Risk No: 57	Date included	29 November 2021	Date revised	15/07/2022
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	2	8
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 • Quality Schedule • Revised clinical and quality governance infrastructure – recruitment complete
	Gaps:	• Embeddedness of the infrastructure consistently across all 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:	• Consistency of DMT reporting – substance and regularity.		

Actions	Date: TBC	Actions: Implementation of the Foundation 4 High Standards programme	Action Owner: DR	Progress: • Ongoing programme – no end date. Implementation in progress

Status: Green

Risk No: 58	Date included	29 November 2021	Date revised	18/07/2022		Consequence	Likelihood	Combined
Objective: S	High Standards				Current Risk	4	3	12
Risk Title:	Insufficient Safeguarding competency may result in 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 local Safeguarding Boards, two Community Safety Partnerships and the Safeguarding Vulnerabilities group. • Adult and Children's Safeguarding Team • Advice line and use of incident reporting system to raise high priority safeguarding issues for specialist oversight by safeguarding team. • Policies and procedures in place		
	Gaps:	• The safeguarding training offer is not fully compliant with national standards and guidelines. • Implementation and embeddedness of the recommendations from the external review and quality improvement plan • Staff skill and knowledge re MCA including Liberty Protection Safeguards • Poor uptake of Bank Staff attending safeguarding suite of training provides a risk of poor quality of care and safety to the patients requiring safeguarding.		
Assurances	Internal:	Source: • Legislative Committee and Safeguarding Committee • Collaborative Safeguarding Report • Mandatory Training Compliance Report • Safeguarding Team training needs analysis • Safeguarding, Public Protection & MCA Report – April 2022	Evidence:	Assurance Rating Amber
	External:	Source: • Internal Audit – Liberty Protection Safeguards (Advisory 2022/23) • External review by quarterly SCAT 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 (SCAT) Membership of four Local Safeguarding Boards, including the Boards' respective sub-committees ,	Evidence: • CQC identified no major safeguarding concerns feedback from the CQC report published 10th November 2021. • Local Safeguarding Board reports and minutes	Assurance Rating Green
	Gaps:			

Actions	Date:	• Actions:	Action Owner:	Progress:	Status
	July 22	• Safeguarding adult training compliance with national standards	All - Safeguarding Dept		Amber
	July 22	• Quality Improvement Plan			
	July 22	• Implement and embed recommendations from the external review.			
	July 22	• Accuracy of training programme			
	July 22	• Training programme to be delivered from June 22			
	Aug 22	• Board Safeguarding training			

Risk No: 59	Date included	29 November 2021	Date revised	15/07/2022		Consequence	Likelihood	Combined
Objective: S	High Standards				Current Risk	4	4	16
Risk Title:	Lack of staff capacity is causing delays in the incident management process, including the review and closure of a backlog of reported incidents, the investigation and report writing of SIs and the closure of resulting actions. This will result in delays in learning and could lead to poor quality care and patient harm as well as reputational damage.				Residual Risk	4	3	12
Risk owner:	Exec: Director of Nursing, AHPs and Quality and Operational Executive Directors		Local: Head of Patient Safety		Tolerance level Significant 16-20 (Appetite Quality-Seek)			
Governance:	IOG, Quality Forum, QAC / Board - Monthly Review							

Controls	Description:	• Centralised SI reporting and oversight process • Incident reporting policy • Additional SI investigators recruited for newly reported SI's • Governance arrangements for escalation • Incident investigation training monthly rolling programme		
	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 • Oversight of performance • Reports/ minutes from Incident Oversight Group and Quality Forum • Quality Summit March 2022 • Monthly Quality Monitoring Report – Patient Safety Incident Investigation Report	Evidence • Directorate improvement plans - monitored via IOG and through to QF	Assurance Rating Red
	External:	Source: • Internal Audit – Patient Safety Incident Response Framework and Plan due Q3 2022/23 • 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: July 2022	Actions: Delivery of Directorate improvement plans for Incident and SI's	Owner: FM/SL/HT	Progress: ongoing	Status: Amber

Risk No: 60	Date included	29 November 2021	Date revised	18/07/2022
Objective: S	High Standards			
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.			
Risk owner:	Exec: Director of Nursing, AHPs and Quality and Director of HR & OD		Local: Associate Director of Nursing and Professional Practice	
Governance:	Quality Forum, SWC/QAC /Board - Monthly Review			

	Consequence	Likelihood	Combined
Current Risk	4	5	20
Residual Risk	4	4	16

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

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 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 programme
- eRoster – 6 week planning and roster sign off
- Trust wide Safe Staffing policy
- New to healthcare induction programme

