Risk No: 57	Date included	29 November 2021	Date revised	15/01/22
Objective: S	High Standards			
Risk Title:	The lack of an embedded clinical and quality governance infrastructure may result in insufficient or inconsistent application of systems and processes, resulting in poor quality care and patient harm.			
Risk owner:	Exec: Director of Nursing, AHPs and Quality and Medical Director	Local: Associate Director of AHPs and Quality		
Governance:	Quality Forum, QAC / Board - monthly review			

	Consequence	Likelihood	Combined
Current Risk	4	3	12
Residual Risk	4	2	8

Tolerance level Significant 16-20 (Appetite Quality-Seek)

Controls	Description:	• Policies and procedures in place for delivery against all CQC Registration and Health and Social Care act requirements (i.e. core standards) • Clinical and quality governance model - systems and processes • Corporate Governance structures (3-tiered model) • Clinical quality teams in place to support delivery against core standards – corporate and directorate		
	Gaps:	• Final implementation of clinical Quality Governance management of change • Integration and embeddedness of the model consistently across all clinical directorates		
Assurances	Internal:	Source • Quality Forum and QAC • SEB/OEB • DMTs	Evidence: • Monthly and Bi-Monthly oversight/escalation reports from level 3 committees. • SEB/OEB regular quality and safety agenda • DMTs – Regular quality reports to DMT	Assurance Rating Green
	External:	Source • CQC Inspection (2021) • Internal Audit	Evidence: • CQC identified weaknesses with local governance processes. • Management of Fixed Ligature Points – Split assurance	Assurance Rating Amber
	Gaps:	• Outstanding Internal audit reports • Weaknesses in local clinical governance processes identified by CQC • Consistency of DMT reporting – substance and regularity.		

	Date:	Actions:	Action Owner:	Progress:	Status
Actions	Mar 22	Embed revised clinical and quality governance infrastructure.	Associate Director of AHPs and Quality (DR)	• Management of change complete – recruitment to be finalised for CHS. Recruitment in progress.	Amber
	Mar 22	Delivery of CQC Must Do actions	DR	• CQC action plan in place and in delivery phase.	
	Jan 22	Develop year long programme for the review of current structures to ensure integration	DR	• Initial review initiated.	

Risk No: 58	Date included	29 November 2021	Date revised	12/01/22		Consequence	Likelihood	Combined
Objective: S	High Standards / Sub objective: Safeguarding and Public Protection				Current Risk	4	3	12
Risk Title:	Insufficient capacity and capability within the Safeguarding Team may result in restrictions and limitations on service provision, which may result in poor quality care and patient harm.				Residual Risk	4	2	8
Risk owner:	Exec: Director of Nursing, AHPs and Quality		Local: Head of Safeguarding		Tolerance level Significant 16-20 (Appetite Quality-Seek)			
Governance:	Safeguarding Committee / QAC / Board - Monthly Review							

Controls	Description	• Identified Safeguarding Lead Nurses & Practitioners -Child Lead, Adult Lead) and named Doctor for safeguarding children. • Member of four local Safeguarding Boards, two Community Safety Partnerships and the Safeguarding Vulnerabilities group. • Adult and Children's Safeguarding Team in place. • Advice line and use of incident reporting system to raise high priority safeguarding issues for specialist oversight by safeguarding team.		
	Gaps:	• The safeguarding training offer is not fully compliant with national standards and guidelines.		
Assurances	Internal:	Source: • Legislative Committee and Safeguarding Committee / QAC • Annual Quality Account. • The identified Safeguarding Lead Nurses access safeguarding supervision Annual Safeguarding Report.	Evidence: • Safeguarding report presented to Trust Board upon request and there are regular updates from the DoN to QAC/TB • Key Performance Indicators for the Legislative Committee and SG Committee • Progress and update reports regarding the external review action plan. • 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 Green
	External:	Source: • External review by quarterly SAT return to the CCG • CQC Inspection 2021 • CQC inspections (contribution to CCG Safeguarding Inspections /direct LPT CQC Inspection) • Commissioner meetings, including quarterly safeguarding assurance template (SAT) Membership of four Local Safeguarding Boards, including the Boards' respective sub-committees , i.e. Performance Group, Policy Group and Review Group • External review completed and report accepted by the Trust.	Evidence: • Findings of external review • CQC identified no major safeguarding concerns feedback from the CQC report published 10th November 2021. • Local Safeguarding Board reports and minutes	Assurance Rating Amber
	Gaps:	• Training figures		

Actions	Date:	Actions:	Action Owner:	Progress:	Status
	Ongoing Mar 22 Feb 22	• 2021 -2023 work programme to be implemented • Implement and embed recommendations from the external review. • Training capacity and offer to be reviewed	All - Safeguarding Dept	• Work programme approved safeguarding committee • Action from external review on track • The training offer reintroduces face to face training from January 2022. This is blended with e-learning.	Amber

Risk No: 59	Date included	29 November 2021	Date revised	17/01/22				
Objective: S	High Standards							
Risk Title:	As a result of the shortage of SI investigators, SI reports may not be timely, may be poor quality and may lack sufficient learning, which could lead to poor quality care and patient harm							
Risk owner:	Exec: Director of Nursing, AHPs and Quality and Operational Executive Directors		Local: Head of Patient Safety					
Governance:	IOG, Quality Forum, QAC / Board - Monthly Review							

	Consequence	Likelihood	Combined
Current Risk	4	4	16
Residual Risk	4	3	12

Tolerance level Significant 16-20 (Appetite Quality-Seek)

