| | | | | | 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 | 3 | 12 |
| **Director risk owner:** | Director of Nursing, AHPs and Quality and Medical Director | Date Last Reviewed: | 13/08/21 | 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 (moved to BAU) Deteriorating Patient (added Sepsis work stream), Positive and Safe, non fixed ligatures and Accreditation
- Patient Safety Plan - aligned to the National Patient Safety Strategy / Patient Safety Improvement Group (PSIG)
- Nutrition Group – now reporting to QF
- 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
- Coordinated approach to SI and complaint investigations

**Gaps:**

- Revised model for clinical and quality governance which includes Trust wide learning lessons

**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
- reporting flow in place and oversight infrastructure including the embedding of SI assurance reporting to QAC / Board – on track

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: |
|---|---|---|---|---|
| Sept 21<br>Dec 21 | Delivery of revised clinical and quality governance infrastructure<br>Delivery of revised clinical and quality governance framework to include how we strengthen learning Trust Wide learning lessons | Deanne Rennie<br>Nursing<br>Heads of Nursing and governance leads | MoC consultation to start September 2021<br>Framework under development | Amber |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **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: | 13/08/21 | 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 .<br>• Legislative Committee oversight under new Quality Governance Framework which has separated out the safeguarding work from the LEG.<br>• Identified Safeguarding Lead Nurses (Trust Lead, Child Lead, Adult Lead) and named Doctor for safeguarding children.<br>• Internal governance structure to manage safeguarding in place via Directorate oversight.<br>• Members of four local Safeguarding Boards, two Community Safety Partnerships and the Safeguarding Vulnerabilities<br>• Executive Committee.<br>• Adult and Children's Safeguarding Team in place.<br>• All vacant posts recruited to<br>• New level 2 Safeguarding Committee<br>• 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.<br>• The safeguarding training offer is not fully compliant with national standards and guidelines. |

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|---|---|---|---|---|
| **Assurances** | Internal: | Source:<br>• Legislative Committee and Safeguarding Committee<br>• QAC provides oversight and challenge to the Safeguarding and Legislative Committee.<br>• Annual Quality Account.<br>• External review commissioned regarding safeguarding structures within LPT outlined 32 recommendations<br>• The identified Safeguarding Lead Nurses access safeguarding supervision external to the organisation.<br>• Annual Safeguarding Report. | Evidence:<br>• Safeguarding report presented to Trust Board upon request and there are regular updates from the DoN to QAC/TB<br>• Key Performance Indicators for the Legislative Committee and SG Committee<br>• Progress and update reports regarding the external review action plan.<br>• 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. | Assurance Rating Amber |
| | External: | Source:<br>• CQC inspections (contribution to CCG Safeguarding Inspections /direct LPT CQC Inspection)<br>• 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<br>• External review completed and report accepted by the Trust. | Evidence:<br>• External review of safeguarding structures report<br>• CQC report<br>• Local Safeguarding Board reports and minutes | Assurance Rating Green |
| | Gaps: | • Training figures | | |

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

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|---|---|---|---|---|---|---|---|
| **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: | 11.08.21 | Residual Risk | 4 | 2 | 8 |
| **Governance / Review:** | PSIG, Quality Forum, QAC / Board - Monthly Review | | | Risk Appetite / Target Risk | | | 8 |

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|---|---|---|---|---|
| **Controls** | Description: | • Centralised process for identifying, processing, investigating, scrutiny and identifying Learning through the Serious Incident Process<br>• Complaints process and PALs team<br>• Patient and Staff Safety Incident review via triage and directorate responsibility<br>• Outcomes from Clinical Audit & service evaluation<br>• Learning from Deaths Group using a human factors approach<br>• Learning lessons Exchange Group operating as a community of practice to embed a learning culture using a human factors approach<br>• Patient Safety Improvement Group aligning with national patient safety strategy using a human factors approach<br>• Appropriate groups for sharing learning in place and to follow up on progress against actions<br>• Centralised SI reporting and oversight process<br>• Recruited additional SI investigators | | |
| | Gaps: | • Ensuring cross governance working to identify risk and share learning | | |
| **Assurances** | Internal: | Source:<br>• Learning from deaths report<br>• Patient safety bi monthly report<br>• Highlight report from Patient safety group<br>• Highlight report from the Learning Lessons Exchange<br>• Foundation for Great Patient Care<br>• Escalation from Quality Forum to QAC<br>• Incident review group meet weekly to review potential SI's and all COVID19 incidents and escalate to ICC<br>• SUTG: High Standards Work streams<br>• Performance Report: STEIS SI action plans completed within timescales.<br>• Triangulation with Claims, Safeguarding, Complaints and F2SU Guardian | Evidence:<br>• Monthly SI performance report for Quality Forum and QAC<br>• Bi monthly patient safety report to Board<br>• Highlight information and escalation processes<br>• Reduction in harm and incidents<br>• Reduction in concerns and complaints<br>• Improved staff feedback<br>• Performance Report<br>• Internal reviews of learning | Assurance Rating Amber |
| | External: | Source:<br>• Feedback from patients/families<br>• CQC statutory inspection framework<br>• Quality and Serious Incident oversight by Commissioners & specialist commissioning<br>• Coroner feedback<br>• National Confidential Enquiries<br>• Solicitor feedback learning points<br>• Internal Audit report – Duty of Candour | Evidence:<br>• Patient experience report to QAC<br>• CQC report / verbal feedback | Assurance Rating Green |
| | Gaps: | | | |

