					Consequence	Likelihood	Combined
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.			Current Risk	4	4	16
Director risk owner:	Director of Nursing, AHPs and Quality	Date Last Reviewed:	19.04.21	Residual Risk	4	2	8
Governance / review:	PSIG, Quality Forum, QAC / Board - monthly review			Risk Appetite / Target Risk			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 / Some training suspended – mitigating actions detailed within Ulysses
- Model for governance / Availability of staff to investigate incidents and drive improvements forward.

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:

- Accreditation work paused (Nov 20 to date)

Actions

Date:	Actions:	Action Owner:	Progress:	Status:
May 21	Develop and deliver plan for a coordinated approach to SI and complaint investigations	AS/SW/AK	Being discussed through exploring Governance – ongoing.	Amber
May 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	Timescale delayed due to on-going discussion / approval of plan for approach and reporting.	

Risk No: 2	High Standards	Date included:	01.10.19		Consequence	Likelihood	Combined
Risk Title:	The Trust's safeguarding systems do not fully safeguard patients and support frontline staff and services.			Current Risk	4	3	12
Director risk owner:	Director of Nursing, AHPs and Quality	Date Last Reviewed:	16/04/2021	Residual Risk	4	2	8
Governance / Review:	Safeguarding Committee / QAC / Board - Monthly Review			Risk Appetite / Target Risk			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 which has separated out the safeguarding work from the LEG. • 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 safeguarding training offer is not compliant with national standards and guidelines. • Sufficient access to medical advice

Assurances	Internal:	Source: • Legislative Committee and Safeguarding Committee • QAC provides oversight and challenge to the Legislative 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 and SG 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		

	Date:	Actions:	Action Owner:	Progress:	Status:
Actions	May 21	• Implement and embed the 32 recommendations from the external review.	Neil King	• Action plan ongoing – timescale extended to accommodate further work required.	Amber
	May 21	• Training capacity and offer to be reviewed	Neil King	• Training timescale deferred due to demands of Covid.	

Risk No: 3	High Standards	Date included:	01.10.19		Consequence	Likelihood	Combined
Risk Title:	The Trust does not learn from incidents and events and does not effectively share that learning across the whole organisation.			Current Risk	4	3	12
Director risk owner:	Director of Nursing, AHPs and Quality	Date Last Reviewed:	15.04.21	Residual Risk	4	2	8
Governance / Review:	PSIG, Quality Forum, QAC / Board - Monthly Review			Risk Appetite / Target Risk			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 • Ensuring cross governance working to identify risk and share learning

Assurances	Internal:	Source: • 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	Evidence: • 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	Assurance Rating Amber
	External:	Source: • 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	Evidence: • Patient experience report to QAC • CQC report / verbal feedback	Assurance Rating Green
	Gaps:			

Actions	Date: May 21 May 21	Actions: Plan a redesign of Directorate clinical governance structure Exploration of trained investigator model to strengthen investigator process and comply with patient safety strategy	Action Owner: Anne Scott Anne Scott	Progress: Draft model developed through exploring governance – plan being developed. Timescale delayed due to ongoing discussion / approval of approach.	Status: Amber

Risk No: 4	High Standards	Date included:	01.10.19		Consequence	Likelihood	Combined
Risk Title:	Services are unable to meet 'safe staffing' requirements			Current Risk	4	4	16
Director risk owner:	Director of HR / Director of Nursing, AHP's and Quality	Date Last Reviewed:	16.04.21	Residual Risk	4	3	12
Governance / Review:	Learning and OD Group, Quality Forum, QAC / Board - Monthly Review			Risk Appetite / Target Risk			8

Controls

Description:

Descriptor – this refers to the operational staffing of services to keep patients safe. See risk 26 for the central resourcing, supply, recruitment and retention of staff

- 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, with an Annual reset 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 measurement
- National safe staffing return recommenced
- Face to face training programme for Mappa and ILS and all other local skills training i.e. insulin administration currently being reviewed by the ICC education cell.
- Bame risk assessments
- Fast track programme of support for redeployed staff linked to additional covid beds or surge wards - Additional surge beds opened on 12.1.21, redeployed staff training and supervision provided
- Process in place for non registered LPT staff who hold a nursing registration oversees to complete application for programme to achieve NMC registration
- Training and support and clinical readiness preparation for redeployed / mutual for charnwood
- Recruited 'new to healthcare' staff in non registered roles with a bespoke induction package

Gaps:

- Trust wide safe staffing safeguards SOP

Assurances

	Source:	Evidence:	
Internal:	• Weekly staffing meeting to review staffing risks, escalate areas to note, and actions to address any staffing shortfalls. • 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	• 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 Amber
External:	Source: • NHSE Safe staffing trends – monthly submission • The Department of Health and Social Care's group annual governance statement - NHSI	Evidence: • Unify and Health roster data • SOF / AGS	Assurance Rating Green

Gaps:

- Evidence based acuity and dependency data for all in-patient areas – 8 April interview for Matron post, responsibility to include completion of annual establishment reviews.