Controls	Description:	• Centralised SI reporting and oversight process • Incident reporting policy • Additional SI investigators recruited for newly reported SI's • Governance arrangements for escalation			
	Gaps:	• Directorate staff capacity for reviewing reported incidents and undertaking SI investigations from the backlog. See staffing vacancies risk 60 and the impact of covid on staffing risk 74. • Implementation of identified actions resulting from SI investigations			
Assurances	Internal:	Source: • Incident Oversight Group (IOG) • Quality Forum • Quality Assurance Committee • Incident Review Meeting (IRM) • Operational risk 4620 managed at IOG	Evidence: • Incident oversight Group – November 2021 highlight report limited assurance • Quality Forum - patient safety monthly report Nov 2021 – highlight report limited assurance • QAC – Quality Forum November 2021 – highlight report limited assurance • IRM to determine an SI		Assurance Rating Amber
	External:	Source: • CQC Inspection 2021 • CCG sign off and feedback for SI reporting	Evidence: • CQC feedback The trust must ensure that managers review incident in a timely way, in line with trust policy. (Reg17 (1)) • CCG – number of reports signed off / number returned for additional work		Assurance Rating Amber
	Gaps:	• Internal assurance / evidence to demonstrate learning			

Actions	Date: Feb 22 Jan 22 Ongoing	Actions: Quality Summit focussing on SI investigation process Delivery of CQC actions –must do 16 Incident investigation training monthly rolling programme	Owner: A.Scott F.Myers/ Michelle Churchard T.Ward	Progress: Planned 3 Feb 2022 CQC action plan agreed and monitored, see risk 60 Directorate training in place	Status Amber

Risk No: 60	Date included	29 November 2021	Date revised	06/01/22		Consequence	Likelihood	Combined
Objective: S	High Standards				Current Risk	4	4	16
Risk Title:	A high vacancy rate for registered nurses, AHPs, HCSWs and medical staff, is leading to high agency staff usage, which may result in poor quality care and patient harm.				Residual Risk	4	3	12
Risk owner:	Exec: Director of Nursing, AHPs and Quality		Local: Associate Director of Nursing and Professional Practice		Tolerance Level Significant 16-20 (Appetite People-Seek)			
Governance:	Quality Forum, SWC/QAC /Board - Monthly Review							

Controls	Description:	LPT controls • NHS Developing Workforce Safeguards standards incorporated into monthly staffing reviews • Directorate safe staffing SOPs in place for business continuity, escalation and management including deployment of bank and agency staffing • Dedicated workforce and safe staffing matron and an international recruitment matron • Trust retention and attraction schemes • LLR System and LWAB working together on system initiatives • Flexible working guidance launched • Home first - Aging well started / Community Service Redesign Aging well recruitment • International recruitment – 30 nurses recruited by end December 2021 with a second bid to recruit a further 48 IR nurses by March 2023 • eRoster – early winter planning and roster sign off	**System Controls in response to increased sickness levels due to covid (6 Jan 22)** • Each organisation has risk assessed staffing • Implemented escalation & mitigation plans • NHSE&I – winter assurance plans completed • Origination Accountable Officers Letter – about positive risk taking • NMC & Four Chief Nursing Officer letter to all registrants – acknowledging the current risks • System Workforce Cell • Workforce Sharing Agreement • Chief Nurses and Deputies regular communication • System escalation for Clinical Executive • System discussion and joint decision making prior to significant derogation from NQB staffing levels/ skill mix
	Gaps:	• National workforce shortages – particularly in LD, mental health and community nursing. • Workforce Planning capacity • Medical Consultant capacity in AMH/CAMHS • Trust wide Safe Staffing policy	
Assurances	Internal:	Source: Daily safe staffing huddle Winter Preparedness 2021 Nursing Safer Staffing BAF November 2021 National safe staffing return 6 monthly establishment reviews Monthly safe staffing reports to QAC/Trust Board Trust wide local induction checklist for bank and agency staff	Evidence: • Self-assessment complete 4 key themes to enhance assurance, action plan developed • 16 of each month date of last national submission • July 2021 date of last 6 monthly establishment review, submitted to QAC in July 2021, then Trust Board in August 2021 • Staffing report Oct/Nov. Highlight report from QAC significant assurance • Weekly situational and forecast staffing meeting – updates and actions to assurance to Director of Nursing
	External:	• The Department of Health and Social Care's group annual governance statement – NHSI • CQC Inspection 2021	• Noted in the organisational risk and monthly reporting.
	Gaps:		

Actions	Date:	Actions:	Action Owner:	Progress:	Status
	Jan 22	• Proposal for super enhancing recruitment and attraction campaign	John Edwards	Ongoing	Amber
	Jan 22	• All age MH standard recruitment to working planning capacity	Elaine Curtin	Policy drafted, under consultation	
	Jan 22	• To develop a Trust wide safe staffing policy	Louise Evans	Task and finish group set up	
	Jan 22	• Consideration of staff redeployment from low priority areas to support safe staffing	ICC		
	Mar 23	• Recruit additional 44 international nurses	Emma Wallis		

Risk No: 61	Date included	29 November 2021	Date revised	17/01/22		Consequence	Likelihood	Combined
Objective: S	High Standards and Equality, Leadership, Culture				Current Risk	4	4	16
Risk Title:	A lack of staff with appropriate skills will not be able to safely meet patient care needs, which may lead to poor patient outcomes and experience.				Residual Risk	4	3	12
Risk owner:	Exec: Director of Nursing, AHPs and Quality and Director of HR & OD		Local: Head of Education, Training and Development		Tolerance level Significant 16-20 (Appetite Quality-Seek)			
Governance:	SWC, QAC / Board - Monthly Review							

Controls	Description:	• Mandatory and Role Essential Training Policy, Study Leave Policy • National and local People Plan • Safer staffing policies and guidance • MHOST tool for review of patient acuity and dependency measurement • E rostering in place across inpatient services and community • Auto planner within CHS / E rostering in place across inpatient services and community • On-going recruitment programme		
	Gaps:	• National tools to measure therapy staffing for patient acuity and dependency • Low compliance to ILS and BLS mandatory training		
Assurances	Internal:	Source: • SWC , Directorate Workforce groups , retention working group • Quarterly workforce triangulation to ops exec - hotspots and action • Workforce and Wellbeing Board • Transformation committee • Hotspots identified on Directorate Risk Registers • Weekly safe staffing meeting	Evidence: • Mandatory Training and Role Essential Training Flash Report (December) • Noc trust board and SEB deep dive • Directorate risk registers received at DMTs • Quarterly triangulation document to Exec Team with action plan.	Assurance Rating Green
	External:	• NHS retention support and benchmarking data		Assurance Rating Green
	Gaps:			