| | | | | | |
|---|---|---|---|---|---|
| **Actions** | Date:<br>Dec 21 | Actions:<br>Implementation of re-designed clinical and quality governance structure and framework – see risk 1. | Action Owner:<br>Anne Scott | Progress:<br>See risk 1 | Status:<br>Amber |

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|---|---|---|---|---|---|---|---|
| **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: | 05.08.21 | 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
- Recruited to the international l recruitment matron post
- Directorate safe staffing SOPs in place for escalation and management including deployment of bank and agency staffing

**Gaps:**

- Pause on annual establishment review – to re-start
- National difficulties in recruitment – particularly to mental health and community nursing.

## Assurances

**Internal:**

Source:
- 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

Evidence:
- 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
- National tools to measure therapy staffing for patient acuity and dependency

## Actions

| Date: | Actions: | Action Owner: | Progress: Ongoing | Status: |
|---|---|---|---|---|
| Oct 21 | Winter planning and Trust preparedness for redeployed staff | Emma Wallis | | Amber |
| Aug 21 | Looking to Joint community and I/P therapy recruitment – to consider if feasible | Deanne Rennie | | |
| Dec 21 | Recruit 30 international nurses - timeline by end December 2021 | Asha Day | | |
| Dec 21 | Completion of annual establishment reviews (the workforce and safe staff matron) | Elaine Curtin | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **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: | 09/08/21 | 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
- 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<br>• Self assessment checklist<br>• Quality surveillance tracker<br>• Quality forum<br>• AMAT tool – tracker including areas identified for further support showing closures<br>• Foundation for Great Patient Care<br>• SUTG: High Standards Work streams<br>• Self assessment against all areas previously rated as inadequate | Evidence:<br>• Monthly assurance report to QAC / Board<br>• Monthly report to Strategic Exec Team<br>• Foundation for Great Patient Care highlight report to Quality Forum<br>• Deep dives at the Foundation for Great Patient Care<br>• Information provided to the CQC under the TMA | Assurance Rating Green |
| **External:** | • Proactive design of information flow to CQC to inform the TMA with ongoing feedback<br>• Ongoing focus groups, drop in sessions and invites for CQC to attend events<br>• CQC inspection and engagement meetings / focus group outcomes<br>• Third line assurance over compliance (outside of the CQC)<br>• Quality and Performance system meetings – discussions with Commissioners<br>• Regulator inspections including HSE, NHSEI/IPC<br>• KPMG value for money conclusion | Evidence:<br>• TMA feedback from the CQC<br>• Internal re-rating including buddy trust peer review<br>• Feedback from focus groups<br>• Minutes of CQC engagement meeting<br>• 3rd party assurance reports (HSE, IPC, NHFT buddy visits) | Assurance Rating Green |
| **Gaps:** | Current CQC rating - latest inspection date May-June (core service) July (well led) 2021 awaiting findings | | |

## Actions

| Date: | Actions: | Action Owner: | Progress: | Status: |
|---|---|---|---|---|
| Sept 21 | Delivery of CQC actions around medical devices. | Deanne Rennie | Ongoing | Amber |
| Sept 21 | Review and refresh of CQC action improvement and assurance oversight | Deanne Rennie | Ongoing | |

| | | | | | | |
|---|---|---|---|---|---|---|
| **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
- Consultation process is concluding

Gaps:

**Assurances**

| | | | |
|---|---|---|---|
| Internal: | Source:<br>• Large scale co-production events<br>• Project Initiation Document<br>• LPT Trust Board quarterly updates<br>• Directorate Management Team (DMT)<br>• Implementation plan<br>• SUTG: Step up to Great Mental Health | Evidence:<br>• Transformation Committee update papers<br>• SUTG project delivery dashboard<br>• Out of area improvement | Assurance Rating Green |
| External: | Source:<br>• NHSE Strategic Direction<br>• Health and Wellbeing Board scrutiny<br>• STP Better Care Together Plan – Mental Health work stream<br>• System MH Partnership Board governance<br>• City MH partnership Board scrutiny<br>• MH Clinical Forum monthly updates<br>• CPM monthly progress updates<br>• MH collaborative<br>• Clinical senate review of clinical model - approved | Evidence:<br>• External presentations<br>• CQC engagement minutes | Assurance Rating Green |
| Gaps: | | | |

**Actions**

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

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **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 | 3 | 12 |
| **Director risk owner:** | Director, FYPC and LD Services | Date Last Reviewed: | 14.08.21 | Residual Risk | 4 | 2 | 8 |
| **Governance / Review:** | Transformation Committee, FPC / Board - Monthly Review | | | Risk Appetite / Target Risk | | | 12 |

