Risk No: 58	Date included	29 November 2021	Date revised	14/09/2022
Objective: S	High Standards			
Risk Title:	Insufficient Safeguarding competency may result in limitations on service provision, which may result in poor quality care and patient harm.			
Risk owner:	Exec: Director of Nursing, AHPs and Quality		Local: Head of Safeguarding	
Governance:	Safeguarding Committee / 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

- 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
- Safeguarding training offer fully compliant with national standards and guidelines
- Training programme set in place

Gaps:

Assurances

Internal:

Source:
- 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:	Owner	Progress:	Status
				Amber

Risk No: 59	Date included	29 November 2021	Date revised	16/09/2022
Objective: S	High Standards			
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.			
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	3	12
Residual Risk	4	2	8

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 support and escalation
- Incident investigation training monthly rolling programme
- Quality summit x3 action plans for improvement within directorates
- Clinical governance structure
- Interim Group Director of Patient Safety appointed 1 September 2022
- Directorate improvement plans in place monitored via Incident Oversight Group

Gaps:

- Directorate achievement of trajectories in improvement plans

Assurances

	Source	Evidence	Assurance Rating
Internal:	• Reports/ minutes from Incident Oversight Group and Quality Forum and Executive Team. • Quality Summit March 2022 • Monthly Quality Monitoring Report – Patient Safety Incident Investigation Report	• Directorate improvement plans - monitored via IOG and through to Quality Forum	Assurance Rating Green
External:	• Internal Audit – Patient Safety Incident Response Framework and Plan due Q3 2022/23 • CQC Inspection 2021 • CCG sign off and feedback for SI reporting	• 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 Green
Gaps:			

Actions

Date:	Actions:	Owner:	Progress:	Status
Sept.2022	Review of blocks to incident closure, SI completion and SI action closure by Directorates	FM/SL/HT	Reports to be presented at IOG and reviewed against trajectory for improvement agreed at Quality Forum.	Amber
October 2022	Revised improvement plans/trajectories re incident closure, complete Sis and closure SI actions	FM/SL/HT	Further actions to be implemented in September 2022. New 90% target for completion of open incidents within 15 days has been agreed.	
November 2022	Engage with the ICB and system partners to co-produce a plan in relation to incident investigations and the transition to the new Patient Safety Incident Response Framework.	JM		

Risk No: 61	Date included	29 November 2021	Date revised	16/09/2022
Objective: S	High Standards and Equality, Leadership, Culture			
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.			
Risk owner:	Exec: Director of HR & OD		Local: Head of Education, Training and Development	
Governance:	SWC, 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:

- Mandatory and Role Essential Training Policy, Study Leave Policy
- National and local People Plan
- Safer staffing policies and guidance
- Pre learning mandatory training prior to first day
- Mandated clinical supervision
- Role applicable competency framework
- Annual training needs analysis
- E rostering in place across inpatient services and community
- On-going recruitment programme
- STAR days
- Annual establishment reviews

Gaps:

- Mandatory training compliance for ILS and BLS

Assurances

Internal:

Source:

- SWC , Directorate Workforce groups , retention working group
- Quarterly workforce triangulation to ops exec - hotspots and action
- LLR People Programme Delivery Group
- Workforce planning supply Trust Approach
- Hotspots identified on Directorate Risk Registers
- Weekly safe staffing meeting
- Learning from SI's and quality improvements
- Monthly clinical education forum

Evidence:

- Mandatory Training and Role Essential Training Flash Report- monthly
- Supervision compliance report- monthly
- Noc trust board and SEB deep dive
- Directorate risk registers received at DMTs
- Quarterly triangulation document to Exec Team with action plan.
- Training capacity DNA spaces monitored at Training Education Development Group Monthly

Assurance Rating Green

External:

Assurance Rating Green

Gaps:

Actions

Date:	Actions:	Owner:	Progress - All actions ongoing	Status
Oct 22	New process for amending compliance requirements to position numbers	AOD / Helen Briggs		Green
Oct 22	Manager compliance and DNA reports live on ulearn	AOD / Helen Briggs		
Oct 22	Deteriorating Workforce and Sepsis Group to progress and review training and compliance for ILS and BLS	AOD / Helen Briggs		
Oct 22	Reporting and monitoring of monthly course unutilised spaces and cancelled courses/places	AOD / Helen Briggs		
Oct 22				

Risk No: 64	Date included	29 November 2021	Date revised	16/09/2022
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