System controls

- Each organisation has risk assessed staffing
- Implemented escalation & mitigation plans
- NHSE&I – winter assurance plans completed
- Origination Accountable Officers Letter – about positive risk taking
- Workforce Sharing Agreement
- 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
- Resource capacity to respond fully to system wide urgent and emergency bed pressures

Assurances

Internal:

Source:
Incident Review Meeting
Daily safe staffing huddle, Winter Preparedness 2021 Nursing Safer Staffing BAF November 2021, National safe staffing return
6 monthly establishment reviews and monthly safe staffing reports to QAC/Trust Board
Trust wide local induction checklist for bank and agency staff
Safe staffing

Evidence:

- Self-assessment complete 4 key themes to enhance assurance, action plan developed
- Weekly situational and forecast staffing meeting

Assurance Rating Amber

External:

- Internal Audit – Recruitment and Retention due Q1 2022/23
- Internal Audit – Agency Staffing due Q3 2022/23
- The Department of Health and Social Care's group annual governance statement – NHSI
- CQC Inspection 2021

Assurance Rating Green

Gaps:

Actions

Date:	Actions:	Action Owner:	Progress:	Status
Jul 22	• MH Recruitment plan against 22/23 investment	John Edwards		Amber
Mar 23	• Recruit additional 44 international nurses	Asha Day	Second cohort of nurses are in post – on track	
Aug 24	• Develop a volunteer to career framework	Minaxi Patel	Framework in place to support volunteers – to be expanded	
Sept 22	• Recruit trainees to the HEE new roles training programme	SW / Louise Evans	Submitted a bid, meeting to review new roles governance framework June 2022	
Sept 22	• Increase our nursing associate recruitment for the Sept 22 cohort	Emma Wallis	Workforce planning session July 2022	
July 22	• PMO workstream to reduce reliance on agency spend project	PMO coordinator-ToD	Met in June 2022, ongoing project scoping with timescales	
August 22	• Task and Finish Group to review MH therapeutic and safe observations	Michelle Churchard	Established with ongoing meetings	
Oct 22	• HCSW Zero vacancy tasks and finish group	Jay Patel	Ongoing programme	

Risk No: 61	Date included	29 November 2021	Date revised	18/07/2022		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 • Recovery of Mandatory Training compliance action log reported to Training Education and Development Group monthly		
	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 **KPIs** • Core Mandatory Training Compliance for substantive staff - Target is >=85% (Feb 22 = 90%)	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. • Month 12 performance report (March 2022)	Assurance Rating Green
	External:	• NHS retention support and benchmarking data		Assurance Rating Green
	Gaps:			

	Date:	Actions:	Owner:	Progress	Status
Actions	Jul 22	• New process for amending compliance requirements to position numbers	AOD / Helen Briggs	Progress ongoing, deadline moved to July 22	Amber
	Jul 22	• Manager compliance and DNA reports live on ulearn	AOD / Helen Briggs		
	Sept 22	• Pilot safe care and review establishment	Amrik Singh	Imperial Innovations and Allocate (system suppliers) have agreed that evidence based tools can be used in SafeCare however the license for each tool has to be purchased. Paper will be sent to Execs for approval.	
	Sep 22	• Deteriorating Workforce and Sepsis Group to progress and review training and compliance for ILS and BLS	Margot Emery	Ongoing	
	Sep 22	• STAR days	AOD / Helen Briggs	Promotion material sent out	

Risk No: 62	Date included	29 November 2021	Date revised	11/07/2022
Objective: S	High Standards			
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.			
Risk owner:	Exec: Director of Nursing, AHPs and Quality	Local: Lead for Quality, Compliance and Regulation		
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 Moderate 9-11 (Appetite Regulation-Cautious)

Controls0	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 • Work programme in place for Foundation for Great Patient Care to ensure cross Trust learning.
	Gaps:	• Implementation of the Foundations 4 High Standards programme • Staff capacity to support implementation of the programme and delivering on the improvement actions. (see risk 59 for mitigations)

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: • CQC must do action plan - complete • Mental Health Act inspection action plans in progress • CQC Re-inspection action plan devised	Assurance Rating Green
	External:	Source: • CQC Inspection 2021 / re-inspection report – published 5 May 2022 • Mental Health Act inspections • Urgent and Emergency Care system wide inspection – April 2022 • External Audit value for money conclusion 2021/22 (awaiting)	Evidence:	Assurance Rating Green
	Gaps:			