## Controls

**Description:**

- TCP Collaborative formed led by LPT delivering improved performance and de-escalation of LLR by NHSEI June 21 – LeDeR, Annual Health Checks and admission trajectory on track.
- Executive as jt SRO and AD leadership of system response.
- 3 year road map for investment and improvement agreed with NHSEI and system partners – robust programme management arrangements in place
- New developments established to reduce admission – ie. Specialist Autism Team, strengthened outreach mode and LD Forensics offers.
- TCP Hub developed to co-ordinate LLR social care discharge work
- Adult and CYP discharge planning scrutinised weekly by AD led multiagency group.
- LPT LD service Quality Improvement Programme for inpatient and community services delivering large scale change informed by service users/carers
- Risk of Admission Register (ROAR) and associated e-learning, multiagency Dynamic Support Register in place.
- AMH TCP Group established to improve and coordinate response
- Increased LD Matron capacity to support transformation and TCP work programme
- Provider forum in place to develop community capacity
- Short breaks offer in place
- Mobilisation of Forensics, Outreach expansion and Post Diagnosis 14+ ASD services - pending Early Intervention cohorts for SAT team
- Agnes Unit financial model and financial recovery plan agreed with commissioning team

**Gaps:**

- Further controls/services under development as part of 3 year plan include Dynamic Support Pathway to increase early intervention
- DMH autism pathway in development
- Appropriate community placements in LLR including facility for 'unplanned care' response.
- Poor access to low and medium secure beds resulting in complex ASD case management in DMH and Agnes Unit.

## Assurances

| | Source: | Evidence: | Assurance Rating |
|---|---|---|---|
| **Internal:** | • Board reporting<br>• Transformation Committee report for LD QI and TCP.<br>• DMH TCP Improvement plan<br>• LD QI Programme governance to directorate SUTG DMT | • TCP Annual report. LeDeR report.<br>• Reports into transformation committee<br>• Improvement plan to DMH DMT<br>• LD QI programme plan and progress reports | Amber |
| **External:** | • Multi-agency LD and Autism Executive Board - *reports into STP SLT, and is a Workstream of the STP.*<br>• System wide LeDeR review and timely delivery of quality assurance<br>• Adult & Children Case Managers (CCGs / Specialised Commissioning)<br>• External input into Root Cause Analysis on all admissions<br>• CCG and LAs engagement in LD QI Programme Board<br>• System LD and Autism Executive | • Learning from RCAs to reduce future admissions<br>• Minutes of the TCP Executive Board<br>• System Performance against TCP inpatient trajectory, LeDeR and Health checks. NHSEI de-escalation letter. | Amber |

**Gaps:**

- Reporting to the Transformation Committee not possible due to suspension of forum
- RCA process for admissions to be established in CAMHS

## Actions

| Date: | Actions: | Action Owner: | Progress: | Status: |
|---|---|---|---|---|
| Sept 21 | • Mobilisation of additional AMH leadership resource for ASD admission avoidance and discharge work | MR | Plan drafted. DMT and CCH engagement pending. | Amber |

| | | | | | Consequence | Likelihood | Combined |
|---|---|---|---|---|---|---|---|
| **Risk No: 9** | Environment / High Standards | Date Included on ORR | 01.10.19 | | | | |
| **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: | 05.08.21 | 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
- Service spec updated to introduce a third daily clean to IP areas

**Gaps:**

- Outstanding maintenance work following the environmental audits

## 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
- Additional spot check by UHL Facilities and LPT IPC team following the CRO outbreak and results of the environmental audit.

Assurance Rating Green

**Gaps:**

## Actions

| Date: | Actions: | Action Owner: | Progress | Status: |
|---|---|---|---|---|
| Sept 21 | Plan to complete outstanding Estates maintenance jobs as a result of environmental audits – action log oversight at Trust facilities forum. | R Brown | Ongoing planning | Green |
| Sept 21 | Review and implementation of phase one of the national cleaning standards | H Walton & A Hemsley | | |
| Aug 21 | NHSE/I visit for IPC | | | |

| | | | | | 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: | 11.08.21 | **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.
- Specialist estate resources procured from Turner & Townsend (T&T) to support PAM.
- ERIC return submitted
- FM transformation Business Case 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

**Internal:**

Source:
- Estates committee / FPC
- Initial review to identify high risk areas of the estate that require maintenance completed Reporting of FM KPIs to FPC
- Estates risk register
- Audit action plan – track via FM Oversight Group
- Self assessment on premises assurance model
- Foundation for Great Patient Care quality tracker, deep dives and escalation process
- FM Oversight Group currently on hold (COVID) – reinstated starting October 2020