	Source	Evidence	Assurance Rating
Internal:	Transformation Committee Joint Working Group (JWG) of LPT & NHFT Executive, board meetings & board development sessions Finance and Performance Committee	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	Green
External:	Internal Audit HOIAO Feedback from NHS E/I Feedback from stakeholders (CQC, CCG/ICB & local authorities) Attendance at local authority scrutiny meetings	Formal feedback from audit opinion, formal meetings and our stakeholder feedback.	Green
Gaps:	Further building of our work with voluntary and community organisations		

Actions

Date:	Actions:	Owner:	Progress:	Status
October 2022	Launch of LDA Collaborative	Executive Director of Strategy & Partnerships	In final approval	Green
October 2022	Further development of MH Collaborative		Terms of reference and governance being finalised	

Risk No: 65	Date included	29 November 2021	Date revised	16/09/2022
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
- 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
- Significant cleaning vacancies at UHL

Assurances

	Source	Evidence	Assurance Rating
Internal:	FM Oversight Group FM Transformation Board Estates and Medical Equipment Committee FPC Estates risk register	• Provider service review meetings • Ongoing review of audit actions • Monthly estates updates including health and safety reviews • FPC estates updates	Assurance Rating Green
External:	• CQC inspection 2021	• CQC report	Assurance Rating Amber

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

Actions

Date:	Actions:	Action Owner:	Progress:	Status
Oct 22	• Staff engagement/ TUPE sessions jointly planned for Sept/Oct.	CFO	• First engagement session by LPT took place 6th Sept 2022	Amber
Nov 22	• LPT Workstreams in progress including; Comms; Operational readiness; People; FM delivery model; Supple Chain; CAFM; Finance; Operational Plans; IT; Assets	CFO	• Date agreed with UHL for FM Transformation for 1st November 2022 • All workstreams have project plan reported monthly	
Oct 22	• Creating asset information and job plans	CFO/Estates Team	• New Computer Aided Facilities Management in place and data being added	
Sept 22	• Commenced recruitment of cleaning staff and contractors			

Risk No: 66	Date included	29 November 2021	Date revised	16/09/2022
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:
- 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

	Source	Evidence	Assurance Rating
Internal:	• Strategic Property Group • Estates and Medical Equipment Committee • Finance and Performance Committee • Health and Safety Committee. Directorate Health and Safety Action Groups	• 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:	• CQC Inspection 2021, 2022 • Consideration of NHP expression of interest submitted 2022.	• 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	15/09/22
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:	
Internal:			Assurance Rating Red
External:	Request to LLR Greener Board for support Work to share across the Group with NHFT knowledge and experience on sustainability	Greener Board – November 2021 Committees in Common – November 2021	Assurance Rating Amber
Gaps:			

Actions

Date:	Actions:	Owner:	Progress:	Status
Sept 22	Draft LLR ICS Green Plan to be shared with Trust Board	CFO	On agenda	Amber
Dec 22	Exploring scope of using posts group wide	CFO		

Risk No: 68	Date included	29 November 2021	Date revised	09/09/22
Objective: G	Well Governed			
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.			
Risk owner:	Exec: Director of Finance & Performance		Local: Head of Information	
Governance:	Data Privacy Committee; FPC / Board - Monthly Review			

	Consequence	Likelihood	Combined
Current Risk	4	3	12
Residual Risk	4	2	8
Tolerance Level Moderate 9-11 (Appetite Regulatory-Cautious)			

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

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

Evidence:

- DSPT 'standards met' annual submission made in June 2022
- Data quality actions reported to FPC via Data Privacy Committee highlight report – assurance rating Green (August)
- 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, phase 1 has defined the frameworks for quality data, phase 2 of action plan needs to fully embed the approach
- External Account (quality account indicators) Not undertaken for 19/20 or 20/21 and not required for 21/22

Actions

Date:	Actions:	Owner:	Progress:	Status
Sept 22	Restructure of information team	SM	In progress	Green
Dec 22	Delivery of data quality training	SM	Phase 2 data quality action plan being developed	
Mar 23	Delivery of phase 2 of data quality plan – embedding processes & implementing kitemark approach	SM	Phase 2 data quality action plan being developed	

Risk No: 69	Date included	29 November 2021	Date revised	09/09/22
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

	Source:	Evidence:	Assurance Rating
Internal:	• 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	• Routine performance reporting with committee dashboards to FPC / QAC /Board – assurance rating amber (August 2022) • Escalated items from performance reviews reported to OEB. • Performance reports narrative updated by Directorate Business Managers prior to release.	Assurance Rating Amber
External:	• CQC inspection 2021 • External and internal audit	• 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:	Actions:	Action Owner:	Progress:	Status
Sept 22	Restructure of information team	SM	In Progress	Amber
Dec 22	Phase 2 review of information team, including approach to performance framework management	SM	In Progress	
Oct 22	Board development session to review Board performance report	SM		
Dec 22	Complete refresh of Board performance report	SM		

Risk No: 72	Date included	29 November 2021	Date revised	16/09/2022
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.		