Actions

Date:	Actions:	Action Owner:	Progress:	Status:
July 21	• To develop a Trust wide safe staffing safeguards SOP	Emma Wallis	Recruiting to a Workforce and safe staffing Matron post which will progress the SOP and the Task Group	Amber
July 21	• Annual clinical readiness preparation programme – task group to be scoped			
July 21	• Looking to Joint community and I/P therapy recruitment – to consider if feasible	Steph O'Connell		

Risk No: 5	High Standards	Date included:	01.10.19		Consequence	Likelihood	Combined
Risk Title:	Capacity and capability to deliver regulator standards			Current Risk	4	3	12
Director risk owner:	Director of Nursing, AHPs and Quality	Date Last Reviewed:	16.04.21	Residual Risk	4	2	8
Governance / Review:	Foundation for GPC, Quality Forum, QAC / Board - Monthly Review			Risk Appetite / Target Risk			8

Controls

Description:

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

Gaps:

- Completed actions following the peer review and self assessment.

Assurances

Internal:	• Audit and Quality Accreditation programmes • Self assessment checklist • Quality surveillance tracker • Quality forum • AMAT tool – tracker including areas identified for further support showing closures • 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 • Information provided to the CQC under the TMA	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 / focus group outcomes • Third line assurance over compliance (outside of the CQC) • CQRG – discussions with Commissioners • Regulator inspections including HSE, NHSIPC • KPMG value for money conclusion	Evidence: • TMA feedback from the CQC • Internal re-rating including buddy trust peer review • Feedback from focus groups • Minutes of CQC engagement meeting • 3rd party assurance reports (HSE, IPC, NHFT buddy visits)	Assurance Rating Green

Gaps: Current CQC rating

Actions

Date:	Actions:	Action Owner:	Progress:	Status:
May 21	Delivery of the CQC action plan resulting from the peer review and self assessment exercise.	Julie Rubenzer	Actions determined and assigned to owners and relevant Director owners. Aligned to self assessment and peer review work.	Amber

Risk No: 6	Transformation	Date Included on ORR	01.10.19		Consequence	Likelihood	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	2	8
Director risk owner:	Director MH	Date Last Reviewed:	15.04.21	Residual Risk	4	2	8
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)
- JHOSC agreed
- Clinical senate agreed
- NHSE panel approval

Gaps:

- Quality and timeliness of engagement with external partners
- Robust stakeholder management and engagement plan

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 Green
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:			

Actions

Date:	Actions:	Action Owner:	Progress:	Status:
May 21	Consultation process conclusion	Gordon King	Timescale now May 2021 due to covid	Amber

Risk No: 8	Transformation	Date Included on ORR	01.10.19		Consequence	Likelihood	Combined
Risk Title:	The transformation plan does not deliver improved outcomes for people with LD and/or autism.			Current Risk	4	4	16
Director risk owner:	Director, FYPC and LD Services	Date Last Reviewed:	16.04.21	Residual Risk	4	3	12
Governance / Review:	Transformation Committee, FPC / Board - Monthly Review			Risk Appetite / Target Risk			12

Controls

Description:

- Transforming care pre-admission process for people with LD and / or autism
- Risk of Admission Register (ROAR) and associated e-learning, multiagency Dynamic Support Register in place.
- Full RCA for anyone that falls outside of the defined process for admission
- Care and Treatment Reviews
- LD Outreach team offer alternative to admission
- 12 point discharge plan is utilised and monitored via discharge planning meetings
- LD forensic training package for health and social care staff
- 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.
- 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
- AD leadership of LD QI programme and TCP response. Governance arrangements in place. Reporting to DMT, TCP Executive and Transformation Committee.
- LPT leadership of Integrated Admission Avoidance and Discharge Team. LPT Executive leadership of partnership/system response.
- Local LD rehab, ASD post diagnosis and forensics capacity being increased
- Collaborative in LLR and group model work with NHFT provides a coordinated approach for managing patients with LD and/or Autism

Gaps:

- Treatment and support for ASD only diagnosis (without LD) – recruitment underway for new 14 + ASD post diagnosis team (Community Transformation Fund).
- Appropriate community placements in LLR including facility for 'unplanned care' response – delay escalated to Local Authority colleagues.
- 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
- System based support for effective discharge of Ministry Of Justice cases into the community (escalated to NHSEI for support)

Assurances

	Source:	Evidence:	Assurance Rating
Internal:	• SOP for in hours and out of hours CTRs and CETRs to reduce risk of admission • Risk of admission register • Root Cause Analysis for all admissions • Transformation Committee report • Improvement plan for AMH team • LLR weekly review of TCP cohort	• 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: • Multi-agency LD and Autism Executive Board - *reports into STP SLT, and is a Workstream of the STP.* • System wide LeDeR review and timely delivery of quality assurance • Adult & Children 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	Evidence: • 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

Actions

Date:	Actions:	Action Owner:	Progress: Timescales put back to May for further update next month	Status:
May 21	• Deliver LD Rehab SDIP	HT	• Links to rehab proposal awaiting CCG approval	Amber
May 21	• Full mobilisation of Forensics, Outreach expansion and Post Diagnosis 14+ ASD services	HT	• Recruitment underway. 2021/22 funding tbc for forensics/ASD	
May 21	• Mobilisation of additional AMH leadership resource for ASD admission avoidance and discharge work	HP	• AMH DMT agreed resource Feb 21.	