Actions	Date:	Actions:	Action Owner:	Progress	Status
	Jan 22	1. New process for amending compliance requirements to position numbers	Head of Education Training/Dev	Since previous month -improvement seen in resus courses by 2-3%, drop in compliance with MAPA course by 2-3 %	Amber
	Jan 22	2. Remove 6 month topic refresher extension from 1st January		Overall Trust position for all mandatory topics (including e-learning) remains good	
	Jan 22	3. Recovery of Mandatory Training compliance action log reported to Training Education and Development Group monthly		Received at ops exec and actions underway	
	Dec 21	4. Manager compliance and DNA reports live on ulearn	Amrik Singh / Emma Wallis	Underway – current progress remains static – no change from last month (17/01/2022)	
	March 22	5. Pilot safe care and review establishment			
		6. Implementation of bespoke training days for Bank staff to complete BLS and mandatory training compliance	A Scott		
		7. Workstream as part of Deteriorating Workforce and Sepsis Group to progress and review training and compliance for ILS and BLS			
		8. Consideration of staff redeployment from low priority areas to support safe staffing	Emma Wallis		

Risk No: 62	Date included	29 November 2021	Date revised	6/01/22		Consequence	Likelihood	Combined
Objective: S	High Standards				Current Risk	4	3	12
Risk Title:	Insufficient understanding and oversight of regulatory standards and key lines of enquiry may result in non-compliance and/or insufficient improvement in priority areas, leading to sub-standard care.				Residual Risk	4	2	8
Risk owner:	Exec: Director of Nursing, AHPs and Quality		Local: Lead for Quality, Compliance and Regulation		Tolerance Level Moderate 9-11 (Appetite Regulation-Cautious)			
Governance:	Foundation for GPC, Quality Forum, QAC / Board - Monthly Review							

Controls	Description:	• Quality Improvement work programme / Quality accreditation • Foundation for Great Patient Care with KLOEs driving the agenda • Quality Surveillance Tracker • Core standards training / 3 phased methodology • Trust self-assessment for KLOE/Well Led framework • CQC inspection preparation checklist • Procedure for responding to a CQC Inspection • Time to Shine Booklet and Training • Well Led information pack		
	Gaps:	• Embedded clinical and quality governance framework to support directorate well led and KLOE improvement		
Assurances	Internal:	• Quality surveillance tracker • CQC action plan • Weekly CQC action plan assurance meeting • Foundation for great patient care / Quality forum / QAC / Trust Board • 15 Steps • Feedback from Focus Groups • Patient feedback	Evidence: • QST • CQC action plan	Assurance Rating Green
	External:	Source: • CQC Inspection 2021 • External Audit value for money conclusion 2020/21	Evidence: CQC overall rating Requires Improvement	Assurance Rating Amber
	Gaps:	06/01/22 The Trust is required to respond to the Covid-19 pandemic and escalated to level 4 restriction which may detrimentally impact on achieving the CQC must and should do action plan, in particular relation to: Attendance at required meetings Achieving training compliance Process of auditing against compliance Safe staffing of inpatient areas with increased staff incidence.		

Actions	Date: Multiple March 22	Actions: • Delivery of actions on the CQC action plan. Must and Should Do's • Redesign Foundation for Great Patient Care to ensure cross Trust learning of actions arising from the CQC action plan.	Action Owner: Deanne Rennie/Jane Howden	Progress: Date deferred to March 2022 due to required trust response to Covid-19 level 4 status	Status Amber

Risk No: 63	Date included	29 November 2021	Date revised	17/01/22			
Objective: S	High Standards and Equality, Leadership & Culture						
Risk Title:	Demand of winter pressures and covid on staff availability to attend mandatory training will lead to poor training compliance, which may lead to poor quality care.						
Risk owner:	Exec: Director of Nursing, AHPs and Quality and Director of HR & OD		Local: Head of Education, Training and Development				
Governance:	Foundation for GPC, Quality Forum, QAC / Board - Monthly Review						

	Consequence	Likelihood	Combined
Current Risk	4	3	12
Residual Risk	4	2	8

Tolerance Level Significant 16-20 (Appetite Quality-Seek)

Controls	Description:	• Policy for Mandatory and Role specific training • ULearn live reporting on compliance • Monthly flash reports • Weekly compliance reports • Increased trainer capacity • Rostering and deployment of staff			
	Gaps:	• Covid secure training spaces • Winter pressures • Covid having an impact on trainers capacity and attendees			
Assurances	Internal:	Source: Operational exec Training and education group ted QAC Safe staffing reports monthly Weekly staffing reviews DMT review in workforce meetings DMT have local action plans in place	Evidence: SWC spc charts November 2021 (amber assurance rating) Workforce Reports to DMTs monthly Flash reports weekly QAC performance report – November 2021 (amber assurance rating) workforce triangulation quarterly to Exec Team to consider hots spots with action plan		Assurance Rating Amber
	External:	Source:	Evidence:		Assurance Rating
	Gaps:				

Actions	Date: April 22	Actions: Implement Bank staff action to stop booking shifts until compliance is achieved	Owner Amrik Singh	Progress: Ongoing	Status Amber

Risk No: 64	Date included	29 November 2021	Date revised	17/01/22				
Objective: T	Transformation							
Risk Title:	If we do not retain existing and/or develop new business opportunities, we will have less financial sustainability and infrastructure resulting in a loss of income and influence within the LLR system.							
Risk owner:	Exec: Director of Strategy and Business Development			Local: Head of Strategy				
Governance:	Transformation Committee / FPC / Board - Monthly Review							

	Consequence	Likelihood	Combined
Current Risk	4	3	12
Residual Risk	3	3	9
Tolerance Level Moderate 9-11 (Appetite Financial-Cautious)			