Actions	Date:	Actions:	Owner:	Progress:	Status
	Sept 22	Reaching out delivery plan as part of the Step Up to Great (SUTG) strategy and plan	David Williams	Revised timescales – September 2022	Amber
	Sept 22	Social value framework co-produced	David Williams	Discussions with HACT Re framework and tool taking place and proposal received.	
	Sept 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 Sept 2022	
	Sept 22	Development of inequalities data in an accessible format	Information Team		

Risk No: 73	Date included	29 November 2021	Date revised	16/09/2022
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
- WRES and WDES data reports to QAC (August 22)

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
Oct 22	Revision of WRES and WDES action plans and six high impact Race Equality Actions following analysis of latest data.	Haseeb Ahmed	Progress ongoing, deadline moved to October 2022	Green
Oct 22	Launch of refreshed Zero Tolerance Campaign and guidance	HA/ Kamy Basra		
Oct 22	Delivery of Cultural Competency Programme	HA (with Bina Kotecha)		
Oct 22	Establishing Equality Objectives within staff appraisals	HA		
Oct 22		HA		

Risk No: 74	Date included	29 November 2021	Date revised	14/09/2022
Objective: E	Equality, Leadership, Culture			
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.			
Risk owner:	Exec: Director of HR & OD		Local: Deputy Director of HR and OD	
Governance:	SWC, QAC / Board - Monthly Review			

	Consequence	Likelihood	Combined
Current Risk	3	3	9
Residual Risk	3	2	6
Tolerance Level Significant 16-20 (Appetite People - Seek)			

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

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

Risk No: 75	Date included	29 November 2021	Date revised	20/09/2022
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:	Improving Access Committee, FPC / 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
- 22/23 access priorities agreed and plans in place
- Approaches in services to reduce risk of harm while waiting by supporting service users with appropriate information

Gaps:

- Capacity and resources / workforce

Assurances

	Source:	Evidence:	
Internal:	• Improving Access Committee • Directorate level performance reviews • Waiting time performance reported to Finance and Performance Committee • Checks of safety of patients waiting • Directorate risks including access where appropriate	• Performance dashboards and reporting to DMTs , OEB and Trusts Board • Trajectory for improvement and measurement against trajectory • Transformation plans	Assurance Rating Amber
External:	• Internal Audit – Remote Consultations 2022/23 • Internal Audit – Patient Experience 2022/23 significant assurance • CQC inspection • System performance monitoring • NHSE QRSM • National benchmarking data • Quality / Contract Monitoring with ICB		Assurance Rating Amber
Gaps:			

Actions

Date:	Actions:	Owner:	Progress:	Status
ongoing	Delivery of priority service plans for reducing waiting lists	Directors of MH FYPC CHS	In progress – ongoing	Amber

Risk No: 77	Date included	1 December 2021	Date revised	14/09/2022
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:	SEB / Trust Board - monthly review			

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

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

Controls

Description:	• National Public Inquiry Chair and Terms of Reference • Detail of the first three modules • Joint Lead for the Public Inquiry with NHFT • Comprehensive backlog of evidence including data, overarching narrative and lessons learned collated and mapped in readiness for enquiries • Process for the receipt of enquiries
Gaps:	

Assurances

	Source	Evidence:	Assurance Rating
Internal:	• SEB		
External:			
Gaps:			

Actions

Date:	Actions:	Action Owner:	Progress:	Status

Risk No: 78	Environment / High Standards	Date reviewed:	14/09/2022		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:	Exec Lead Chief Finance Officer	Local Lead – Associate Director of Estates and Facilities		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
- Garden cleaning

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:	Actions:	Action Owner:	Progress	Status:
Ongoing	Implementation of the cleaning turnaround plan with evidence	UHL – oversight R. Brown	Progress report not received at the IPC ops meeting 13.9.22	Amber
Nov 22	To develop a service specification for garden cleaning and maintenance	Helen Walton		
Oct 22	Deputy DIPaC to attend Trust cleaning forum to review clinical oversight and grip to ensure cleanliness standards that facilitate the prevention and control of infection	Emma Wallis		
March 23	Reintroduction of annual PLACE inspections	Helen Walton		

Risk No: 79	Date included	29.03.22	Date revised	09/09/22
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	4	16
Residual Risk	4	3	12
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
- Phishing simulation exercise August 2022 enabled assessment of Trust's vulnerability

