					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 and Medical Director	Date Last Reviewed:	18.06.21	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- BAF report to Trust Board
- 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)
- Learning Lessons Exchange Group including learning from thematic reviews
- 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 and accreditation process being implemented
- 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 including new Investigation Leads
- 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.
- Directorate level risk 4620 Due to the lack of consistent robust systems and processes within the Trust for the management of serious incident investigations, there is a risk that the organisation will not learn lessons and there will be delays in implementing the actions required. This could adversely impact on the safety of patient care, the experiences of patients, their families and staff, as well as causing reputational damage to the Trust. Gaps in controls and assurances identified – Directorate led actions identified required for mitigation – oversight at IOG.
- Effective learning lessons across Trust

Assurances

Internal:	• QAC Chair attendance at Quality Forum • Quality Forum / Quality Assurance Committee / Strategic Workforce Committee • Quality Accreditation • 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 • 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 and CCG 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:
Jun 21	Deliver the plan for a coordinated approach to SI and complaint investigations	AS/SW/AK	Plan has been developed and standardised	Amber
Jun 21	Development of reporting flow and oversight infrastructure including the embedding of SI assurance reporting to QAC / Board – on track	TW	Directorate Clinical Governance architecture designed and architecture aligning from floor to board is in progress.	

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:	14/06/2021	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
- New level 2 Safeguarding Committee
- SystmOne Safeguarding Unit now live improving oversight and access to records.

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.

Assurances

	Source:	Evidence:	Assurance Rating
Internal:	• Legislative Committee and Safeguarding Committee • QAC provides oversight and challenge to the Safeguarding and 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.	• 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. • New collaborative Safeguarding new assurance templates for CCG, and the 4 safeguarding boards has been instigated to make the assurance meaningful and delivered in a timely , responsive manner.	Amber
External:	• 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.	• External review of safeguarding structures report • CQC report • Local Safeguarding Board reports and minutes	Green

Gaps:

- Training figures
- Full implementation of the external review recommendations

Actions

Date:	Actions:	Action Owner:	Progress:	Status:
Sept21	• Implement and embed the 32 recommendations from the external review.	Neil King	• Action plan mainly delivered [NK outstanding items]. Redesigned Team. Invested in increasing capacity, new posts in place.	Amber
Sept 21	• Training capacity and offer to be reviewed	Neil King	• Training is ongoing as part of consistent and constant team development.	

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:	07.06.21	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: Jun 21 Jun 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: Final model agreed. Redesigned architecture to ensure floor to board alignment of clinical governance across the Trust. Posts within the architecture are currently being redesigned and recruited to including SI investigators	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:	08.06.21	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
- Recruited to a new workforce and safe staffing matron – to be in post in June 2021
- Recruited to the international l recruitment matron post – commenced in April 2021

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 • Performance Report with updated KPIs • 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 Nurse Sensitive Indicators has not identified correlation between staffing and impact to quality, safety and patient outcomes	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

Actions

Date:	Actions:	Action Owner:	Progress: Ongoing	Status:
July 21 July 21 July 21 Oct 21 Oct 21	• To develop a Trust wide safe staffing safeguards SOP • Annual clinical readiness preparation programme – task group to be scoped • Looking to Joint community and I/P therapy recruitment – to consider if feasible • Recruit 30 international nurses - timeline by October 2021 • Completion of annual establishment reviews (the workforce and safe staff matron)	Emma Wallis Steph O'Connell International recruitment matron	Safe staffing and international recruitment matrons in post – currently designing architecture for internal recruitment and planning for staffing establishment review.	Amber

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:	07.06.21	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
- Robust governance framework for grip and control QST with confidence

Gaps:

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:
Jun 21	Delivery of CQC actions around medical devices.	Julie Rubenzer	Ongoing	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:	07.06.21	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: Jun 21	Actions: Consultation process conclusion	Action Owner: Gordon King	Progress: Timescale now Jun 2021 due to covid	Status: Amber