Risk No: 9	Environment / High Standards	Date Included on ORR	01.10.19		Consequence	Likelihood	Combined
Risk Title:	Inability to maintain the level of cleanliness required within the Hygiene Standards			Current Risk	4	3	12
Director risk owner:	Director of Nursing, AHP's and Quality and Chief Finance Officer	Date Last Reviewed:	14.04.21	Residual Risk	4	2	8
Governance / Review:	IPCC, QAC and FPC / Board - Monthly Review			Risk Appetite / Target Risk			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
- 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)
- On outbreak wards staff aligned to task for whole shift. System in operation and working.
- Appointment of x6 additional rapid response staff due 1/4/2021

Gaps:

- Plan to form Trust wide groups for Waste, Water Safety and Ventilation from March / April 2021

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
- 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 Amber

Gaps:

Shared services KPIs reports for cleaning audits – assurance level reduced. Re-instating facilities forum in March 2021 with UHL, NHSPS and IPC and Service Leads

Actions

Date:	Actions:	Action Owner:	Progress:	Status:
May 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	Timescales put back to May for further update next month Webinar and elearing complete. Reported to IPC. Action to align to staff training. IPC to lead in future.	Amber
May 21	- Service spec update to introduce a third daily clean to IP areas	H Walton / Cheryl Shuttlewood / NHSPS		

Risk No: 10	Environment	Date Included on ORR	01.10.19		Consequence	Likelihood	Combined
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			Current Risk	4	4	16
Director risk owner:	Chief Finance Officer	Date Last Reviewed:	15.04.21	Residual Risk	4	3	12
Governance / Review:	Estates Committee, FPC / Board - Monthly Review			Risk Appetite / Target Risk			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 (see corresponding gap)
- FM Transformation Board (Jan 2020 onwards)
- PPM schedules (12 month forward view) received from UHL Dec 2019 and assessed as adequate
- Resources appointed to support FBC. FBC complete.

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
- Unable to obtain detailed report and assurance over planned preventative maintenance leaving the Trust unable to apply suitable mitigations

Assurances

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

Gaps:

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

Actions

Date:	Actions:	Action Owner:	Progress: Timescales put back to May for further update next month	Status:
May 21	• Procure specialist estate resources to support PAM.	R Brown	• E&F to procure specialist resources. Route to deliver this through FM Transformation FBC.	Amber
May 21	• Co-operation Agreement (2106) not signed by UHL.	RB		

Risk No: 11	Environment	Date Included on ORR	01.10.19		Consequence	Likelihood	Combined
Risk Title:	The current estate configuration does not allow for the delivery of high quality healthcare			Current Risk	4	4	16
Director risk owner:	Chief Finance Officer	Date Last Reviewed:	16.04.21	Residual Risk	4	3	12
Governance / Review:	Estates Committee, FPC / Board - Monthly Review			Risk Appetite / Target Risk			12

Controls	Description:	• A dedicated estates team in place • Estates Strategy approved by the Trust Board in Oct 2019. • Capital resource prioritisation framework • Condition surveys have been completed in priority areas (in-patient estate) • The mental health inpatient re-provision SOC. • Health and Safety Risk Assessments in place • Clinical risk assessment to mitigate re privacy and dignity • Business case for interim dormitory solution approved by the Board Jan 20 • Approved Strategic plan for the elimination of dormitory accommodation • Clinical model for Beacon Project approved by SEB in June 2020 • Recruited a new Head of Capital Projects & Property		
	Gaps:	• Lack of derogation process to the Board • Premises Assurance Model to be updated • Challenges around availability of capital funding		
Assurances	Internal:	Source: • New Strategic Property Group established and operational • 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	Evidence: • 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	Assurance Rating Amber
	External:	Source: • 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	Evidence: • CQC report • 360 audit • Exec approval to OBC fee request.	Assurance Rating Green
	Gaps:	• LPT does not have Premises Assurance Model (PAM) • LPT to revisit Estates Return Information Collection (ERIC) data set		

Actions	Date: ongoing	Actions: Implementation of plan for main Dormitory Eradication projects currently on track, acknowledging covid access issues and re-phasing.	Action Owner: Richard Brown	Progress: • Progressing. Potential impact of other estates work on the eradication plan currently being reviewed	Status: Amber

Risk No: 16	Well Governed	Date Included on ORR	01.10.19		**Consequence**	**Likelihood**	**Combined**
Risk Title:	The Leicester/Leicestershire / Rutland system is unable to deliver the agreed plan for Integrated Care System			**Current Risk**	3	2	6
Director risk owner:	Director of Strategy and Business Development	Date Last Reviewed:	15.03.21	**Residual Risk**	3	2	6
Governance / Review:	Transformation Committee , FPC / Board - Monthly Review			**Risk Appetite / Target Risk**			6

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 • LPT contribution to the LLR recovery cell / HETCG (Health Economy Tactical Group), HESCG (strategic coordinating group), SAGE (Technical advice) and Recovery Cell. • ICS approved April 21.
	Gaps:	

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
	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
	Gaps:			