Actions	Date: Ongoing	Actions: Implementation of the Foundations 4 High Standards programme	Action Owner: Deanne Rennie/Jane Gourley	Progress: Programme in its infancy, pillar leads identified, plans on a page developed and monthly programme meetings in place. No end date for programme

Status
Amber

Risk No: 64	Date included	29 November 2021	Date revised	18/07/2022
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 • SUTG delivery plans	
	Gaps:		
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
	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.
	Gaps:	Further building of our work with voluntary and community organisations	

Actions	Date: Ongoing July 22	Actions: Regular attendance at ICS Board meetings, transition and steering groups Development of robust business development road map for bid development	Owner: Chair & CEO Executive Director of Strategy & Partnerships	Progress: Achieving (this action will be on-going) Complete	Status Green

Risk No: 65	Date included	29 November 2021	Date revised	13/07/2022		Consequence	Likelihood	Combined
Objective: E	Environments				Current Risk	4	4	16
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.				Residual Risk	4	3	12
Risk owner:	Exec: Chief Finance Officer		Local: Associate Director Estates & Facilities		Tolerance Level Significant 16-20 (Appetite Quality-Seek)			
Governance:	Estates Committee, FPC / Board - Monthly Review							

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:	• Lack of information available from UHL including asset information, job plans and TUPE information		

	Date:	Actions:	Action Owner:	Progress:	Status
Actions	Oct 22	• Staff engagement/ TUPE sessions jointly planned for Sept/Oct.	CFO	Date agreed with UHL for FM transformation for 1 November 2022	Amber
	August 22	• LPT Workstreams in progress including; Comms; Operational readiness; People; FM delivery model; Supple Chain; CAFM; Finance; Operational Plans; IT; Assets	CFO	• All workstreams have project plan reported monthly	
	Sept 22	• Creating asset information and job plans	CFO/Estates Team	• New Computer Aided Facilities Management purchased	

Risk No: 66	Date included	29 November 2021	Date revised	13/07/2022		Consequence	Likelihood	Combined
Objective: E	Environments				Current Risk	4	3	12
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.				Residual Risk	4	2	8
Risk owner:	Exec: Chief Finance Officer		Local: Associate Director Estates & Facilities		**Tolerance** level Significant 16-20 (Appetite Quality-Seek)			
Governance:	Estates Committee, FPC / Board - Monthly Review							

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:	• Finalise ward moves to confirm phasing order for dormitories. Works continue on programme. • Directorate and enabling business plans to support wider Estate Strategy development

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, 2022 • Consideration of NHP expression of interest submitted 2022.	Evidence: • CQC report • NHSEI updated monthly on track.	Assurance Rating Amber
	Gaps:			

Actions	Date:	Actions:	Action Owner:	Progress:	Status
	Ongoing	• Implementation of Dormitory Eradication programme.	Richard Brown	• Dorm scheme. Complex project - remains on plan, reported to NHSE Estates.	Amber
	March 23	• Estates delivery plan	Richard Brown	• In draft – estimated trajectory 6 to 12 months	

Risk No: 67	Date included	29 November 2021	Date revised	18/07/22	
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

	Source:	Evidence:	Assurance Rating
Internal:			Red
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	Amber
Gaps:			

Actions

Date:	Actions:	Owner:	Progress:	Status
Jun 22	Funding approval for sustainability posts	CFO	Awaiting confirmation	Amber
Oct 22	Outline chapters drafted and shared with provisional chapter leads	CFO	CFO taking the lead on research to support draft chapters and working with System partners - deadline Oct 22	

Risk No: 68	Date included	29 November 2021	Date revised	13/07/22		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	2	8
Risk owner:	Exec: Director of Finance & Performance		Local: Head of Information		Tolerance Level Moderate 9-11 (Appetite Regulatory-Cautious)			
Governance:	Data Privacy Committee; 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
- Data Quality Kitemark & Framework approved by DQC, will be implemented for 22/23 reporting.

Gaps:
- Incomplete data quality reports for local and national data sets
- Insufficient monitoring of data quality incidents does not allow for learning opportunities
- Configuration of systems to support requirements of information standards and NHS data models
- Robust technical infrastructure to support timely and accessible use of data
- Ownership of data quality across the Trust – 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
- Accessible data for front line clinical teams

Assurances

	Source:	Evidence:	
Internal:	• 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	• DSPT 'standards met' annual submission made in June 2022 • Data quality actions reported to FPC via Data Privacy Committee highlight report – assurance rating Green (June) - Local risks reviewed in Data Privacy Committee - Delivery of phase 1 21/22 data quality work plan	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 – significant assurance • DSPT 21/22 360 assurance audit – Significant assurance	Assurance Rating Green