					Consequence	Likelihood	Combined
Risk No: 8	Transformation	Date Included on ORR	01.10.19				
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:	07.06.21	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 Jun for further update next month	Status:
Jun 21	• Deliver LD Rehab SDIP	HT		Amber
Jun 21	• Full mobilisation of Forensics, Outreach expansion and Post Diagnosis 14+ ASD services	HT		
Jun 21	• Mobilisation of additional AMH leadership resource for ASD admission avoidance and discharge work	HP		

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:	08.06.21	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
- KPIs from UHL now available
- LPT participation in NHSEI cleaning with confidence (CwC) campaign – training programme added to Ulearn
- Rapid response team funded to support outbreak management and increase clearing where there are increased incidents of infection

Gaps:

- Plan to form Trust wide groups for Waste, Water Safety and Ventilation from May 2021
- Lack of task and finish group to review touch point cleaning frequency.
- Staff not reporting maintenance issues linked to the environment e.g. chips in plaster.

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)
- Environmental audit
- 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 Amber

External:

Source:

- NHSI IPC audit
- CQC inspections
- PLACE audits

Evidence:

- PLNational Guidance on cleaning for COVID-19
- Premises Assurance Model
- CQC IPC summary inspection report
- Daily SitRep reports received from UHL

Assurance Rating Green

Gaps:

Actions

Date:	Actions:	Action Owner:	Progress	Status:
Aug 21	Service spec update to introduce a third daily clean to IP areas	H Walton / Cheryl Shuttlewood / NHSPS	Complete [EW and HW]	Green
Jun 21	Additional spot check by UHL Facilities and LPT IPC team following the CRO outbreak and results of the environmental audit.		Complete – CRO outbreak closed.	
Sept 21	Plan to complete outstanding Estates maintenance jobs as a result of environmental audits – action log oversight at Trust facilities forum.	R Brown	Updated the Spec but no confirmed start date.	
Aug 21	Task and finish group to be established to review two hourly touch point cleaning and complete service base risk assessment for on-going touch point cleaning requirements.	A Hemsley		

					Consequence	Likelihood	Combined
Risk No: 10	Environment	Date Included on ORR	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			**Current Risk**	4	4	16
Director risk owner:	Chief Finance Officer	Date Last Reviewed:	15.06.21	**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
- Now that the FM business case has been approved, any implementation risk will be identified and managed through the next ORR cycle

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 • Emergency reactive maintenance performance is good • Cleaning audits – good performance and in line with KPIs	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
- 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:	Status:
Jun 21	• Procure specialist estate resources to support PAM.	Richard Brown	T&T Appointed	Amber
Jun 21	• FM transformation Business Case complete.	RB	Business Case complete	
Aug 21	• Additional Compliance capacity approved.	RB	T&T appointed	
Sep 21	• PAM, ERIC surveys to be undertaken in 2021.	RB	T&T appointed	
TBD	• In line with legal advice, create and exit agreement for FM services	R Wheeler		

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	3	12
Director risk owner:	Chief Finance Officer	Date Last Reviewed:	15.06.21	Residual Risk	4	2	8
Governance / Review:	Estates Committee, FPC / Board - Monthly Review			Risk Appetite / Target Risk			8

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
- Priority of fire safety works have been completed - implementation plans being finalised.
- Priority of ligature works has been agreed - initial phase ensuite doors is being undertaken.

Gaps:

- Premises Assurance Model to be updated
- Challenges around availability of capital funding – nine million of national funding secured in three MoUs (now all signed)
- Finalisation of the remedial fire works
- Action to upgrade ensuite and unobserved doors with modern safety products

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 to revisit Estates Return Information Collection (ERIC) data set		

Actions

Date:	Actions:	Action Owner:	Progress:	Status:
Ongoing	Implementation of plan for main Dormitory Eradication projects currently on track, acknowledging covid access issues and re-phasing.	Richard Brown	• Progressing. Potential impact of other estates work on the eradication plan currently being reviewed	Amber
Sep 21	ERIC return	RB. S.Woodier	• To be progressed. Supported by T&T full site surveys.	