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

Risk No: 20	Well Governed	Date Included on ORR	01.10.19		Consequence	Likelihood	Combined
Risk Title:	Performance management framework is not fit for purpose			Current Risk	4	2	8
Director risk owner:	Director of Finance & Performance	Date Last Reviewed:	16.04.21	Residual Risk	4	1	4
Governance / Review:	FPC / Board - Monthly Review			Risk Appetite / Target Risk			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 • 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	Internal:	Source: • FPC / QAC • Bi monthly Performance review meeting routine established • DMT meetings • Trust Board • Revised business rhythm for level 1 committees	Evidence: • 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 11 reviews reduced to 1 hour to focus on key performance issues only, as part of the wave 2 covid response • Performance reports are reviewed by Directorate Business Managers prior to release. • Evaluation of performance review meetings & performance report & level 2 dashboard implementation	Assurance Rating Amber
	External:	Source: • Contract monitoring of quality indicators by Commissioners • Finance, Technical and Performance monitoring of contracted performance indicators • NHSI / CQC inspections SIAM • External and internal audit	Evidence:	Assurance Rating Amber
	Gaps:	• Fully embedded system (demonstrated once level 2 dashboards are fully implemented) • External Quality Account audit – no data testing due to COVID in 19/20 or 20/21, will be optional in future • Trust wide approach to reporting planned post covid performance & capacity		

Actions	Date:	Actions:	Action Owner:	Progress: April dates put back to May 21 for further update next month
	May 21	• Consideration of avoidable harm measures including impact of partial or full COVID related closures	AS/ A Scott	
	May 21	• Develop work plan for revised Board performance report implementation	SM	
	Jun 21	• Consider ORR links to performance report	SM/KD	

Status: Amber

Risk No: 24	Equality, Leadership, Culture	Date Included on ORR	01.10.19		Consequence	Likelihood	Combined
Risk Title:	Failure to deliver workforce equality, diversity and inclusion			Current Risk	3	4	12
Director risk owner:	Director of HR & OD	Date Last Reviewed:	15.04.21	Residual Risk	3	3	9
Governance / Review:	SWC, QAC / Board - Monthly Review			Risk Appetite / Target Risk			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:

- WRES cultural pilot programme. On hold due to national WRES team changes
- Delivery against outcome measures / WRES and diversity metrics
- Embeddedness of WRES/WDES

Assurances

	Source:	Evidence:	Assurance Rating
Internal:	• 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	• 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	Green
External:	• Staff survey • National WRES metrics and report • Engagement with national WRES team	• Trust Board reports on national WRES programme	Green

Gaps:

Actions

Date:	Actions:	Action Owner:	Progress:	Status:
May 21 June 21	• Delivery of WeNuture OD sessions • Anti – Racism strategy co production with NHFT	Haseeb Ahmed HA	• In development – timescale delayed due to delay in progress • Progressing well	Amber

					Consequence	Likelihood	Combined
Risk No: 25	Equality, Leadership, Culture	Date Included on ORR	01.10.19				
Risk Title:	Staff do not fully engage and embrace the Trusts culture and collective leadership			Current Risk	4	2	8
Director risk owner:	Director of HR & OD	Date Last Reviewed:	13.04.21	Residual Risk	4	2	8
Governance / Review:	SWC, QAC / Board - Monthly Review			Risk Appetite / Target Risk			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: • 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	Evidence: 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	Assurance Rating Green
	External:	Source: • 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	Evidence: Staff survey results TMA feedback from the CQC CQC engagement meeting feedback	Assurance Rating Green
	Gaps:			

Actions	Date:	Actions:	Action Owner:	Progress	Status:
	May 21	• Leadership development programme linked to leadership behaviours	SW	Ongoing – date put back to May 21 for further update next month	Green

Risk No: 26	Equality, Leadership, Culture	Date Included on ORR	01.10.19		Consequence	Likelihood	Combined
Risk Title:	Insufficient staffing levels to meet capacity and demand and provide quality services			Current Risk	4	4	16
Director risk owner:	Director of HR & OD	Date Last Reviewed:	16.04.21	Residual Risk	4	3	12
Governance / Review:	SWC, QAC / Board - Monthly Review			Risk Appetite / Target Risk score			12

Controls

Description:

Descriptor – the central resourcing, supply, recruitment and retention of staff. See risk 4 for the operational staffing of services to keep patients safe.

- Recruitment action plan in place
- Service level workforce groups with action plans in place
- 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
- Significant Covid related recruitment activity taken place to support Surge capacity - Bring back staff/Retirees
- Aging well started / Community Service Redesign Aging well recruitment
- Recruitment team moving to business as usual recruitment / Camhs Recruitment Plan

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
- Transformation programme on centralised recruitment – paused due to covid

Assurances

Internal:

Source:

- Three cohorts per year - nurse associate roles
- Degree nurse apprenticeship route
- HCA vacancy ambition
- Further development of other roles
- Reengineering of clinical roles
- SWC , Directorate Workforce groups , retention working group
- Workforce and Wellbeing Board
- Transformation committee
- Staff staffing report
- SUTG: Workforce Transformation Programme Plan
- Performance Report: Targets x 2 for sufficient staffing (Turnover and Vacancy)

Evidence:

- Progress reports to SWC
- Performance dashboard monthly
- Workforce reports monthly
- International Recruitment Plan
- HCSW recruitment plan

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:

Actions

Date:	Actions:	Action Owner:		Status:
June 21	• Ageing well programme	Sarah Willis	All in progress	Amber
June 21	• HCSW Recruitment Programme			
June 21	• International Recruitment			

Risk No: 27	Equality, Leadership, Culture	Date Included on ORR	01.10.19		**Consequence**	**Likelihood**	**Combined**
Risk Title:	The health and well being of our staff is not maintained and improved			**Current Risk**	3	3	9
Director risk owner:	Director of HR & OD	Date Last Reviewed:	14.04.21	**Residual Risk**	3	2	6
Governance / Review:	SWC, QAC / Board - Monthly Review			**Risk Appetite / Target Risk**			6

Controls	Description:	• Occupational health service wellbeing strategy and implementation plan • Workforce and wellbeing group • Wellbeing calendar – including a range of wellbeing events - Wellbeing Wednesday launched • Counselling service • 1:1s, Supervision, Appraisals linked to Leadership Behaviours Framework (see action on risk 26) • 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 • All staff risk assessments in place supporting health and wellbeing - part of supervision and appraisal conversations • System mental health HWB hub • System level support for post incident psychological support for staff via HUB • System wide virtual health and wellbeing week
	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:			

Actions	Date:	Actions:	Action Owner:	Progress:	Status:
	June 21	• Review of progress against the health and wellbeing approach and action plan	Kathryn Burt	Update requested in June 2021	Amber

Risk No: 28	Access to Services	Date Included on ORR	01.10.19		Consequence	Likelihood	Combined
Risk Title:	Delayed access to assessment and treatment impacts on patient safety and outcomes			Current Risk	4	4	16
Director risk owner:	Divisional Directors / Medical Director	Date Last Reviewed:	13.04.21	Residual Risk	4	2	8
Governance / Review:	Waiting List and Harm Prevention Committee, FPC and QAC / Board - Monthly Review			Risk Appetite / Target Risk			8

Controls	Description:	• Access Policy • Step up to Great MH transformation programme • Strategic waiting times and harm review committee • Covid Executive Team • OPEL framework/daily escalation tool/calls in place • 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) • Revised performance report with narrative / Directorate level performance and accountability reviews in place • Revised NHSI demand and capacity management training complete • Planning for 21/22
	Gaps:	• Demand and capacity modelling in response to additional challenges resulting from Covid-19 / long Covid • Outputs from EM demand and capacity modelling for MH • Outputs from joint LLR/Northants demand and capacity work including physical health • Contract roll-over resulting in shortfall of funds to match growth of population / prevalence / demand

Assurances	Internal:	Source: • Directorate performance reports • Waiting time performance reported to Finance and Performance Committee monthly • 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 / QAC / FPC • Notes of the East Midlands Alliance are shared with the Exec Board meeting	Assurance Rating Amber
	External:	Source: • NHS Improvement Support Team review of CAMHs • CQC inspection process • Contract performance monitoring • NHSI Regional Escalation oversight of 4 hr performance • National benchmarking data • Quality / Contract Monitoring with CCG & Specialised Commissioning with escalation route • LLR Transferring Care Safely Group/LPT engaged (acute/secondary provider feedback) • System-wide Clinical Forums for mental health, community services and children and young people.	Evidence: • Contract monitoring reports • Oversight reports to NHSEI • CQC Reports /focus groups	Assurance Rating Amber
	Gaps:	• Triangulation of evidence of harm with Trust wide data connecting incidents, SI's and complaints with people waiting • CQC inspection		

Actions	Date:	Actions:	Action Owner:	Progress:	Status:
	May 21	Agree priorities for MHIS and growth with commissioners	MH Partnership	East Midlands MH alliance working with NHSEI to develop MH capacity planning model	Amber
	May 21	Joint East Midlands wide Mental Health demand and capacity modelling	Directorates		
	May 21	Clarifying the programme of work to respond to the modelling	Directorates	Agreed joint working approach between LLR and Northants system to undertake demand and capacity modelling	
	June 21	Triangulate evidence of harm with Trust wide data			
	June 21	Develop Covid sensitive trajectories for waiting time improvement of priority services			

Risk No: 33	Well Governed	Date Included on ORR	01.10.19		Consequence	Likelihood	Combined
Risk Title:	Insufficient executive capacity (including Shared Chief Executive role) to cover demand and impacts on LPT ability to achieve it's strategic aims			Current Risk	4	3	12
Director risk owner:	Director of Governance and Risk (transition only) Deputy Chief Executive substantively	Date Last Reviewed:	16.04.21	Residual Risk	4	2	8
Governance / Review:	Strategic Exec Board / Board - Monthly Review			Risk Appetite / Target Risk			8

Controls	Description:	• Shared Chief Executive appointed with NHFT (NHFT rated outstanding overall and outstanding for well led domain) • 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 • Recruitment of substantive Director of Adult Mental Health • Substantive Appointment of deputy CEO • Appointment of substantive Director of Nursing, AHPS and Quality • Appointment of a substantive Medical Director • Appointment of Director of Finance and Performance
	Gaps:	• Retirement of CHS Director