Gaps:
- Data quality group revised approach started in February 2021, not yet fully embedded actions in to services
- External Account (quality account indicators) Not undertaken for 19/20 or 20/21 and not required for 21/22

Actions

Date:	Actions:	Action Owner:	Progress:	Status
Sept 22	• Restructure of information team	SM	In progress	Green
Sept 22	• implementing the Data Quality Plan aligned to delivery of the Data Quality framework	SM	Phase 2 plan	
Sept 22	• Delivery of tools to support clinical team data quality assessments	SM	Phase 2 plan	
Dec 22	• Delivery of data quality training	SM	Phase 2 plan	

Risk No: 69	Date included	29 November 2021	Date revised	13/07/22
Objective: G	Well Governed			
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.			
Risk owner:	Exec: Director of Finance & Performance		Local: Director of Finance & Performance	
Governance:	FPC / Board - Monthly Review			

	Consequence	Likelihood	Combined
Current Risk	4	2	8
Residual Risk	4	1	4

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

Controls	Description:	• Board approved Performance management framework • Board level performance dashboard • Revised governance framework • SUTG plan • SOP in place • New automated report in place for 22/23 reporting		
	Gaps:	• Capacity of the information team due to demands from national sitrep reporting • Level 2 committee dashboards – implementation delayed due to COVID • Investment in information team capacity and a new performance team for the Trust supported by March 22 OEB, but funding in 22/23 not approved		
Assurances	Internal:	Source: • FPC / QAC / Trust Board reports • Bi monthly Performance review meetings • Simplified, directorate owned, board reporting and an agreed set of 2022/23 KPIs for the Board • Review of Information Team capacity & delivery model	Evidence: • Routine performance reporting with committee dashboards to FPC / QAC /Board – assurance rating green (April 2022) • Escalated items from performance reviews reported to OEB. • 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 21/22 – significant assurance	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		

Actions	Date: Sept 22 Dec 22	Actions: • Restructure of information team • Phase 2 review of information team, including approach to performance framework management	Action Owner: SM SM	Progress: In Progress In Progress	Status Amber

Risk No: 71	Date included	29 November 2021	Date revised	13/07/22		Consequence	Likelihood	Combined
Objective: G	Well Governed				Current Risk	5	2	10
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.				Residual Risk	5	2	10
Risk owner:	Exec: Director of Finance & Performance		Local: Deputy Director of Finance		Tolerance Level Moderate 9-11 (Appetite Financial-Cautious)			
Governance:	FPC / Board monthly							

Controls	Description:	• LPT & LLR system 4-year financial strategy defines plan deliverables • LPT Financial & Operational Planning process supports plan development • H1 & H2 financial plan delivered a breakeven position for LPT 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 • Culture change required across system partners • LLR capital strategy not yet defined • LPT & LLR ICS April plan submissions show a combined deficit of £49m		
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 • Board approval of final 2022/23 plans • Submitted LPT finance, activity, workforce & performance plans to ICS/NHSI	Evidence: • Draft plans presented to OEB, SEB, FPC & Trust Board December – April • Efficiency plan delivery presented to Transformation Committee • Draft 22/23 operational & finance plans submitted 17/03/22 • Final Trust board plan sign off of April plan 28/04/22 • Revised June plan board sign off before submission on 20/06/22	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	Jun 22	Respond to & manage actions required as a result of any NHSI escalation & plan resubmission requirements	SM	LPT plan submitted on 20/06/22	Green
	Dec 22	LLR ICS capital & financial strategy development	SM	Action captured within the in-year plan delivery in Risk 81	

Risk No: 72	Date included	29 November 2021	Date revised	18/07/2022
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	3	12
Residual Risk	4	2	8

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 Regular attendance at system meetings	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	July 22	Reaching out delivery plan as part of the Step Up to Great (SUTG) strategy and plan	David Williams	Revised timescales – end July 2022	Amber
	Aug 22	Social value framework co-produced	David Williams	Discussions with HACT Re framework and tool taking place and proposal received.	
	July 22	Further agreement on our approach and calculating impact and value	David Williams	To be developed once the SUTG delivery plan completed – as above revised timescales end of July 2022	
	July 22	Development of inequalities data in an accessible format	Information Team		

Risk No: 73	Date included	29 November 2021	Date revised	18/07/2022
Objective: E	Equality, Leadership, Culture			
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.			
Risk owner:	Exec: Director of HR & OD		Local: Head of Equality, Diversity and Inclusion	
Governance:	SWC, QAC / Board - Monthly Review			

	Consequence	Likelihood	Combined
Current Risk	3	4	12
Residual Risk	3	3	9

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

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.
- 8th We Nurture OD targeted sessions for BAME staff delivered
- Reverse mentoring. Second cohort completed and third cohort launched.
- National and LPT People Plan priorities being addressed.
- WRES and WDES action plans revised annually and being implemented.