Controls	Description:	• Engagement and support to LLR wide system strategy meetings, including ICB/ICP meetings, system executive meetings, local authority scrutiny and health and well-being board meetings. • A clear Step Up to Great Strategy (SUTG) developed and shared with stakeholders. The SUTG strategy sets out a 3 year vision and is supported by an annual operational delivery plan. This annual delivery plan enables a regular conversation with our stakeholders to understand our changing environments. • Engagement and support by LPT to the development of models of Integrated Care within LLR • Project development risk registers			
	Gaps:	• SUTG delivery plans			
Assurances	Internal:	Source: Transformation Committee Joint Working Group (JWG) of LPT & NHFT Executive, board meetings & board development sessions Finance and Performance Committee	Evidence: Transformation Committee will review progress of internal transformational priorities. JWG reviews progress on key joint priorities. Executive, Board meetings and development sessions include a focus on our strategic priorities and transformation. Evidence available in papers, agenda and minutes Business pipeline report		Assurance Rating Green
	External:	Source: Internal Audit HOIAO Feedback from NHS E/I Feedback from stakeholders (CQC, CCG/ICB & local authorities) Attendance at local authority scrutiny meetings	Evidence: Formal feedback from audit opinion, formal meetings and our stakeholder feedback.		Assurance Rating Green
	Gaps:	Further building of our work with voluntary and community organisations			

Actions	Date: Jan 22 Ongoing	Actions: SUTG delivery plans Regular attendance at ICS Board meetings, transition and steering groups	Owner: David Williams Chair & CEO	Progress: In draft – delayed to Jan due to covid Achieving (this action will be on-going)	Status Green

Risk No: 65	Date included	29 November 2021	Date revised	17/01/22			
Objective: E	Environments						
Risk Title:	The present FM provision does not meet our quality standards or requirements, leading to the inability to provide effective hard and soft Facilities Management and maintenance services. This impacts compliance, timeliness of maintenance responses and quality of estates provision for patients, staff and visitors.						
Risk owner:	Exec: Chief Finance Officer		Local: Associate Director Estates & Facilities				
Governance:	Estates Committee, FPC / Board - Monthly Review						

	Consequence	Likelihood	Combined
Current Risk	4	4	16
Residual Risk	4	3	12

Tolerance Level Significant 16-20 (Appetite Quality-Seek)

Controls	Description:	• FM Business Case approved by the Board • Legal Exit Agreement in progress • FM Transformation Programme compliance and business case capacity through external contract • Relentless focus on driving up standards, with governance through EMEC • Increased property manager capacity to work with Operational teams on estates management • Compliance manager in post to oversee the data provided by contractors and escalate high risk areas requiring maintenance		
	Gaps:	• Exit legal agreement and staff engagement sessions via UHL as employer • Data on compliance has been very slow to be provided through our contract • Lack of supplier ownership and proactive management of estates risks • Poor KPIs performance with maintenance and repairs are not always undertaken in a timely manner		
Assurances	Internal:	Source: FM Oversight Group FM Transformation Board Estates and Medical Equipment Committee FPC Estates risk register	Evidence: • Provider service review meetings • Ongoing review of audit actions • Monthly estates updates including health and safety reviews • FPC estates updates	Assurance Rating Green
	External:	Source: • CQC inspection 2021	Evidence: • CQC report	Assurance Rating Amber
	Gaps:	• Unable to obtain detailed report and assurance over planned preventative maintenance leaving the Trust unable to apply suitable mitigations • Joint staff communications and engagement to support TUPE		

Actions	Date: Jan 22	Actions: • Exit agreement to be agreed and staff engagement/ TUPE sessions jointly planned.	Action Owner: Richard Wheeler	Progress: In progress	Status: Amber

Risk No: 66	Date included	29 November 2021	Date revised	17/01/22			
Objective: E	Environments						
Risk Title:	The lack of detail around accommodation requirements in strategic business planning, means that the Estates Strategy cannot adequately plan for potential building solutions, leading to an estate configuration which is not fit to deliver high quality healthcare.						
Risk owner:	Exec: Chief Finance Officer		Local: Associate Director Estates & Facilities				
Governance:	Estates Committee, FPC / Board - Monthly Review						

	Consequence	Likelihood	Combined
Current Risk	4	3	12
Residual Risk	4	2	8

Tolerance level Significant 16-20 (Appetite Quality-Seek)

Controls	Description:	• Approved Strategic plan for the elimination of dormitory accommodation • New Hospitals Programme (NHP) Expression of Interest submitted • Refresh of Mental Health inpatient Strategic Outline Case and bed modelling • Tripe R outputs • Estates Strategy refresh in progress • Capital resource prioritisation framework • Refreshed SUTG strategy 2021		
	Gaps:	• Clarity on clinical model changes and mental health expansion estates impact • Finalised estates strategy and delivery plan • Directorate and enabling business plans		
Assurances	Internal:	Source: • Strategic Property Group • Estates and Medical Equipment Committee • Finance and Performance Committee • Health and Safety Committee. Directorate Health and Safety Action Groups	Evidence: • Reports to EMEC • Consideration of estates strategy with directorates • Monthly report to FPC on progress against the Estate Strategy • Health and Safety Reports and confirmation of compliance	Assurance Rating Amber
	External:	Source: • CQC Inspection 2021 • Consideration of NHP expression of interest	Evidence: • CQC report • NHSEI	Assurance Rating Amber
	Gaps:			

Actions	Date: Ongoing Jan 22	Actions: • Implementation of Dormitory Eradication programme. • Estates delivery plan	Action Owner: Richard Brown Richard Brown	Progress: • Complex project - remains on plan • In draft	Status Amber

Risk No: 67	Date included	29 November 2021	Date revised	17/01/22			
Objective: E	Environments						
Risk Title:	The Trust does not have a Green Plan or identified resource for the green agenda, leading to non-compliance with the NHS commitment to NHS Carbon Zero.						
Risk owner:	Exec: Chief Finance Officer		Local: Chief Finance Officer				
Governance:	Estates Committee, FPC / Board - Monthly Review						

	Consequence	Likelihood	Combined
Current Risk	3	4	12
Residual Risk	3	3	9
Tolerance Level Moderate 9-11 (Appetite Regulation-Cautious)			

Controls	Description:	• Chief Finance Officer asked to take the Executive lead in November 2021. • Self assessment undertaken on the Green Plan requirements. • Consideration of the requirements and self assessment through Board Development and Strategic Executive Board sessions • Chapter provisional leads identified • LLR Greener NHS Board authentic representation of the position and request for support made • Job Descriptions drafted for Head of Sustainability, and Sustainability Manager (potential secondment/development role)
	Gaps:	• Lack of data on carbon footprint • Lack of historic Sustainable Development Management Plan • Corporate Social Responsibility Strategy 2016 – 2021 not implemented • Chapter leads to be confirmed • Job Descriptions awaiting banding and funding approval • 100% renewable energy to be purchased from 1 April 2021, work is in progress to move over to this.