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 • Overall Well-led inadequate rating from CQC at last inspection	Assurance Rating Green
	Gaps:	• Inspection due to provide re-rate for well led		

Actio	Date: Apr 21	Actions: • Interviews for Director of CHS	Action Owner: SW/CEO	Progress: Ongoing

Status: Green

					Consequence	Likelihood	Combined
Risk No: 35	Well Governed	Date Included on ORR	01.10.19	Current Risk	4	4	16
Risk Title:	The quality and availability of data reporting is not sufficiently mature to inform quality decision making			Residual Risk	4	3	12
Director risk owner:	Director of Finance & Performance	Date Last Reviewed:	16.04.21	Risk Appetite / Target Risk			12
Governance / Review:	FPC / Board - Monthly Review						

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 • Data quality may be impacted following the single EPR implementation

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 • Data quality group included in updated Data Privacy TOR & alternate meetings will focus on data quality - Revised Terms of reference with responsibility for data quality approved at Data Privacy Committee on 11/02/21	Evidence: • Quarterly DQIP report to FPC (~~last one 17.03.20~~) closed previous DQIP actions • DSPT regular updates for FPC (last one August 20) • Data quality actions will be reported to FPC via Data Privacy Committee highlight reports	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 or 20/21 • 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 revised approach started in February 2021, not yet embedded actions in to services		

Actions	Date:	Actions:	Action Owner:	Progress: timescales moved to May 2021 for an update next month	**Status:**
	May 21	• Output from data quality group (including framework for delivery of reporting)	Sharon M	Assurance / escalation to FPC via highlight report. First data quality meeting in April 21.	Amber
	May 21	• Clarify actions, timescales & resources required to rectify performance reporting issues following System1 migration.	Sharon M	Working with HIS team to manage post migration data issues – timescale delayed to April 2021.	

Risk No: 40	High Standards	Date Included on ORR	27.05.20		Consequence	Likelihood	Combined
Risk Title:	The ability of the Trust to deliver high quality care may be affected during a Coronavirus COVID-19 pandemic			Current Risk	5	3	15
Risk Owner:	Deputy Chief Executive Officer	Date Last Reviewed:	13/04/2021	Residual Risk	5	2	10
Governance / Review:	ICC / Strategic Exec Board / Board - Monthly			Risk Appetite / Target Risk			10

Controls

Description:

- NHS level 3 major incident led by COBR with national, regional and local resilience structures and policies
- COVID-19 Incident Mgt Team and Control Centre open 8 – 8 7days per wk/SPC 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 for IPC, major incident, Flu pandemic, brexit, mgt 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
- UHL/LPT Hospital HUB in place / Workforce Bureau now operational
- COVID positive RED beds in place following surge actions complete
- Mass Vaccination Centre at Peepul Centre and two hospital hubs at Loughborough and Feilding Palmer hospitals are now operational
- Inpatient vaccination programme to be developed and implemented
- 'Big Conversations' plan for staff consultation regarding recovery

Gaps:

- Response to latest escalation level, hospitalisations and infection rates

Assurances

Internal:	• Fortnightly flash report to Board • Covid vaccination programme board established • 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 • Ongoing consideration of interim governance arrangements at Exec Team	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:			

Date:	Actions:	Action Owner:	Progress: timescales – May for update next month	Status:
May 21	• Workforce Bureau interviewing & rapid on-boarding staff c 500 for LLR Vaccination Bank	SW	Ongoing	Amber
May21	• Review escalation levels in light of recent reductions.	DW	Ongoing review	

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		
Director risk owner:	Director of HR & OD	Date Last Reviewed:	07.04.21
Governance / Review	ICC / Strategic Exec Board / Board - Monthly		

	Consequence	Likelihood	Combined
Current Risk	5	2	10
Residual Risk	5	2	10
Risk Appetite / Target Risk			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
- Oversight of vaccine hesitancy for BAME staff embedded in ICC

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 covid communications All staff risk assessments and HWB conversations	
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	

Gaps:

Actions

Date:	Actions:	Action Owner:	Progress	Status:
				Green

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:	Director, FYPC&LD	Date Last Reviewed:	07.04.21
Governance / Review	ICC / Strategic Exec Board / Board - Monthly		

	Consequence	Likelihood	Combined
Current Risk	4	2	8
Residual Risk	4	2	8
Risk Appetite / Target Risk			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 and circulation of accessible 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
- Quality impact assessments for Short breaks service suspension
- 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
- LD team engaged in Covid 19 vaccination programme to build capacity for specialist vaccination work when LD&A cohort included
- Re-mobilisation plan reviewed for Short breaks service in January. Re-mobilisation progressing with April go live target.