Gaps:

- Improved delivery against outcome measures / WRES and diversity metrics
- Embeddedness of WRES/ WDES/ Together Against Racism action plan/ NHSEI high impact actions (Inclusive talent management implementation)

Assurances

Internal:	• Diversity workforce dashboard reported to SWC • Regular reporting of equalities progress against measures to level 2 and 1 committees • Annual Equalities Action Plans revised and produced for WRES, WDES and GPG • Staff survey results inform action planning	• EDI annual report to EDI committee / EDI group • WRES/WDES DATA published action plan to QAC/SWC – highlight report that include 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 • EDI projects and programmes being resourced and delivered across the system and internally • WRES and WDES metrics have improved in most areas.	Assurance Rating Green
Gaps:			

Actions

Date:	Actions:	Owner:	Progress:	Status
Aug 22	Revision of WRES and WDES action plans and six high impact Race	Haseeb Ahmed		Green
Aug 22	Equality Actions following analysis of latest data.	HA/ Kamy Basra		
Oct 22	Launch of refreshed Zero Tolerance Campaign and guidance	HA (with Bina Kotecha)		
Sept 22	Delivery of Cultural Competency Programme	HA		
Sept 22	Establishing Equality Objectives within staff appraisals	HA		

Risk No: 74	Date included	29 November 2021	Date revised	18/07/2022		Consequence	Likelihood	Combined
Objective: E	Equality, Leadership, Culture				Current Risk	3	3	9
Risk Title:	As a result of covid 19, 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 • Health and Wellbeing Lead / People Promise Manager (starting May 22)		
	Gaps:	- Impact of financial pressures on health and wellbeing – task and finish group to review cost of living in place		
Assurances	Internal:	• Financial HWB support task and finish group • Daily Sickness absence monitoring • Sickness and workforce reports to SWC / QAC • Sickness reviews within divisions • Staff side – monthly meetings • Referrals to OH and Amica	Evidence: • Sickness absence rate LPT target 4.5% - current performance (March 22) 5.2% • Staff side – feedback • Action plan reporting through SG AND ICC	Assurance Rating Amber
	External	Source: • Be well midlands staff engagement process by NHSEI • NHSI reporting • LLR workforce group • Health and wellbeing taskforce group	Evidence: • NHSI benchmarking reports • Attendance at external NHSI wellbeing workshops • MHWB hub data	Assurance Rating Green
	Gaps:			

Actions	Date: Oct 22 Nov 22	Actions: • Delivery of the Health and Wellbeing Action Plan • Codesign review of the anti bullying and harassment policy	Action Owner: Amy Huckle Claire Taylor	Progress: Reviewing HWB framework to identify gaps Progressing	Status Amber

Risk No: 75	Date included	29 November 2021	Date revised	18/07/2022		Consequence	Likelihood	Combined
Objective: A	Access to Services				Current Risk	4	4	16
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.				Residual Risk	4	2	8
Risk owner:	Exec: Medical Director		Local: Operational Executive Directors		**Tolerance Level** Significant 16-20 (Appetite Quality-Seek)			
Governance:	Waiting List and Harm Prevention Committee, FPC and QAC / Board - Monthly Review							

Controls	Description:	• Access Policy / EQIA 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:	• 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 • Agreed joint working approach between LLR and Northants system to undertake demand and capacity modelling	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: • Internal Audit – Remote Consultations due Q1 2022/23 • Internal Audit – Patient Experience due Q1 2022/23 • 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 – reinspection report awaited for April 2022	Assurance Rating Amber
	Gaps:			

	Date:	Actions:	Owner:	Progress:	Status
Actions	July 22	Understanding the outputs of the demand and capacity modelling and feeding into the transformation programme	Director of MH AS/AvH		Amber
	July 22	Consideration of avoidable harm measures including impact of partial or full COVID related closures			

Risk No: 77	Date included	1 December 2021	Date revised	18/07/2022
Objective: G	Well Governed			
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.			
Risk owner:	Exec: Deputy Chief Executive		Local: Deputy Director of Governance and Risk	
Governance:	Public Inquiry Programme Board / SEB / Trust Board - monthly review			

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

Tolerance level Moderate 9-11 (Appetite Reputational–Cautious)