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:	03.06.21	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 2021/22 KPIs for the Board
- Committee dashboards with KPIs owned by QAC/FPC
- Performance review meetings
- Highlight reporting for escalated items
- Annual committee reviews undertaken and 6 month interim reviews scheduled in work plans

Gaps:

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

Assurances

Internal:	Source: • 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 2021/22 KPIs for the Board Report • Month 1 reviews reduced to 1 ½ hours to focus on key performance issues , as part of the covid recovery • 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 • 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:	Status:
Jun 21	• Consideration of avoidable harm measures including impact of partial or full COVID related closures	AS/ A Scott	Qliksense project is underway, with established project team.	Amber
Sept 21	• Revised Board performance report implementation	SM		
Sept 21	• Consider ORR links to performance report	SM/KD	Met to agree next steps for linking report & ORR; new staff will progress	

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:	04.06.21	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:	
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	Assurance Rating Green
External:	Source: • Staff survey • National WRES metrics and report • Engagement with national WRES team	Evidence: • Trust Board reports on national WRES programme	Assurance Rating Green
Gaps:			

Actions

Date:	Actions:	Action Owner:	Progress:	Status:
Aug 21 June 21 June 21 June 21 July 21	• Delivery of WeNuture OD sessions • Anti – Racism strategy co production with NHFT part of group model • EDI Taskforce running a workshop with EDI leads to establish system wide priorities for 2021/22 • Response to 6 high impact actions linked to Race Equality and Inclusion Strategy • WDES action plan development in collaboration with the MAPLE staff support network	Haseeb Ahmed HA	• The we Nurture targeted BAME training is underway with one cohort who have completed the programme. cohort 2 commencement during summer 2021. • 10 action areas agreed. Joint action plan being developed. Project Group established and being led by Chris Oakes • TBC • 6 high impact action submission has been signed off by EDI Workforce Group and will be considered as part of consolidated WRES action plan • Head of EDI is working with chair of MAPLE researching best practice and agreeing priorities for 2021/22 WDES action plan	Green

					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:	07.06.21	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
- 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
- OD delivery plan
- E-learning training programme commenced
- Appraisal system aligned with leadership behaviours framework – new appraisal programme launched
- Senior leadership monthly meetings
- Leadership plan developed and signed off 'Leadership for all' engagement plan developed
- Leadership development programme linked to leadership behaviours
- People plan in place

Gaps:

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 • People plan	Evidence: Leadership + Leadership engagement plans to be signed off May 2021 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 People plan taken to SLF SWC QAC Trust board	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:
June 21	• Updated leadership Plan to be implemented will include collective leadership, coaching for leaders and Compassionate & inclusive leadership training, along with conference plan	FMc	implementation will commence straight away	Green
June 21	• Leadership Plan listening session to take place to inform engagement plans	FMc		Green
June 21	• Plan in place to support all staff to take part in the leadership behaviours training	FMc		

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:	04.06.21	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 and community
- 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
- Home first - Aging well started / Community Service Redesign Aging well recruitment – integrated system website for nursing and therapy hubs
- Recruitment team moving to business as usual recruitment / Camhs Recruitment Plan

Gaps:

- Workforce Planning capacity
- Home first / Aging well
- National workforce nursing supply challenges
- Medical consultant capacity concerns in AMH/CAMHS
- All Age metal health investment standards has significant work recruitment expectation

Assurances

	Source:	Evidence:	
Internal:	• 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)	• Progress reports to SWC • Performance dashboard monthly • Workforce reports monthly • International Recruitment Plan • HCSW recruitment plan • SWC paper on internally recruitment progress	Assurance Rating Amber
External:	• National NHS people plan • NHS retention support and benchmarking data • Benchmarking reports • LLR People Board	• Engagement with development of NHS people plan	Assurance Rating Green
Gaps:			

Actions

Date:	Actions:	Action Owner:		Status:
June 21	• Ageing well programme	CHS / HR	Workforce group meeting to take forward	Amber
June 21	• HCSW Recruitment Programme	Sarah Willis	On going work progressing plans to supports workforce	
June 21	• International Recruitment	HR / Nursing	Paused due to Indian pandemic – planning still working through	
Sep 21	• All age mental health investment standard workforce meetings	Asha day HR / MH	Meeting to pull together plans and activity	