Gaps:

Assurances

Internal:	Source: • Daily SitRep which records COVID-19 deaths with LD / Autism condition • Communications structures to staff • 7-day per week COVID related National Guidance • Short breaks mobilisation plans shared with DMT and CRG	Evidence: Sub cell feedback Staff communications Service plans	Assurance Rating
External:	Source: • Department of health / Public Health England / NHSEI / Cobra / Chief Medical Officer • Government and LLR system advice and planning / Joint CEO exec daily • Gov.uk COVID-19 information email alerts / National webinars • Buddy relationship with NHFT • System response - LD&A sub cell (moving to LD&A Design Group)	Evidence: • Records of Joint CEO daily conference calls • NHSEI weekly data of deaths which includes those who have been treated for a mental health condition or have a learning disability and/or autism • Benchmarking against National Advisory Group for people with learning disabilities and autistic people standards	Assurance Rating
Gaps:	• Short breaks remobilisation plan shared with CRG – timeline refined to ensure safe transition of Agnes Unit staffing changes. Aim for April re-start.		

Actions

Date:	Action Owner:	Progress:	Status:
			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.		
Director risk owner:	Medical Director	Date Last Reviewed:	07.04.21
Governance / Review	LEG / Strategic Exec Board / Board - Monthly		

	Consequence	Likelihood	Combined
Current Risk	5	2	10
Residual Risk	5	2	10
Risk Appetite / Target Risk			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.
- Legal input into implications related to the Devon judgement
- 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 / 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:

Assurances

Internal:	Source: • 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	Evidence: 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
External:	Source: • 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 • 360 assurance audit	Evidence: CQC MHA reviewer reports / internal action plans CQC feedback provided to LEG	Assurance Rating
Gaps:			

Actions

Date:	Actions:	Action Owner:	Progress	Status:
				Green

Risk 44	Access to Services / 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		
Director risk owner:	Director of Strategy and Business Development / Divisional Dir.	Date Last Reviewed:	12.04.21
Governance / Review	ICC / Strategic Exec Board / Board – Monthly		

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

Controls

Description:

Impact of this is managed through Risk 28 'Delayed access to assessment and treatment impacts on patient safety and outcomes'

- Strategic waiting times and harm review committee
- NHSI demand and capacity management training complete
- Step up to Great MH transformation programme
- Planning for 21/22
- 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
- Covid Executive Team
- System design groups in place

Gaps:

- Post Covid19 demand and capacity modelling in light of digital first, reduced face to face capacity and non-availability of group work
- Outputs from EM demand and capacity modelling for MH
- Outputs from joint LLR/Northants demand and capacity work including physical health
- Implications for long covid

Assurances

Internal:	Source: • 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	Evidence: East Midlands Alliance meeting notes Performance reporting 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:	Source: • 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:

- Performance reporting on growth in referrals / activity levels

Actions

Date:	Actions	Action Owner:	Progress: timescales now April 2021 due to ongoing progress	Status:
Apr 21	Joint East Midlands wide Mental Health demand and capacity modelling	DW/AS	Ongoing	Amber
Apr 21	Clarifying the programme of work to respond to the modelling	DW/AS	Ongoing	
	PROPOSAL TO MERGE WITH RISK 28			

Risk 48	Well Governed	Date Included on ORR	24.06.20		Consequence	Likelihood	Combined
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.			Current Risk	5	2	10
Director risk owner:	Director of Finance & Performance	Date Last Reviewed:	16.04.21	Residual Risk	5	2	10
Governance / Review	FPC / Board monthly			Risk Appetite / Target			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:

- 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.
- Material income flows are being received by the Trust at short notice, making an unplanned surplus position a possibility
- Uncertainty around covid vaccination cost reimbursement process

Assurances

Internal:	Source: • Finance and Performance Committee report includes I & E, cash & capital reporting • Audit Committee • 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 to be reviewed in June 2021	Status:
June 21	Ongoing monitoring and reporting of financial delivery	Sharon Murphy		Green

Risk 52	High Standards / Equality, Leadership and Culture	Date Included on ORR	11.11.20		Consequence	Likelihood	Combined
Risk Title	Without sufficient student placement capacity, the health and social care system will have a shortfall in the availability of a qualified workforce			Current Risk	5	3	15
Director risk owner:	Director of Nursing, AHPs and Quality / Medical Director / Director of HR and OD	Date Last Reviewed:	16.04.21	Residual Risk	5	2	10
Governance / Review	SWC and QAC / Board - monthly review			Risk Appetite / Target			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 • Development Programme on pause due to covid.		
Assurances	Internal:	Source: Clinical Reference Group Learning and OD Group Medical Education Group Multi Professional Education Team Annual QAC Chair attendance at SWC	Evidence: • 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	Assurance Rating Green
	External:	Source: Health Education England Workforce Planning Groups LLR People Board LLR Placement Strategy Group Health Education England NMC / HCPC / GMC University of Leicester	Evidence: 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	Assurance Rating 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)		

	Date:	Actions	Action Owner:	Progress:	Status:
Actions	May 21	Technology project to enable remote and digital placements	Alison O'Donnell	Timescales moved from March to May to reflect ongoing progress for each action.	Amber
	May 21	Provision of blended placement offers	Elaine Curtin		
	May 21	Recruitment of additional AHP leadership capacity for clinical placement expansion project	Deanne Rennie		
		Piloting new placements offers including digital and peer placements			
	May 21	Increasing utilisation of patient simulators	Deanne Rennie		
	May 21	Widening the range of pathway placement supervisors to include enabling teams to include is	Director of Medical Education		
	May 21	safeguarding and patient safety teams	Elaine Curtin		
	May 21	Establishing remote mentoring for Private Voluntary and Independent sector	Elaine Curtin		