Controls	Description:	• National Public Inquiry Chair and Terms of Reference • 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 • Local strategy for the National Public Inquiry approved		
	Gaps:			
Assurances	Internal:	Source • SEB • 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: July 22	Actions: Ongoing collation of evidence	Action Owner: Clare Lacey	Progress: In progress and on track

Status
Amber

Risk No: 78	Environment / High Standards	Date reviewed:	18/07/2022		Consequence	Likelihood	Combined
Risk Title:	If levels of cleanliness are not sustained, the Trust will not comply with the requirements of the National Cleanliness Standards and Hygiene Code which may impact on patient safety and experience.			Current Risk	4	3	12
Director risk owner:	Director of Nursing, AHP's and Quality and Chief Finance Officer			Residual Risk	4	2	8
Governance / Review:	IPCC, QAC and FPC / Board - Monthly Review			**Tolerance** level Moderate 9-11 (Appetite Reputational–Cautious)			

Controls	Description:	• 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 • LPT estates rep sits on/reports into IPC Group (cleaning/water/waste/decontamination) • Infection control team / IPC quarterly report and annual report / • SOPs in place to describe key responsibilities • Audit programme includes Cleaners rooms and trolleys / Clear and agreed reporting mechanism against the Hygiene code • 21/22 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. • Additional rapid response staff • LPT participation in NHSEI cleaning with confidence (CwC) campaign – training programme added to Ulearn • Service spec updated to introduce a third daily clean to IP areas • Inpatient ward matron cleaning roles and responsibility meetings with the Director for Infection, Prevention and Control • IPC operational meeting		
	Gaps:	Progress with the FM transformation including; • Progress with sustained implementation of the turnaround plan • Appropriately trained estates team in place • UHL / NHSPS representation at LPT IPC Group and Cleaning Forum • Inconsistent reporting with cleaning scores • Number of audits completed KPI not being met		
Assurances	Internal:	Source: • Implemented the National Standards of Healthcare Cleanliness 2021 • Align pandemic cleaning routine to the National Standards of Healthcare Cleanliness • Cleaning report to the Estates Committee • 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. • 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 • Contractual cleaning audit findings • Regular performance reports against hygiene standards and regular review at IPC	Assurance Rating Amber
	External:	Source: • NHSI IPC audit • CQC inspections	Evidence: • National Guidance on cleaning for COVID-19 • CQC IPC summary inspection report	Assurance Rating Green
	Gaps:	UHL Facilities Cleaning Turnaround plan - plan received 4.10.21 - nothing further to IPC Group.		

Actions	Date: Ongoing	Actions: Implementation of the cleaning turnaround plan with evidence	Action Owner: UHL – oversight R. Brown	Progress All actions are on-going	Status: Amber

Risk No: 79	Date included	29.03.22	Date revised	13/07/22
Objective: G	Well Governed			
Risk Title:	The Cyber threat landscape is currently considered significant due to the geopolitical conflicts, high prevalence of cyber-attack vectors, increase in published vulnerabilities, etc which could lead to a significant impact on IT systems that support patient services and potential data breaches			
Risk owner:	Exec: Director of Finance & Performance/SIRO		Local: Head of Data Privacy	
Governance:	Data Privacy Committee, FPC/Bi-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:

- Multiple tiers of controls that are technical and organisational, including ongoing assessment and scanning of boundaries, geo-blocking and supporting information security policies
- Governance controls – reporting to Data Privacy Committee and IM&T Committee on Cyber and Information Security
- External scrutiny at multiple levels – Police Cyber resilience, National Cyber Security Centre (NCSC), BitSight assessment, NHS Secure Boundary scanning and reporting
- Audits on Information Security Management System (ISMS), ISO, DSPT – with significant assurance
- Internal and External Auditors – 360 Assurance (DSPT), KPMG – Understanding of IT 20/21 Audit
- Continuity Planning and Disaster Recovery – exercises and reviews
- Incident Response capabilities – active real world testing e.g. Russian Attack
- Risk averse position taken in relation to mobile and remote working such as requests for working abroad with a default 'no' position
- Cyber security training – focused for local situations and delivered by LHIS Cyber Team
- Increased collaborative working with other NHS organisations to share intelligence and learning
- SIRO Structure
- Membership of Cyber Associated Network for early notification of national and local issues
- Authentication of identity at service desk contact – implementation of multifactor authentication at all levels of the organisation
- Where weaknesses/vulnerabilities are identified there is constant learning and immediate remediation plans in place

Gaps:

- Authentication of identity at service desk contact – implementation of multifactor authentication at all levels of the organisation
- New digital posts required such as CIO
- Phishing simulations delayed due to covid

