health Education England
- Regular LLR system wide groups including HEI partners

Gaps:

- Impact of covid on availability of supervisory staff
- Control over withdrawal of students from placements due to health status / local infection rates
- Control over availability of placements within services due to covid related closures

Assurances

	Source	Evidence	Assurance Rating
Internal:	Clinical Reference Group Learning and OD Group Medical Education Group Multi Professional Education Team Annual QAC Chair attendance at SWC	• Education and training weekly update to the CRG including figures • Multi professional education lead quarterly reports to Learning and OD Group • Weekly monitoring of Nursing and AHP placements at the Clinical Reference Group • Annual report to Trust Board • CRG and MEG reports to SWC • SWC highlight report to QAC / Board	Green
External:	Health Education England Workforce Planning Groups LLR People Board LLR Placement Strategy Group Health Education England NMC / HCPC / GMC University of Leicester	Nursing and AHP reporting Three times a year report to Health Education England Medical reporting to UoL and Health Education England LLR Placement Strategy Group reporting into LLR People Board Health Education England fortnightly placement call	Amber

Gaps:

- LLR wide robust system for capturing, monitoring and tracking of placements across multiple providers.
- National directive around full time equivalent availability for students (currently opt in/out system for taking on students)

Actions

Date:	Actions	Action Owner:	Progress	Status:
Feb 21	Technology project to enable remote and digital placements	Alison O'Donnell	All being progressed within timescales	Amber
Dec 20	Provision of blended placement offers	Elaine Curtin		
Jan 21	Recruitment of additional AHP leadership capacity for clinical placement expansion project	Deanne Rennie		
April 21	Piloting new placements offers including digital and peer placements	Deanne Rennie		
June 21	Increasing utilisation of patient simulators	Director of Medical Education		
April 21	Widening the range of pathway placement supervisors to include enabling teams to include is safeguarding and patient safety teams	Elaine Curtin		
Dec 20	Establishing remote mentoring for Private Voluntary and Independent sector	Elaine Curtin		