Assurances	Internal:	Source:	Evidence:	Assurance Rating
	External:	Source: Request to LLR Greener Board for support Work to share across the Group with NHFT knowledge and experience on sustainability	Evidence: Greener Board – November 2021 Committees in Common – November 2021	Assurance Rating
	Gaps:			

	Date:	Actions:	Owner:	Progress:	Status
Actions	Jan 22	Funding approval for sustainability posts	RW	Currently with banding panel – delayed due to staffing pressures. Estimated January 2022 and remains under review	Amber
	Mar 22	Outline chapters drafted and shared with provisional chapter leads	RW	CFO taking the lead on research to support draft chapters	
	Jan 22	Consideration of PMO support	RW	Support to establish a structure programme across estates	
	Jan 22	Draft Green Plan produced for Board	RW	Drafted	

Risk No: 68	Date included	29 November 2021	Date revised	12/01/22		Consequence	Likelihood	Combined
Objective: G	Well Governed				Current Risk	4	4	16
Risk Title:	A lack of accessibility and reliability of data reporting and analysis will impact on the Trust's ability to use information for decision making, which may impact on the quality of care provided.				Residual Risk	4	3	12
Risk owner:	Exec: Director of Finance & Performance		Local: Head of Information		Tolerance Level Moderate 9-11 (Appetite Regulatory-Cautious)			
Governance:	FPC / Board - Monthly Review							

Controls	Description:	• Executive senior information risk officer (SIRO) sponsorship • Information asset owners in place • Clinical system training in place • Performance management framework (which includes the 6 dimensions of data quality) • Data quality policy and procedure		
	Gaps:	• Incomplete data quality reports for local and national data sets; data quality framework being developed through Data Quality Committee • 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 – being picked up with support of Change Champion attendance at Data Quality Committee • Capacity of the information team due to demands from national sitrep reporting, changes to information team members		
Assurances	Internal:	Source: • Performance review meetings include Directorate level metrics • FPC / Trust Board • Clinical audit • Annual record keeping audit • Data security and protection toolkit self assessment • Regular oversight reports from the IM&T Committee • Data quality committee • Local Risk register	Evidence: • DSPT 'standards met' annual submission made in June 2021 • Data quality action reported to FPC via Data Privacy Committee highlight report – assurance rating Green (November) - Local risks reviewed in Data Quality Committee	Assurance Rating Green
	External:	Source: • Annual benchmark reporting against peers • Internal audit programme for data quality and reporting • Internal audit review of our data security and protection toolkit (DSPT) • Commissioner scrutiny	Evidence: • Data quality framework 21/22 audit due Q4 • DSPT 21/22 audit due Q1 2022/23 (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 • External Account (quality account indicators) Not undertaken for 19/20 or 20/21		

	Date:	Actions:	Action Owner:	Progress:	Status
Actions	Feb 22	• Delivery of 21/22 data quality work plan, including trust wide ownership of data quality	SM	On track	Amber
	Feb 22	• New data quality kite mark implementation	SM	On track	
	Feb 22	• Review of system 1 data quality live issues in Data Quality Committee	SM	On track	
	Apr 22	• External audit of quality accounts	SM	24/12/21Reducing the burden letter stated external audit of quality accounts not required for 21/22	

Risk No: 69	Date included	29 November 2021	Date revised	12/01/22		Consequence	Likelihood	Combined
Objective: G	Well Governed				Current Risk	4	2	8
Risk Title:	If we do not appropriately manage performance, it will impact on the Trust's ability to effectively deliver services, which could lead to poor quality care and poor patient experience.				Residual Risk	4	1	4
Risk owner:	Exec: Director of Finance & Performance		Local: Director of Finance & Performance		Tolerance Level Moderate 9-11 (Appetite Regulatory-Cautious)			
Governance:	FPC / Board - Monthly Review							

Controls	Description:	• Board approved Performance management framework • Board level performance dashboard • Revised governance framework • SUTG plan • SOP in place		
	Gaps:	• 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 / Trust Board reports • Bi monthly Performance review meetings • Simplified, directorate owned, board reporting and an agreed set of 2021/22 KPIs for the Board	Evidence: • Routine performance reporting with committee dashboards to FPC / QAC /Board – assurance rating amber (November) • Actions & risks from performance reviews reported to Board • Performance reports narrative updated by Directorate Business Managers prior to release.	Assurance Rating Amber
	External:	Source: • CQC inspection 2021 • External and internal audit	Evidence: • Internal audit review of performance framework being undertaken Q3 21/22.	Assurance Rating Green
	Gaps:	• Fully embedded system (demonstrated once level 2 dashboards are fully implemented) • Trust wide approach to reporting planned post covid performance & capacity		

	Date:	Actions:	Action Owner:	Progress:	Status
Actions	Feb 22	• Revised Board performance report implementation	SM	Report delayed due to technical issue with SPC chart reporting	Amber
	Feb 22	• Consider ORR links to performance report	SM/KD	Revised date of February 2022 for the ORR links to the performance report, to be led by the new Risk and	
	Jan 22	• Review of Information Team capacity & delivery model	SM	Assurance Lead now in post.	
	Apr 22	• Quality accounts reporting & management of actions	SM	Options paper going to OEB 21/01/22 21/12/21 Reducing the burden letter stated external audit of quality accounts not required for 21/22	