Risk No: 54	Well Governed	Date Included on ORR	17.02.21
Risk Title:	We are unable to deliver the LPT 2021/22 financial plan , LPT operational plans or LLR system plans.		
Risk Owner:	Director of Finance & Performance	Date Last Reviewed:	16.04.21
Governance / Review:	FPC / Board monthly		

	Consequence	Likelihood	Combined
Current Risk	5	3	15
Residual Risk	5	2	10
Risk Appetite / Target			6

Controls

Description:

- 2021/22 Quarter 1 financial arrangements will roll over from 2020/2021 quarter 4 arrangements
- 2021/22 Q2-4 financial planning will follow LPT agreed process and governance
- LPT financial plan is part of the agreed LLR 4 year financial strategy to deliver recurrent system breakeven by year 4
- System groups will lead the development of pathway plans , transformation proposals and flow of funds.
- System oversight will track organisational & system delivery of plans
- LPT Financial governance & control framework in place through SFIs with reporting to Audit Committee
- Transformation committee oversight of CIP & investment /transformation plans
- Operational oversight & management of cost forecasts through Directorate Management Teams
- Underlying cost run rate analysis feeds financial plans
- Capital Management Committee's oversight of capital planning and agreed governance processes; Capital Financing strategy
- Treasury management policy , cash flow forecasting
- LPT operational plan will define service priorities , including enabling, and inform financial, activity, workforce & performance plans

Gaps:

- 2021/22 planning guidance hasn't been published
- Uncertainty over ability to deliver workforce and spend assumptions for investment/transformation, particularly MHIS
- Covid direct costs are not included in current plans
- No activity backlog assumptions are included in current plans
- No long covid or post covid MH changes to demand are included in current plans
- System transformation work and design group outputs aren't feeding into organisational plans yet
- System wide approach to financial planning & in year management is new & untested
- Culture change required across system partners, particularly for UHL to move away from PBR funding model
- LLR capital strategy not yet clear
- 2021/22 Contracting arrangements beyond Q1 not clear

Assurances

	Source:	Evidence:	
Internal:	• Finance and Performance Committee report includes I & E, cash & capital reporting • Audit Committee • Capital management committee review & agreement of capital bids & development of capital plan & in year management • Transformation Committee oversight of CIPs, transformation & investments	• Formal I & E, cash & capital monitoring • Standing Financial instructions • Highlight report • Monthly Director of Finance report • Highlight report	Assurance Rating Green
External:	• KPMG audit of 20/21 annual accounts and value for money conclusion • Internal Audit Plan 2020/21: Integrity of the General Ledger and Financial Reporting Q3/4; Financial Systems Q3/4	• 2019/20 annual accounts unqualified opinion • Significant assurance IA opinions issued 2019/20	Assurance Rating Green

Gaps:

Actions

Date:	Actions:	Action Owner:	Progress:	Status:
Jun 21	Draft summary financial & operational plan review at Operational Exec	Sharon Murphy	All progressing, dates to be confirmed and monitored, indicated as June 2021 - for ongoing review	Amber
Jun 21	Q1 budget approval at SEB & FPC	SM		
Jun 21	LPT Transformation committee oversight of CIP, transformation & investment plans	SM		
Jun 21	Review & finalise operational & finance plans following planning guidance publication	SM		
Jun 21	Submit LLR & LPT finance, activity, workforce & performance plans to NHSI	SM		

Risk No: 55 DRAFT	Well Governed	Date Included on ORR	07.04.21
Risk Title:	The Leicester/Leicestershire / Rutland system does not deliver the transformation needed to deliver a successful ICS		
Director risk owner:	Director of Strategy and Business Development	Date Last Reviewed:	07.04.21
Governance / Review:	Transformation Committee , FPC & Board		

	Consequence	Likelihood	Combined
Current Risk	4	2	8
Residual Risk	3	2	6
Risk Appetite / Target Risk			6

Controls

Description:	• A consistent agreed objective and system narrative that is used and tested in all system meetings, with all partners. • System wide vision implemented and delivered • Regular attendance at system meetings from senior LPT staff. • Regular discussion and engagement with our Senior Leadership Team. • Chief officers meeting fortnightly • New collaborative ways of working demonstrated in transformed care pathways based on need and place
Gaps:	• Ensuring individual organisations maintain commitment to the agreed priorities for the ICS • An agreed system risk share/approach

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.	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 • 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	Assurance Rating Green
Gaps:	• No national blue-print • The development of a successful ICS must involve wider stakeholders including local authorities and the voluntary and community sector		

Actions

Date:	Actions:	Action Owner:	Progress:	Status:
Jun 21 By Mar 22	• Agree system plan for 21/22 • Implement new ways of working to deliver an ICS from April 21 onwards, reviewing learning to inform future new ways of working • Deliver greater partnership working between organisations which enable the provider alliance concept to be tested.	CEO, DCEO, DoF, DoS, DoN & MD DCEO, Dir of MH & DoS	LPT is participating in system meetings and created a process for the internal development and review of the plan. Community & primary care, Mental Health and Learning Disability services provide opportunities for new ways of working	Green