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:	04.06.21	**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 • Mental health and Wellbeing Hub
	Gaps:	• Embedding of National / Local People Plan and 6 step to recovery

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
	July 21	• Triple R health and wellbeing workforce in place	Kathryn Burt	Plan on a page signed off	
	July 21	• Individual health and wellbeing process refreshed and launched	Kathryn Burt	Progressing guidance	

					Consequence	Likelihood	Combined
Risk No: 28	Access to Services	Date Included on ORR	01.10.19				
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:	07.06.21	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
- 21/22 priorities agreed and H1 and H2 plan in place
- EM demand and capacity modelling for MH
- Triple R programme in place
- Covid sensitive trajectories for waiting time improvement of priority services

Gaps:

- Demand and capacity modelling in response to additional challenges resulting from Covid-19 / long Covid
- 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
- Access Policy not fully implemented
- EM demand and capacity modelling limited to MH
- Triple R programme impact yet to be understood
- Still a level in variation between directorates in the approach safety of patients whilst waiting

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
- Spot checks of safety of patients waiting

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
- Audit of twenty ND cases

Assurance Rating Amber

External:

Source:
- CQC inspection process
- System performance monitoring
- NHSI Regional Escalation oversight
- 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
- Assurance on harm reduction and harm monitoring is limited

Actions

Date:	Actions:	Action Owner:	Progress:	Status:
July 21	Development of report to triangulate evidence of harm with Trust wide data from Patient Safety and Patient Experience	MH Partnership TW/ AK	East Midlands MH alliance working with NHSEI to develop MH capacity planning model	Amber
Oct 21	Implementation of Access Policy	ASenior	Agreed joint working approach between LLR and Northants system to undertake demand and capacity modelling	
Dec 21	Understanding the outputs of the demand and capacity modelling and feeding into the transformation programme	Director of MH		

					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:	03.06.21	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
- Annual benchmark reporting against peers
- Experienced subject matter experts in the corporate information team
- National guidance
- Electronic patient records (EPR)
- 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
- Ownership of data quality across the Trust
- New data quality kite mark approach is being developed

Assurances

Internal:	Source: • FPC / Trust Board • Clinical audit • Annual record keeping audit • 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.	Evidence: • DSPT 'standards met' annual submission made in June 2021 • Data quality actions will be reported to FPC via Data Privacy Committee highlight reports • New Trust wide data quality group has started to meet and has agreed the data quality 21/22 work plan	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 20/21 360 assurance audit – 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:	**Status:**
Feb 22	• Delivery of 21/22 data quality work plan	Sharon M	ongoing	Green

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	2	10
Risk Owner:	Deputy Chief Executive Officer	Date Last Reviewed:	08/06/2021	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
- 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
- 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

Gaps:

- Response to latest escalation level, hospitalisations and infection rates

Assurances

Internal:	• Flash report by exception 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: • Regular COVID staff briefing • 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 – June for update next month	Status:
Jun 21	• Workforce Bureau interviewing & rapid on-boarding staff c 500 for LLR Vaccination Bank	SW	Ongoing	Amber
Jun 21	• Review escalation levels in light of recent reductions.	MP	Escalation levels continue to be reviewed weekly in line with government guidance	

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:	03.06.21	Residual Risk	5	1	5
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 on financial systems 2020/21	Assurance Rating Green
	Gaps:	NHSEI agreed plan in place		

	Date:	Actions	Action Owner:	Progress	Status:
Actions	June 21	Ongoing monitoring and reporting of financial delivery	Sharon Murphy	Draft accounts submitted & all statutory duties achieved.	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:	07.06.21	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	Jun 21	Technology project to enable remote and digital placements	Alison O'Donnell	All actions ongoing	Amber
	Jun 21	Provision of blended placement offers	Elaine Curtin	Piloting digital placement	
	Jun 21	Recruitment of additional AHP leadership capacity for clinical placement expansion project Piloting new placements offers including digital and peer placements	Deanne Rennie	Blended placement offers complete	
	Jun 21	Increasing utilisation of patient simulators	Deanne Rennie	Regular collaboration with both Universities.	
	Jun 21	Widening the range of pathway placement supervisors to include enabling teams to include is	Director of Medical Education		
	Jun 21	safeguarding and patient safety teams	Elaine Curtin		
	Jun 21	Establishing remote mentoring for Private Voluntary and Independent sector	Elaine Curtin		