Risk No: 70	Date included	29 November 2021	Date revised	12/01/22
Objective: G	Well Governed			
Risk Title:	Inadequate control, reporting and management of the Trust's 2021/22 financial position could mean we are unable to deliver our financial plan and adequately contribute to the LLR system plan, resulting in a breach of LPT's statutory duties and financial strategy (including LLR strategy).			
Risk owner:	Exec: Director of Finance & Performance		Local: Deputy Director of Finance	
Governance:	FPC / Board monthly			

	Consequence	Likelihood	Combined
Current Risk	5	3	15
Residual Risk	5	2	10
Tolerance Level Moderate 9-11 (Appetite Financial-Cautious)			

Controls	Description:	• National H2 planning guidance • LPT Financial & Operational Plan • Standing Financial Instructions • Treasury management policy , cash flow forecasting • Capital Financing strategy & plan • LPT & LLR Financial strategy		
	Gaps:	• Culture change required across system partners, particularly for UHL to move away from PBR funding model		
Assurances	Internal:	Source: • Audit Committee • Operational oversight & management of cost forecasts through Directorate Management Teams • Capital Management Committee's oversight of capital delivery and agreed governance processes; • Finance and Performance Committee report includes I & E, cash & capital reporting	Evidence: • Reports & updates from Internal & external auditors • Monthly Director of Finance report to FPC / Trust Board – highlight report assurance rating Green (November)	Assurance Rating Green
	External:	Source: • KPMG audit of 20/21 annual accounts and value for money conclusion • Internal Audit Report 2021/22: Key financial systems • Internal Audit Report 2021/22: Integrity of the general ledger and financial reporting • Internal Audit Report 2021/22: Capital expenditure processes	Evidence: • 2020/21 annual accounts unqualified opinion • Significant assurance • Report due Q4 • Report due Q4	Assurance Rating Green
	Gaps:			

Actions	Date:	Actions:	Action Owner:	Progress:	Status
	Mar 22	Ongoing oversight and management of all aspects of financial position against plans	SM	On track	Green
	Mar 22	Monthly reports to OEB/SEB/FPC/Board/ICS finance committee on all aspects of delivery against plan	SM	On track	
	Mar 22	Mitigation plans for capital and revenue to ensure plans are delivered	SM	On track	

Risk No: 71	Date included	29 November 2021	Date revised	12/01/22				
Objective: G	Well Governed							
Risk Title:	If we do not have a sufficiently detailed financial plan for 2022/23, the Trust will not have clarity over the actions required to deliver the plan, resulting in a plan which is not fit for purpose for the Trust or LLR.							
Risk owner:	Exec: Director of Finance & Performance		Local: Deputy Director of Finance					
Governance:	FPC / Board monthly							

	Consequence	Likelihood	Combined
Current Risk	5	3	15
Residual Risk	5	2	10

Tolerance Level Moderate 9-11 (Appetite Financial-Cautious)

Controls	Description:	• LPT & LLR system 4-year financial strategy defines plan deliverables • LPT Financial & Operational Planning process supports plan development • H1 & H2 financial plan forecasts a breakeven position for LPT & LLR system, ensuring solid foundations for 22/23 planning • Agreed prioritisation criteria for internal investments • LLR Triple lock process for system funded investments • Transformation Committee oversight of efficiency plan development • Capital Management Committee develops the capital plan with input from key estates & I, M & T leads & prioritises schemes against agreed criteria • Standing Financial instructions underpin planning approach			
	Gaps:	• System wide approach to financial planning & in year management is new & untested • Trust's transformation & value approach to identifying efficiencies is new • LLR Design groups ability to identify & deliver sufficient savings • No long covid or post covid MH changes to demand are included in current plans • Culture change required across system partners, particularly for UHL to move away from PBR funding model • LLR capital strategy not yet defined			
Assurances	Internal:	Source: • Plan reports for committees includes I & E, cash, efficiency & capital plans to deliver against NHSI guidance , statutory requirements and the LPT & LLR financial strategy		Evidence: • Draft plans will be presented to OEB, SEB, FPC & Trust Board December – April • Efficiency plans continue to be presented to Transformation Committee • Final Trust board plan sign off target date 19/04/22	Assurance Rating Green
	External:	Source: • ICS Finance committee with Executive & Non-Executive leads from each NHS LLR organisation • ICB sign off of ICS financial plan • NHSI acceptance of submitted plan		Evidence: Highlight report presented to ICB Minutes of meeting	Assurance Green
	Gaps:				

	Date:	Actions:	Action Owner:	Progress:	Status
Actions	Mar22	Develop 22/23 operational & finance plans following planning guidance			Green
		Trust Board approval of 2022/23 plans	SM	On track	
	Apr 22	Submit LPT finance, activity, workforce & performance plans to ICS/NHSI	SM		
	TBC		CP	On track	

Risk No: 72	Date included	29 November 2021	Date revised	17/01/22
Objective: R	Reaching Out			
Risk Title:	If we do not have the capacity and commitment to proactively reach out, we will not fully address health inequalities which will impact on outcomes within our community.			
Risk owner:	Exec: Director of Strategy and Business Development		Local: Head of Strategy	
Governance:	Transformation Committee / FPC bi-monthly / Board Quarterly			

	Consequence	Likelihood	Combined
Current Risk	4	4	16
Residual Risk	4	3	12
Tolerance Level Significant 16-20 (Appetite Quality-Seek)			

Controls	Description:	• We are supporting our most vulnerable in society; raising health equity across LLR, through attendance at LLR Health inequalities meetings. • Our people plan and our system people plan supports a sustainable local community in LLR, through the development of our workforce and the support to staff and the development of new roles. • We are seeking to positively support environmental, economic & regeneration improvements, policies and practices in LLR
	Gaps:	• Publication of the LPT response to the NHS Green plan • The development of our own information and data to address inequalities • Internal capacity to deliver and transform our planned change

Assurances	Internal:	Source: Transformation Committee Joint Working Group (JWG) of LPT & NHFT Executive, board meetings & board development sessions	Evidence: Transformation Committee will review progress of internal transformational priorities. JWG reviews progress on key joint priorities. Executive, Board meetings and development sessions include a focus on our strategic priorities and transformation. Evidence available in papers, agenda and minutes	Assurance Rating: Green
	External:	Source: Internal Audit HOIAO Feedback from NHS E/I Feedback from stakeholders (CQC, CCG/ICB & local authorities) Attendance at local authority scrutiny meetings	Evidence: Formal feedback from audit opinion, formal meetings and our stakeholder feedback.	Assurance Rating: Green
	Gaps:	Calculating the impact/value of the reaching out programme to LPT and to our communities.		