Evidence:
- 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

Assurance Rating: Amber

**External:**

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

Evidence:
- Audits and reports
- PLACE scores

Assurance Rating: Amber

**Gaps:**

- Lack of assurance on information received from UHL
- 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: |
|---|---|---|---|---|
| Sep 21 | • To utilise the additional resources via T&T to support the ongoing data collection and actions relating to PAM until submission date | Richard Brown | Ongoing | Green |

| | | | | | Consequence | Likelihood | Combined |
|---|---|---|---|---|---|---|---|
| **Risk No: 11** | Environment | Date Included on ORR | 01.10.19 | | | | |
| **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: | 11.08.21 | 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.
- ERIC return completed and submitted on time May 2021

**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

| | Source: | Evidence: | |
|---|---|---|---|
| **Internal:** | • New Strategic Property Group established and operational<br>• Monthly report to FPC on progress against the Estate Strategy<br>• Health and Safety Reports and confirmation of compliance with actions<br>• The SOC was signed off by the Board in October 2019<br>• Strategic Estates and Medical Equipment Committee<br>• Finance and Performance Committee<br>• Health and Safety Committee. Directorate Health and Safety Action Groups<br>• Building of new CAMHS Unit (complete)<br>• Annual PLACE inspections<br>• 3 year plan to eliminate dormitory accommodation (AMH/MHSOP) agreed by Trust Board | • Monthly report to FPC on progress against the Estate Strategy<br>• Health and Safety Reports and confirmation of compliance with actions<br>• The SOC was signed off by the Board in October 2019<br>• PLACE report for 2019 | Assurance Rating Amber |
| **External:** | Source:<br>• PLACE audits complete and actions in hand by Property Officers<br>• NHSI / CQC / HSE<br>• Fire service<br>• KPMG audit of financial and quality accounts<br>• In-patient reconfiguration to eliminate dormitories. Phase 1 OBC approved by Exec | Evidence:<br>• CQC report<br>• 360 audit<br>• 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 Dormitory Eradication programme. | Richard Brown | • Currently on plan. Strong engagement. Willows and Bosworth complete. | 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: | 13.08.21 | Residual Risk | 4 | 1 | 4 |
| **Governance / Review:** | FPC / Board - Monthly Review | | | Risk Appetite / Target Risk | | | 4 |

| | | |
|---|---|---|
| **Controls** | Description: | • Information asset owners in place<br>• SIRO in place<br>• Clinical system training in place<br>• Board approved Performance management framework<br>• Board level performance dashboard<br>• Revised governance framework<br>• SUTG plan<br>• SOP in place<br>• Simplified board reporting and an agreed set of 2021/22 KPIs for the Board<br>• Committee dashboards with KPIs owned by QAC/FPC<br>• Performance review meetings<br>• Highlight reporting for escalated items |
| | Gaps: | • Avoidable harm measures<br>• Capacity of the information team due to demands from national sitrep reporting, changes to information team members<br>• Level 2 committee dashboards – implementation delayed due to COVID |

| | | | | |
|---|---|---|---|---|
| **Assurances** | Internal: | Source:<br>• FPC / QAC<br>• Bi monthly Performance review meeting routine established<br>• DMT meetings<br>• Trust Board<br>• Revised business rhythm for level 1 committees | Evidence:<br>• Routine performance reporting to FPC / QAC /Board<br>• Agreement by QAC/FPC on the set of 2021/22 KPIs for the Board Report<br>• Performance framework review meetings scheduled until end of the year<br>• Performance reports are reviewed by Directorate Business Managers prior to release.<br>• Evaluation of performance review meetings & performance report & level 2 dashboard implementation – Focussed review meeting planned for October 2021. | Assurance Rating Amber |
| | External: | Source:<br>• Contract monitoring of quality indicators by Commissioners<br>• Finance, Technical and Performance monitoring of contracted performance indicators<br>• NHSI / CQC inspections<br>• External and internal audit | Evidence: | Assurance Rating Amber |
| | Gaps: | • Fully embedded system (demonstrated once level 2 dashboards are fully implemented)<br>• External Quality Account audit – no data testing due to COVID in 19/20 or 20/21, will be optional in future – The Trust's Auditor panel has agreed the quality accounts audit will be included in the Service Specification in the current external audit tender exercise.<br>• Trust wide approach to reporting planned post covid performance & capacity | | |

| | Date: | Actions: | Action Owner: | Progress: | Status: |
|---|---|---|---|---|---|
| **Actions** | Sept 21 | • Consideration of avoidable harm measures including impact of partial or full COVID related closures | AS/ A Scott | | Amber |
| | Sept 21 | • Revised Board performance report implementation | SM | Qliksense project is underway, with established project team. | |
| | Sept 21 | • Consider ORR links to performance report | SM/KD | Met to agree next steps for linking report & ORR; new staff will progress | |
| | Dec 21 | • Review of Information Team capacity | SM | | |
| | April 22 | • External audit of quality accounts to be reinstated | SM | | |

| | | | | | Consequence | Likelihood | Combined |
|---|---|---|---|---|---|---|---|
| **Risk No: 24** | Equality, Leadership, Culture | Date Included on ORR | 01.10.19 | | | | |
| **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: | 09.08.21 | Residual Risk | 3 | 3 | 9 |
| **Governance / Review:** | SWC, QAC / Board - Monthly Review | | | Risk Appetite / Target Risk | | | 9 |