Risk No: 54	Well Governed	Date Included on ORR	17.02.21		Consequence	Likelihood	Combined
Risk Title:	We are unable to deliver the LPT 2021/22 financial plan , LPT operational plans or LLR system plans.			Current Risk	5	3	15
Risk Owner:	Director of Finance & Performance	Date Last Reviewed:	03.06.21	Residual Risk	5	2	10
Governance / Review:	FPC / Board monthly			Risk Appetite / Target			6

Controls

Description:

- 2021/22 Quarter 1 & 2 financial arrangements will roll over from 2020/2021 quarter 4 arrangements
- 2021/22 Q3-4 financial planning will follow LPT & LLR system agreed process and governance
- LPT financial plan is part of the agreed LLR system 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 for LPT and LLR system
- 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
- H1 financial plan delivers breakeven position for LPT & LLR system
- H2 plan for LPT & LLR system relies on clarifying & addressing underlying deficit position of all organisations

Gaps:

- 2021/22 H2 planning guidance hasn't been published
- Uncertainty over ability to deliver workforce and spend assumptions for investment/transformation, particularly MHIS
- No activity backlog assumptions are included in current plans – system reserve in place, which LPT can access
- 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 H1 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 for financial systems 2020/21	Assurance Rating Green
Gaps:			

Actions

Date:	Actions:	Action Owner:	Progress:	Status:
Sept 21	LPT Transformation committee oversight of H2 CIP, transformation & investment plans	SM	Regular reporting of financial position to exec team, FPC , Trust Board & LLR forums	Green
July 21	Development of LPT 3 year plan to address underlying position	SM		
Sept 21	Review & finalise H2 operational & finance plans following planning guidance publication	SM		
TBC	Submit LLR & LPT H2 finance, activity, workforce & performance plans to NHSI	SM		
	Management, reporting & delivery of H1 financial plan	SM		

Risk No: 55	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:	07.06.21
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
- Long term funding for the LLR Shared Care Record

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

Risk No: 56	High Standards	Date Included on ORR	05.05.21
Risk Title:	Delivery of service recovery and workforce restoration will not safeguard the health and wellbeing of our staff and service users		
Risk Owner:	Deputy Chief Executive Officer	Date Last Reviewed:	08.06.21
Governance / Review:	ICC / Strategic Exec Board / Board - Monthly		

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

Controls

Description:	• LPT Operational Plan • Service recovery model – 3R programme (reflect, reset and rebuild) approved plan • Recovery programme Communications and Engagement plan • Approval of time limited project manager support to deliver recovery projects • 'Big Conversations' plan being delivered for staff consultation regarding recovery • Recovery programme governance framework in place including the Covid Executive Group • Staff Health and Wellbeing offer
Gaps:	• Plans to address the impact of a surge in activity on wait times and staff resilience. • Post covid surge on demand and the impact on staff capacity – this is modelled within the Directorates and the system is modelling based on national requirement.

Assurances

Internal:	Source: • TripleR programme board and governance arrangements in place • TripleR project groups set up and taking forward key deliverables • Communications plan and structures • Extra project management support sourced • Staff health and well-being offer	Evidence: • Minutes from TripleR meetings • Plans on a Page for TripleR programme • Plan on a page and project deliverables • BIG conversation thematic review • Health and well being communications	Assurance Rating Green
External:	Source: • LLR system planning meetings • Service user and carer forums	Evidence: • BIG conversation with service users and carers • System Operational Group minutes	Assurance Rating Green
Gaps:	• TripleR Programme Director gap from the end of June – recruitment commenced		

Date:	Actions:	Owner:	Progress:	Status:
Jun 21	• Big Conversations and collation of feedback	MP	Complete and themes agreed	Amber
Jun 21	• Communications plan delivery to include ongoing team and all staff engagement sessions	KB	Ongoing	
Jul 21	• Recruit PMO Programme Director	CO	Ongoing – expected completion mid July	