	Date:	Actions:	Owner:	Progress:	Status
Actions	Jan 22	Reaching out delivery plan as part of the Step Up to Great (SUTG) strategy and plan	David Williams	In draft	Amber
	Ongoing	Regular attendance at system meetings	Chair & CEO	Achieving (this action will be on-going)	
	Mar 22	Further agreement on our approach and calculating impact and value	David Williams	To be developed once the SUTG delivery plan completed	

Risk No: 73	Date included	29 November 2021	Date revised	14/01/2022		Consequence	Likelihood	Combined
Objective: E	Equality, Leadership, Culture				Current Risk	3	4	12
Risk Title:	If we don't create an inclusive culture, it will affect staff and patient experience, which may lead to poorer quality and safety outcomes.				Residual Risk	3	3	9
Risk owner:	Exec: Director of HR & OD		Local: Head of Equality, Diversity and Inclusion		Tolerance Level Significant 16-20 (Appetite People - Seek)			
Governance:	SWC, QAC / Board - Monthly Review							

Controls	Description:	• 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. • We Nurture OD sessions for staff • Reverse mentoring. Second cohort complete. • National and LPT People Plan • WRES action plan • WDES action plan		
	Gaps:	• Improved delivery against outcome measures / WRES and diversity metrics • Embeddedness of WRES/ WDES/ Together Against Racism action plan/ NHSEI high impact actions		
Assurances	Internal:	• Diversity workforce dashboard • Trust board equalities report • Annual Equalities Action Plan • Staff survey results	• EDI Bi-annual report to EDI committee / EDI group • WRES/WDES DATA published action plan to QAC/SWC – highlight report assurance ratings? • Staff survey report Trust Board – results	Assurance Rating Green
	External ..	Source: • System wide EDI Taskforce established and identified seven priority areas for implementation	Evidence: • EDI Taskforce – highlight report assurance rating • CQC feedback	Assurance Rating Green
	Gaps:			

Actions	Date: Mar 22 Mar 22 Mar 22	Actions: • Development of EDI strategy • Embed Together Against Racism actions • Delivery of the WRES action plan and six high impact Race Equality Actions.	Owner: Haseeb Ahmed	Progress: • Ongoing • Ongoing • Ongoing	Status Amber

Risk No: 74	Date included	29 November 2021	Date revised	17/01/22		Consequence	Likelihood	Combined
Objective: E	Equality, Leadership, Culture				Current Risk	3	3	9
Risk Title:	As a result of covid 19, winter pressure, service recovery and workforce restoration there is a risk that our staff's health and wellbeing will be compromised, leading to increased sickness levels.				Residual Risk	3	2	6
Risk owner:	Exec: Director of HR & OD		Local: Deputy Director of HR and OD		Tolerance Level Significant 16-20 (Appetite People - Seek)			
Governance:	SWC, QAC / Board - Monthly Review							

Controls	Description:	• Wellbeing, sickness management policy • Counselling service • Anti bullying harassment and advice service • Staff Physiotherapy scheme • Health and wellbeing champions • Leadership Behaviours Framework • NHS People Plan national support • Staff risk assessments / stress indicator • System mental health HWB hub • Mental health and Wellbeing Hub • Occupational health service wellbeing strategy and implementation plan • Occupational health department / Staff reps / Amica		
	Gaps:			
Assurances	Internal:	• Daily Sickness absence monitoring • Sickness and workforce reports (including performance) to SWC / QAC • Sickness reviews within divisions • Staff side – monthly meetings • Referrals to Amica • Workforce and wellbeing group	Evidence: • Sickness absence rate • SWC highlight report – assurance rating amber due to sickness levels • Staff side – feedback • Referral rate for Amica • Workforce and wellbeing group assurance rating	Assurance Rating Amber
	External	Source: • NHSI reporting	Evidence: • NHSI benchmarking reports • Attendance at external NHSI wellbeing workshops • MHWB hub data	Assurance Rating Green
	Gaps:			

Actions	Date: Ongoing	Actions: • Delivery of the Health and Wellbeing Action Plan	Action Owner: Kathryn Burt	Progress: Progressing	Status: Amber

Risk No: 75	Date included	29 November 2021	Date revised	12/01/22
Objective: A	Access to Services			
Risk Title:	Increasing numbers of patients on waiting lists and increasing lengths of delay in accessing services will mean that patients may not be able to access the right care at the right time and may lead to poor experience and harm.			
Risk owner:	Exec: Medical Director		Local: Operational Executive Directors	
Governance:	Waiting List and Harm Prevention Committee, FPC and QAC / Board - Monthly Review			

	Consequence	Likelihood	Combined
Current Risk	4	4	16
Residual Risk	4	2	8

Tolerance Level Significant 16-20 (Appetite Quality-Seek)

Controls	Description:	• Access Policy • Waiting list management approaches and Standardised Operational Processes applied to waiting lists in all services including waiting list validation, patient tracking lists, demand capacity modelling . Trajectories in place to plot performance of waiting times improvement in prioritised services. • Service pathway re-design including measures as part of the Step up to Great MH transformation programme • System planning (design groups) established to manage patient flow and investment • NHSI demand and capacity management training • 21/22 priorities agreed and H1 and H2 plan in place • Triple R programme in place / service recovery plans • Approaches in services to reduce risk of harm while waiting by supporting service users with appropriate information • Covid sensitive trajectories for waiting time improvement of priority services – includes CYP ED as a prioritised service within FYPC • Headroom additional funding received for 2021/22 to increase resource for challenged WL services
	Gaps:	• QIA Policy • 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 • EM demand and capacity modelling limited to MH