## Controls

**Description:**

- Independent focus groups run and led by national WRES team- January 2019
- Delivery of key actions from focus groups
- Electronic system controls to support identification of staff who want to progress in their careers
- Staff survey results analysed and gaps identified annually
- WRES /WDES data and action plans updated and produced annually / Annual Report on WRES and WDES
- CEO sent letter to all BAME staff in response to BLM June 2020
- Risk assessments conducted for all staff
- Staff support networks meet on a regular basis (monthly) and have Executive sponsorship
- Continued listening events with staff
- Reverse mentoring cohorts, second system wide reverse mentoring programme underway (41 matched pairs with LPT having 14 reverse mentoring pairs)
- Cultural ambassadors
- Strong EDI governance in place
- Our Future Our Way / Leadership behaviours (which includes an EDI specific behaviour)
- 6 high impact action submission has been signed off by EDI Workforce Group
- Anti – Racism strategy co production with NHFT part of group model
- EDI Taskforce - 10 action areas agreed. Project Group established and being led by Chris Oakes

**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/ Together Against Racism action plan/ NHSEI high impact actions

## Assurances

**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

- Highlight reports on WRES, WDES and Together Against Racism action plans, presented regularly to relevant governance committees
- 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
- SEB approved recruitment of band 7 EDI Specialist role- June 2021

Assurance Rating Green

**External:**

Source:

- System wide EDI Taskforce established and identified seven priority areas for implementation
- People Plan Drivers embedded within LPT strategies
- Six race equality high impact actions mandated nationally and embedded within key strategies
- EDI strategy being developed

Evidence:

- Presentation of system wide priorities to SRO's scheduled for the 11th August 2021
- System wide funding to support seven key priorities- ongoing
- Coordination of activities through the EDI Taskforce- ongoing with high visibility of key projects, e.g reverse mentoring, key decision making framework, Cultural Intelligence programme and Your Voice tool

Assurance Rating Green

**Gaps:**

## Actions

| Date: | Actions: | Action Owner: | Progress: | Status: |
|---|---|---|---|---|
| Oct 21 | • Delivery of WeNuture OD sessions | Haseeb Ahmed | • The WeNurture targeted BAME training is underway with one cohort who have completed the programme. cohort 2 commencement during summer 2021. On target. | Green |
| Aug 21 | • WDES action plan development in collaboration with the MAPLE staff support network | Haseeb Ahmad | • Head of EDI is working with chair of MAPLE researching best practice and agreeing priorities for 2021/22 WDES action plan. Complete. | |
| Mar 22 | • Embed Together Against Racism actions | Haseeb Ahmad | • Together Against Racism is one of the group strategic priorities for LPT and NHFT's Buddy programme. An action plan has been agreed and will be implemented over the next 12 months. This is in addition to the WRES action plan. | |
| Mar 22 | • EDI Taskforce seven priorities plan | Haseeb Ahmad | • Plan being signed off by SRO's 11th August 2021 | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Risk No: 25** | Equality, Leadership, Culture | Date Included on ORR | 01.10.19 | | Consequence | Likelihood | Combined |
| **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: | 09.08.21 | 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:<br>• Staff survey results<br>• Board approval of change champion programme<br>• Programme plan in place and approved by Trust Board<br>• 92 change champions engaged<br>• Focus groups<br>• Strategic workforce group<br>• Attendance at virtual SLT<br>• Board development<br>• People plan<br>• Leadership for All Plan | Evidence:<br>Leadership + Leadership engagement plans to be signed off May 2021<br>Staff survey report to Board 3rd March<br>Board update on leadership behaviours progress Jan 20<br>Virtual SLT monthly<br>Reports to SWC quarterly meetings continuing – papers include leadership behaviours update, appraisal framework, OD plan for bitesize sessions<br>LPT people plan mapped to national and OFOW Board Development session 6th Oct<br>People plan taken to SLF SWC QAC Trust board<br>Plan gained approval and actions now being taken | Assurance Rating Green |
| External: | Source:<br>• Staff survey / Staff Friends and family test<br>• External recognition of initiatives<br>• NHSI Well led external review<br>• CQC Well Led review<br>• NHSI Support on the culture and leadership programme<br>• WRES programme<br>• People Plan | Evidence:<br>Staff survey results<br>TMA feedback from the CQC<br>CQC engagement meeting feedback | Assurance Rating Green |

Gaps:

**Actions**

| Date: | Actions: | Action Owner: | Progress | Status: |
|---|---|---|---|---|
| Sept 21 | • Commissioning of Compassionate and Inclusive Leadership programme taking place | FMc | On track | Green |
| Sept 21 | • Commissioning of Coaching for Managers programme taking place | FMc | | |
| Nov 21 | • Leadership for All conference taking place to embed collective leadership and LPT behaviours | 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: | 09.08.21 | 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**