Assurances

	Source:	Evidence:	
Internal:	Bi-Monthly report to Data Privacy Committee LHIS re-accreditation of secure email system [ISO27000] and Cyber Essentials Consultancy Review and testing of disaster recovery and business continuity processes in response to real world testing Cyber metrics reported through DPC Dashboard Reporting of incidents	Accreditation reports Output reports and remediation plans Dashboard for Committee meeting Data breach reports to Data Privacy Committee	Assurance Rating Green
External:	LHIS ISO Audit KPMG Understanding IT 21/22 Audit 360 Assurance DSPT Audit 21/22 DSPT submission – standards met 21/22	Accreditation report Audit report Audit Report – substantial assurance NHS Digital submission	Assurance Rating Green
Gaps:			

Actions

Date:	Actions:	Action Owner:	Progress:	Status:
Aug 22	Board Development session re: Cyber Threat	Chris Biddle	Board Development Session 23 August 2022	Green
Sept 22	Cyber Threat update report to Audit Committee	Chris Biddle	Audit Committee Agenda item	
June 22	DSPT submission	Hannah Plowright	Completed 30 June	

Risk No: 80	Date included	29 March 2022	Date revised	18/07/22
Objective:	High Standards / Equality, Leadership and Culture			
Risk Title:	If staff are not vaccinated against influenza, they pose a risk to the health and wellbeing of themselves, colleagues, patients and the wider community. This would adversely impact on Public Health, potentially leading to increased hospitalisation, increased staff sickness levels and staffing challenges and a risk to those who are vulnerable.			
Risk owner:	Exec: Director of Nursing AHPs and Quality		Local: Trust clinical lead for staff flu vaccinations	
Governance:	Trust Strategic Flu and Covid-19 Group / 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:	• Strategic Flu and Covid-19 Group and staff vaccination workforce group • NIVS system for uptake reporting – weekly SITREP and use of QR code to record staff who have been vaccinated outside of LPT. • Flu vaccine order placed mid March 2022 . Sufficient for all frontline healthcare workers • Mixed delivery model of roving vaccinators, peer vaccinators in clinical areas and co-delivery of Flu and COVID vaccinations if advised by JCVI • Implementation of the national best practice vaccination programme principles including flexible access, board endorsement, publicity and comms and staff incentives • Communications plan weekly for clinic availibity with dedicated Comms support • High level action plan which aligns with national and LLR plans and uptake ambitions • Clinical peer vaccinators to support teams on site and during the shift • Focused work through Trust CQUIN group • Vaccine confidence training for all peer vaccinators • Supportive focused clinics for supporting colleagues with needle phobia • Flu group with Directorate champions
Gaps:	• No vegan or vegetarian vaccine available • Considerable vaccine reluctance amongst LPT staff for additional vaccination after Covid vaccination x3 in previous 12 months • Low levels of circulating flu in the wider community has been interpreted as flu vaccination not being required • Flu vaccination uptake correlates with increasing age – younger staff do not see Flu as a health concern for their age group

Assurances

Internal:	Source Monthly review at the Strategic Flu and Covid-19 Group and staff vaccination workforce group with reporting to level 1 and 2 committees Update reporting from NIVS and weekly SITREP CQUIN reports CQUIN action to deliver 70% staff vaccinated	Evidence: Papers to SEB / QF and QAC Data uptake and analysis presented to Strategic Flu and Covid-19 Group Update in highlight report to the Quality Forum Weekly LPT SITREP for flu uptake	Assurance Rating Green
External:	Source LPT reports into the situation reports for the LLR Flu and Covid-19 Board	Evidence: SITREP	Assurance Rating Amber
Gaps:	• Number of staff affected by vaccine reluctance and lack of vegetarian / vegan vaccine is not known • Staff having flu vaccination outside of LPT requires individual staff to confirm this as access through NIMS is no longer available		

Actions

Date:	Actions:	Action Owner:	Progress:	Status
Mar 23	CQUIN action to deliver 70% staff vaccinated	Sarah Clements		Amber
Ongoing	Implementation of the Flu action plan (oversight by Strategic Flu Group)	Sarah Clements	Flu action plan being reviewed at strategic and workforce meetings in June	
July 22	Identify number of staff impacted by lack of vegan/vegetarian vaccine	Directorate Leads		
July 22	Identify number of staff by service / Directorate who have chosen not to take up staff flu vaccination (due to increased vaccinations in last 12 months and allergies	Directorate Leads		