Assurances	Internal:	Source: • Strategic waiting times and harm review committee • Directorate level performance and accountability reviews • Waiting time performance reported to Finance and Performance Committee • Spot checks of safety of patients waiting • Directorate risks including risk 4677 for CYP ED	Evidence: • Performance dashboards and reporting to DMTs , OEB and Trusts Board • Trajectory for improvement and measurement against trajectory • Transformation plans • Report to triangulate evidence of harm with Trust wide data from Patient Safety and Patient Experience	Assurance Rating Green
	External:	Source: • CQC inspection 2021 • System performance monitoring • NHSI Regional Escalation oversight • National benchmarking data • Quality / Contract Monitoring with CCG & Specialised Commissioning with escalation route	Evidence: • CQC inspection 2021 action plan	Assurance Rating Amber
	Gaps:			

Actions	Date:	Actions:	Owner:	Progress:	Status
	Jan 22	Understanding the outputs of the demand and capacity modelling and feeding into the transformation programme	Director of MH AS/AvH	East Midlands MH alliance working with NHSEI to develop MH capacity planning model – moved for an update in Jan 22 Agreed joint working approach between LLR and Northants system to undertake demand and capacity modelling	Amber
	Jan 22	Consideration of avoidable harm measures including impact of partial or full COVID related closures		Actively considered and covered in regular reports – to review for closure in Jan 22	

Risk No: 76	Date included	December 2021	Date revised	17/01/22			
Objective: S	High Standards						
Risk Title:	As a result of the introduction of vaccination as a condition of deployment (VCOD), any staff who have not had two doses of covid vaccine by 1 April 2022 will no longer be able to work in roles involving patient contact. This may cause staffing challenges which could impact on patient safety and staff morale/wellbeing.						
Risk owner:	Exec: Director of Nursing, AHPs and Quality and Director of HR and OD		Local: ICC and Staff Vaccination lead and Deputy Director of HR/OD				
Governance:	SWC / QAC / Board - Monthly Review						

	Consequence	Likelihood	Combined
Current Risk	5	4	20
Residual Risk	5	3	15
Tolerance Level Significant 16-20 (Appetite Quality - Seek)			

Controls	Description:	• Trust and System Covid vaccination programme established with all staff supported to have vaccine. • Weekly vaccination Sitreps for reporting on performance and identifying improvement. • Designated staff clinical vaccination lead • NHSE guidance 'Vaccination as a condition of deployment for healthcare workers: phase one planning and preparation' 6/12/21 • Regulations passed through Parliament and into law on 6 January 2022 • NHSE guidance 'VCOD phase two – implementation' 14/1/2022 • VCOD task and finish group • LPT Strategic Flu and Covid Vaccination Strategic Board • Weekly LLR Workforce Cell meeting • FAQs		
	Gaps:	• Some ongoing work to confirm roles in and out of scope • Some ongoing work around validation of data		
Assurances	Internal:	Source: Mandatory Covid Vaccination Task and Finish Group Strategic Flu and Covid Trust Group.	Notes and actions from T&F Group – now supported by Trust's PMO Directorate reports for ICC twice weekly focused on business continuity and risk Twice Weekly Sitrep report (Monday and Wednesday) Highlight report from Strategic Flu and Covid Trust Group Assurance - Moderate Assurance	Assurance Rating Amber
	External:	Source: LLR System Vaccination Operation Centre NHS Midlands Data	Evidence: Midlands Flu and Covid weekly report summary Weekly Moderate Assurance VCOD reporting to commence shortly	Assurance Rating Amber
	Gaps:			

Actions	Date:	Actions:	Action Owner:	Progress:
	Jan 22	1. Directorates to be supported with resources and training to increase capability to undertake vaccine confidence conversations.	SC/KBa	Guidance issued to assist managers in holding supportive conversations. Available on staffnet. Inbox also set up for queries
	Jan 22	2. Drop in events to be held for staff / managers	Kbu/KBa	Events held on 21 December and 17 January
	Jan 22	3. Directorates to revisit which roles are in and out of scope	Ops leads	Initial work done – being revisited in light of updated guidance
	Jan 22	4. Letter to be sent to staff to support uptake and validation of data.	Kbu	Initial letter sent in January – further letter to be sent by 20 Jan 21
	Dec 21	5. FAQs to be finalised	Kbu	Action completed although regularly updated
	Jan 22	6. Policy and template letters to be finalised	Kbu	
	Jan 22	7. Clear timeline for next steps in HR process post 4 Feb to be determined	KBu	

Status: Amber

Risk No: 77	Date included	1 December 2021	Date revised	17/01/22		Consequence	Likelihood	Combined
Objective: G	Well Governed				Current Risk	4	3	12
Risk Title:	Without the appropriate level of focus, resource and preparation, the Trust cannot adequately support the National Public Inquiry into the Covid Pandemic, leading to a lack of lessons learned, inability to respond effectively to future situations and major incidents, a failure to comply with the Public Inquiry statute and reputational damage.				Residual Risk	4	2	8
Risk owner:	Exec: Deputy Chief Executive		Local: Deputy Director of Governance and Risk		**Tolerance** level Moderate 9-11 (Appetite Reputational–Cautious)			
Governance:	Public Inquiry Programme Board / SEB / Trust Board - monthly review							

Controls	Description:	• LPT Public Inquiry Project Board and Joint Programme Board with NHFT feeding into the Trust Board • Joint Lead for the Public Inquiry with NHFT • Local Lead and interim project lead appointed		
	Gaps:	• Public Inquiry Programme and Project Board paused under the interim governance arrangements – subject to review in Feb 22 • National Public Inquiry Terms of Reference • Local strategy for the National Public Inquiry		
Assurances	Internal:	Source • SEB • Joint Public Inquiry Programme Board • LPT Project Board	Evidence: Highlight reports from the LPT Project board to SEB (last dated 3 December 2021) Amber Assurance	Assurance Rating Amber
	External:	Source	Evidence:	Assurance Rating
	Gaps:			

Actions	Date: Mar 22 Apr 22	Actions: Development of a local strategy. Implementation of the Public Inquiry IM&T strategy	Action Owner: Sandra Mellors /Kate Dyer SM/KD	Progress: Paused. In draft – paused