**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
- SWC paper on internally recruitment progress

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: |
|---|---|---|---|---|
| Sept 21 | Ageing well programme | CHS / HR | Progress ongoing, deadlines moved to September 2021 | Amber |
| Sept 21 | HCSW Recruitment Programme | Sarah Willis | Workforce group meeting to take forward | |
| Sept 21 | International Recruitment | HR / Nursing | On going work progressing plans to supports workforce | |
| Sept 21 | All age mental health investment standard workforce meetings | Asha day | Plans underway | |
| | | HR / MH | Meeting to pull together plans and activity | |

| | | | | | Consequence | Likelihood | Combined |
|---|---|---|---|---|---|---|---|
| **Risk No: 27** | Equality, Leadership, Culture | Date Included on ORR | 01.10.19 | | | | |
| **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: | 09.08.21 | **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
- Triple R health and wellbeing plan on a page

Gaps: Embedding of National / Local People Plan and 6 step to recovery

**Assurances**

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

Gaps:

**Actions**

| Date: | Actions: | Action Owner: | Progress: | Status: |
|---|---|---|---|---|
| Sept 21 | • Review of progress against the health and wellbeing approach and action plan | Kathryn Burt | Progressing, deadline moved to September 2021 | Amber |
| Sept 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: | 13.08.21 | 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 / service recovery plans
- Covid sensitive trajectories for waiting time improvement of priority services – includes CYP ED as a prioritised service within FYPC

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**

| | Source: | Evidence: | Assurance Rating |
|---|---|---|---|
| Internal: | • Directorate performance reports<br>• Waiting time performance reported to Finance and Performance Committee monthly<br>• Plan on a Page, recovery action cards and QIAs for each service<br>• Spot checks of safety of patients waiting<br>• Directorate risk management – including risk 4677 for CYP ED | • Performance management dashboard / dashboards to DMTs<br>• Reports into waiting times and harm review group / QAC / FPC<br>• Notes of the East Midlands Alliance are shared with the Exec Board meeting<br>• Audit of twenty ND cases | Amber |
| External: | Source:<br>• CQC inspection process<br>• System performance monitoring<br>• NHSI Regional Escalation oversight<br>• National benchmarking data<br>• Quality / Contract Monitoring with CCG & Specialised Commissioning with escalation route<br>• LLR Transferring Care Safely Group/LPT engaged (acute/secondary provider feedback)<br>• System-wide Clinical Forums for mental health, community services and children and young people. | Evidence:<br>• Contract monitoring reports<br>• Oversight reports to NHSEI<br>• CQC Reports /focus groups | 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: |
|---|---|---|---|---|
| Sept 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 – ongoing, deadline moved to Sept 21 | Amber |
| Oct 21 | Implementation of Access Policy | ASenior | ongoing | |
| Dec 21 | Understanding the outputs of the demand and capacity modelling and feeding into the transformation programme | Director of MH | Agreed joint working approach between LLR and Northants system to undertake demand and capacity modelling | |

| | | | | | 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: | 06.08.21 | Risk Appetite / Target Risk | | | 12 |
| **Governance / Review:** | FPC / Board - Monthly Review | | | | | | |

| | | |
|---|---|---|
| **Controls** | Description: | • Executive senior information risk officer (SIRO) sponsorship<br>• Performance management framework (which includes the 6 dimensions of data quality)<br>• Performance review meetings include Directorate level metrics<br>• Data quality policy and procedure<br>• Annual benchmark reporting against peers<br>• Experienced subject matter experts in the corporate information team<br>• National guidance<br>• Electronic patient records (EPR)<br>• Dedicated resource which supports Directorate reporting requirements<br>• 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; data quality framework being developed through Data Quality Committee<br>• Insufficient monitoring of data quality incidents does not allow for learning opportunities<br>• Configuration of systems to support requirements of information standards and NHS data models<br>• Robust technical infrastructure to support timely and accessible use of data<br>• Ownership of data quality across the Trust – being picked up with support of Change Champion attendance at Data Quality Committee |

| | | | | |
|---|---|---|---|---|
| **Assurances** | Internal: | Source:<br>• FPC / Trust Board<br>• Clinical audit<br>• Annual record keeping audit<br>• Data security and protection toolkit self assessment<br>• Regular oversight reports from the IM&T Committee<br>• Data quality group included in updated Data Privacy TOR & alternate meetings focus on data quality. | Evidence:<br>• DSPT 'standards met' annual submission made in June 2021<br>• Data quality actions will be reported to FPC via Data Privacy Committee highlight reports<br>• Trust wide data quality group has agreed the data quality 21/22 work plan | Assurance Rating Amber |
| | External: | Source:<br>• Internal audit programme for data quality and reporting<br>• Internal audit review of our data security and protection toolkit (DSPT)<br>• External Account (quality account indicators) Not undertaken for 19/20 or 20/21<br>• Commissioner scrutiny | Evidence:<br>• Data quality framework 19/20 – Significant assurance rating over compliance with policy<br>• 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: |
| | Feb 22 | • Delivery of 21/22 data quality work plan, including trust wide ownership of data quality | SM | Ongoing |
| | Feb 22 | • New data quality kite mark approach is being developed | SM | Ongoing |
| | Feb 22 | • Review of system 1 data quality live issues in Data Quality Committee | SM | Discussion at 11/08/21 meeting |