Risk No: 81	Date included	29 April 2022	Date revised	13/07/22
Objective: G	Well Governed			
Risk Title:	Inadequate control, reporting and management of the Trust's 2022/23 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 planning guidance followed in preparation of the plan • LPT Financial & Operational Plan triangulated with workforce plan • Standing Financial Instructions support control environment • Treasury management policy , cash flow forecasting ensure robust cash management • Capital Financing strategy & plan in place • LPT draft medium term financial strategy in place & presented to Trust Board April 2022
	Gaps:	• Culture change required across system partners • LLR ICS medium term capital strategy not yet in place • LLR ICS medium term revenue strategy not yet in place • LPT 22/23 April plan delivered a £1.4m deficit- revised breakeven, best endeavours plan submitted 20/06/22 • ICS Risk/gain share could adversely impact on LPT's financial position

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 • LLR ICS Finance committee oversight	Evidence: • Reports & updates from Internal & external auditors • Monthly Director of Finance report to FPC / Trust Board – highlight report assurance rating Red (June 2022) • Ongoing oversight and management of all aspects of financial position against plans • Monthly reports to OEB/SEB/FPC/Board/ICS finance committee on all aspects of delivery against plan • Mitigation plans for capital and revenue to ensure plans are delivered
	External:	Source: • KPMG audit of 2021/22 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: • 2021/22 annual accounts unqualified opinion • Significant assurance • Significant assurance • significant assurance
	Gaps:	• ICS financial risk needs to feed into LPT financial risk	

Assurance Rating Amber

Assurance Rating Green

Actions	Date:	Actions:	Action Owner:	Progress:
	Mar23	Continued monitoring and management of all aspects of the Trust's delivery of the financial plan	SM	
	Jul 22	Add in relevant ICS Financial risk content to LPT risk	SM	ICS risks drafted – presented to June ICS finance committee; more work required
	Dec 22	Contribute to LLR ICS capital & financial strategy development	SM	CFOs have discussed approach
	Dec 22	Revise LPT medium term capital & financial strategy to ensure alignment with ICS strategy	SM	

Status: Green

Risk No: 82	Date included	10 May 2022	Date revised	8 July 22
Objective: G	High Standards			
Risk Title:	The loss of the 11+ healthy together contract will mean a change in delivery for this service from LPT to the LA, impacting on Trust staff and income, and continuity of care for secondary school aged children.			
Risk owner:	Exec Lead: FYPCLD Director / Director of Strategy and Partnerships	Local: Janet Harrison		
Governance:	FYPC DMT / Ops Exec Board / Board monthly			

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

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

Controls

Description:

- LA mobilisation plan
- Service specifications
- National Healthy Child Programme
- LPT policies and procedures / standard operating guidance / competency frameworks
- TUPE arrangements confirmed as not applicable due to fragmentation of service; this secures professional supervision and training
- Clarity over framework requirements for SCPHNs, supervision and training resolved through retention of staff ; LA policies and procedures/ SOPs and competency frameworks not relevant now TUPE does not apply
- LSCB / LPT Safeguarding practice and guidance

Gaps:

- Appropriate representation from health partners at Safeguarding strategy calls and conferences
- Ability of the new provider to access the historical electronic clinical record
- Data sharing to provide system partnership alerts e.g. primary care and UHL Emergency Department
- Active caseload handover
- Continuity of single EPR
- Communication with families regarding new provider arrangements
- Suitable alternative employment for all staff involved in the 11-19 service
- Income shortfall and overhead contributions

Assurances

Internal:	Source: • Mobilisation group for 0-11 plus transition to LA 11+ offer • Directorate Management Team • Ops Exec Board • MoC for 5-19 staff	Evidence: Teams project plan Minutes of meetings DMT minutes / De-mobilisation assurance document / financial plan OEB Minutes SOG for caseload handover 1:1's with FSM and HR	Assurance Rating Amber
External:	Source: • Director of Public Health and Commissioners • LCC Integrated Project Meeting 11+ - with 5 workstream groups; Comms; IT; Information Governance; Rutland; Safeguarding Plus operational group	Evidence: ToR and Workstream groups established Operational group established to work through caseload handover	Assurance Rating Red
Gaps:	Health representation for safeguarding from 1 September		

Actions

Date:	Actions:	Action Owner	Progress:	Status
Jun 22	• Raised as a risk to Leicestershire County Council and CCG	D Williams	Raised and actions below confirmed	Amber
8 Jul 22	• Raised with System Executive as a system risk	D Williams		
26 Jul	• System meeting between ICB senior nurse leaders to identify solutions for health representation for safeguarding	C Trevithick		
12 Aug	• Options and recommendations to System Executive	C Trevithick		
31 Aug	• Complete 1:1's with all 5-19 staff as part of MoC	J Harrison		