| **Status:** |
|---|
| Assurance rating Amber |

| | | | | | Consequence | Likelihood | Combined |
|---|---|---|---|---|---|---|---|
| **Risk No: 40** | High Standards | Date Included on ORR | 27.05.20 | | | | |
| **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: | 03/08/2021 | 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 – 6 Monday to Friday, Weekends and Bank Holidays 9-5
- LPT Gold, Silver and Bronze chain of command with role specific cells to support the ICC
- ICC arrangements updated in readiness for third 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 3 - scenario planning exercise complete 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
- LPT Vaccination resource (Vaccination sites & FYPC Phase 3 delivery) impacting on the ability to staff non vaccination services (CHS) and each other

## Assurances

| | | | |
|---|---|---|---|
| **Internal:** | • Flash report by exception to Board<br>• Covid vaccination programme board established<br>• Communications structures to staff<br>• Maintenance of the action, risk and decision log (ICC)<br>• Daily National PPE SitReps<br>• Daily national NHSE/I patient related SitRep also provided to the LLR system<br>• Health Economy Tactical Coordinating Group (HETCG) SitRep (2 times a week)<br>• Daily staffing SitRep<br>• CEO sitrep<br>• Revised COVID19 governance arrangements from 4 December 2020<br>• Finalise clinical and operational governance structure to provide oversight | Evidence:<br>• Regular COVID staff briefing<br>• Monthly risk report to level one committees<br>• Situation Reports (SitReps) (CEO, Directorate, PPE etc)<br>• Regular staff and stakeholder briefings<br>• ICC decision log<br>• Ongoing consideration of interim governance arrangements at Exec Team<br>• Formalise duel COVID & Flu vaccination resource<br>• ICC Clinical Leads to provide operational oversight of vaccination resource across LPT | Assurance Rating Green |
| **External:** | • Department of health / Public Health England / NHSEI / COBR / Chief Medical Officer<br>• LLR system advice and planning / Joint CEO exec daily ( Mon-Fri) reporting structure<br>• Gov.uk COVID-19 information email alerts / National webinars<br>• Buddy relationship with NHFT | Evidence:<br>• Records of strategic gold coordinating group meetings<br>• Records of health economy SCG and TCG<br>• National intervention at the LLR Incident Management Team | Assurance Rating Green |
| **Gaps:** | | | |

| Date: | Actions: | Action Owner: | Progress: ongoing – deadlines moved to Sept to reflect ongoing work undertaken to mitigate | Status: |
|---|---|---|---|---|
| Sept 21 | • Workforce Bureau interviewing & continuation of on-boarding staff c 500 for LLR Vaccination Bank | SW | | Amber |
| Sept 21 | • Review escalation levels in light of recent increases of system infection rates and system pressures | MP | Escalation levels continue to be reviewed weekly in line with government guidance | |
| Sept 21 | • OPEL Level expansion and review to all operational directorates | MP | Revised OPEL Level definitions to be rolled out internally from mid-August | |

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|---|---|---|---|---|---|---|---|
| **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 | 4 | 2 | 8 |
| **Director risk owner:** | Director of Nursing, AHPs and Quality / Medical Director / Director of HR and OD | Date Last Reviewed: | 11.08.21 | Residual Risk | 4 | 2 | 8 |
| **Governance / Review** | SWC and QAC / Board - monthly review | | | Risk Appetite / Target | | | 8 |

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|---|---|---|---|---|
| **Controls** | Description: | • Group placements, pathways and use of technology<br>• Supervisors and assessors development training<br>• Participation in clinical expansion programme for AHPs led by Health Education England<br>• Regular LLR system wide groups including HEI partners<br>• AHP clinical placement capacity project<br>• Piloted new placement models and enhanced use of virtual placements.<br>• Triple R programme – project 2 for enabling remote and digital placements<br>• Provision of blended placement offers including pathway placement supervisors<br>• Development programme re-starting | | |
| | Gaps: | | | |
| **Assurances** | Internal: | Source:<br>Clinical Reference Group<br>Learning and OD Group<br>Medical Education Group<br>Multi Professional Education Team<br>Annual QAC Chair attendance at SWC | Evidence:<br>• Education and training weekly update to the CRG including figures<br>• Multi professional education lead quarterly reports to Learning and OD Group<br>• Weekly monitoring of Nursing and AHP placements at the Clinical Reference Group<br>• Annual report to Trust Board<br>• CRG and MEG reports to SWC<br>• SWC highlight report to QAC / Board | Assurance Rating Green |
| | External: | Source:<br>Health Education England Workforce Planning Groups<br>LLR People Board<br>LLR Placement Strategy Group<br>Health Education England<br>NMC / HCPC / GMC<br>University of Leicester | Evidence:<br>Nursing and AHP reporting Three times a year report to Health Education England<br>Medical reporting to UoL and Health Education England<br>LLR Placement Strategy Group reporting into LLR People Board<br>Health Education England fortnightly placement call | Assurance Rating Amber |
| | Gaps: | • LLR wide robust system for capturing, monitoring and tracking of placements across multiple providers.<br>• National directive around full time equivalent availability for students (currently opt in/out system for taking on students) | | |

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|---|---|---|---|---|
| **Actions** | Date:<br>Sept 21 | Actions<br>Widening the range of remote mentoring for Private Voluntary and Independent sector | Action Owner:<br>Elaine Curtin | Progress:<br>Action ongoing – moved to Sept 21 | Status:<br>Green |

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|---|---|---|---|---|---|---|---|
| **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: | 06.08.21 | Residual Risk | 5 | 2 | 10 |
| **Governance / Review:** | FPC / Board monthly | | | Risk Appetite / Target | | | 6 |

## Controls

**Description:**

- 2021/22 Quarter 1 & 2 financial arrangements rolled 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 priorities 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 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: | Assurance Rating |
|---|---|---|---|
| **Internal:** | • Finance and Performance Committee report includes I & E, cash & capital reporting<br>• Audit Committee<br>• Capital management committee review & agreement of capital bids & development of capital plan & in year management<br>• Transformation Committee oversight of CIPs, transformation & investments | • Formal I & E, cash & capital monitoring<br>• Standing Financial instructions<br>• Highlight report<br>• Monthly Director of Finance report<br>• Highlight report | Green |
| **External:** | • KPMG audit of 20/21 annual accounts and value for money conclusion<br>• Internal Audit Plan 2020/21: Integrity of the General Ledger and Financial Reporting Q3/4; Financial Systems Q3/4<br>• ICS Finance committee with Executive & Non Executive leads from each NHS LLR organisation | • 2020/21 annual accounts unqualified opinion<br>• Significant assurance IA opinions issued for financial systems 2020/21 | Green |
| **Gaps:** | | | |

## Actions

| Date: | Actions: | Action Owner: | Progress: | Status: |
|---|---|---|---|---|
| Aug 21 | Non recurrent activity backlog reserve bids submitted against system reserve | SM | | Green |
| Sept 21 | LPT Transformation committee oversight of H2 CIP, transformation & investment plans | SM | Regular reporting of H1 financial position and H2 plans to exec team, FPC , Trust Board & LLR forums | |
| Sept 21 | Development of LPT long term plan to address underlying position | SM | In progress | |
| Oct 21 | Finalise H2 operational & finance plans following planning guidance publication | SM | | |
| Nov 21 | Submit LLR & LPT H2 finance, activity, workforce & performance plans to NHSI | SM | | |

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|---|---|---|---|
| **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: | 11.08.21 |
| **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:<br>• Formal updates from system meetings to Executive meetings, Board sub-committees and Trust Board.<br>• Regular discussion at executive meetings and with senior leaders.<br>• Collaboratives for learning disabilities and mental health supported<br>• Updated review of Director responsibilities and mapped to key stakeholders in the ICS | Evidence:<br>• Minutes from Executive meetings, Board sub-committees, Trust Board and SLT meetings | Assurance Rating Green |
| **External:** | Source:<br>• System assessment against the ICS maturity matrix<br>• NHS E & I assessment of system maturity<br>• System meetings and system performance dashboards<br>• LLR Strategic Executive system meetings | Evidence:<br>• Joint shared document of our system assessment<br>• Agreed key priorities based on life courses<br>• Summary of NHS E/I assessment of the system<br>• Papers and minutes from system meetings<br>• Joint meetings with Local Authorities to plan for the ICS in place in addition to 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: |
|---|---|---|---|---|
| By Mar 22 | • Agree draft MOU and system ways of working<br>• Implement new ways of working to deliver an ICS from April 21 onwards, reviewing learning to inform future new ways of working<br>• Deliver greater partnership working between organisations which enable the provider alliance concept to be tested. | CEO, DCEO, DoF, DoS, DoN & MD<br><br>DCEO, Dir of MH & DoS | LPT is participating in system meetings and created a process for the internal development and review of the plan.<br><br>Community & primary care, Mental Health and Learning Disability services provide opportunities for new ways of working | Green |

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|---|---|---|---|
| **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: | 11.08.21 |
| **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
- Big Conversations held, themes agreed.
- Triple R comms plan in four tiers
- Project 1 recovery programme - blended working principles and healthy working day guidance agreed

**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: |
|---|---|---|---|---|
| Sept 21 | • Recruit PMO Programme Director | KB | Ongoing. Gemma Clayton Acting up to Head of PMO to support this gap. | Amber |
| Sept 21 | • Each Directorate to develop activity plans to address backlogs that have increased during the pandemic. LLR funding available. | CO | Ongoing | |