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
- Increase in NHS cyber threats seen in August 22
- Some staff clicked through links from phishing exercise

Assurances

	Source	Evidence	Assurance Rating
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:
Ongoing	Cyber security working group convened in response to increased risk	Chris Biddle	Ongoing until safe to step down	Green

Risk No: 80	Date included	29 March 2022	Date revised	14/09/22
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

	Source	Evidence:	Assurance Rating
Internal:	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	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:	LPT reports into the situation reports for the LLR Flu and Covid-19 Board	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	Vaccination delivery commences 29 September 2022.	Amber
Ongoing	Implementation of the Flu action plan (oversight by Strategic Flu Group)	Sarah Clements	Trust strategic flu vaccination delivery plan presented to SEB in August 2022 including an incentive plan in line with best practice checklist Strategic Flu Group meeting monthly for oversight of the delivery plan Clinical directorate questionnaire completed in May/June, analysis has shown approx. 10-20% of staff will not uptake the vaccine	

Risk No: 81	Date included	29 April 2022	Date revised	09/09/22
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	4	20
Residual Risk	5	3	15
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
- Revised forecast & recovery plan drafted in response to financial risks materialising in year

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
- ICS Risk/gain share could adversely impact on LPT's financial position
- Operational pressures in DMH inpatient areas have led to overspends which cannot be fully mitigated by the Trust – Trust's likely case forecast has been revised to £6.5m deficit
- ICB unmitigated pressure c£20m at month 5 (including LPT's likely forecast deficit)

ICB highest scored operational finance risks:

- Workforce recruitment and retention (score 16)
- Delivery of 22/23 financial plan (score 16)
- Unmitigated risks excluded from financial plan (score 20)

Assurances

Internal:

Source:	Evidence:	Assurance Rating
• 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 • Delivery against recovery plan actions will be reported monthly via finance report • LLR ICS Finance committee oversight	• Reports & updates from Internal & external auditors • Monthly Director of Finance report to FPC / Trust Board – highlight report assurance rating Red (August 2022) • Ongoing oversight and management of all aspects of financial position against plans • Monthly reports to OEB/SEB/FPC/Board/ICB finance committee on all aspects of delivery against plan • Mitigation plans for capital and revenue to ensure plans are delivered	Amber

External:

Source:	Evidence:	Assurance Rating
• 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 • HFMA checklist audit Q3 21/22	• 2021/22 annual accounts unqualified opinion • Significant assurance • Significant assurance • significant assurance • Self assessment against checklist completed by trust, audit to review evidence	Green

Gaps:

- ICB financial risk needs to feed into LPT financial risk

Actions

Date:	Actions:	Action Owner:	Progress:	Status
Sep 22	Trust to submit HFMA checklist self-assessment to Internal Audit	SM	Self-assessment completed; approval at September OEB & by CE before submission to Internal Audit	Green
Mar23	Continued monitoring and management of all aspects of the Trust's delivery of the financial plan, including recovery actions	SM	Ongoing	
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		

Risk No: 82	Date included	10 May 2022	Date revised	16/09/22
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	3	12
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

	Source:	Evidence:	Assurance Rating
Internal:	• Mobilisation group for 0-11 plus transition to LA 11+ offer • Directorate Management Team • Ops Exec Board • MoC for 5-19 staff	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	Amber
External:	• Director of Public Health and Commissioners • LCC Integrated Project Meeting 11+ - with 5 workstream groups; Comms; IT; Information Governance; Rutland; Safeguarding Plus operational group	ToR and Workstream groups established Operational group established to work through caseload handover	Red
Gaps:	Health representation for safeguarding from 1 September		

Actions

Date:	Actions:	Action Owner	Progress:	Status
				Amber

Risk No: 83	Date included	August 2022	Date revised	16/09/22
Objective: S	High Standards			
Risk Title:	Restricted access and use of electronic patient record systems will result in incomplete electronic patient records including the recording of physical observations. This will impact on the delivery of effective and safe patient care			
Risk owner:	Exec Lead: Director of Strategy and Business Development			
Governance:	EMB/FPC/ 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:
- Ward staff can contact LHIS (including OOH) to gain temporary, emergency access for staff, to use both SystmOne and Brigid
- Online training available – links are on the Kn (knowledge) base button, on SystmOne home screen. This is available to all SystmOne users.
- Business Continuity Plans implemented in event of handset failure (paper charts)
- Desktop and laptops available to record observations in some wards

Gaps:
- WiFi access inconsistent across LPT sites
- RA sponsor required to manage the access request. Currently, there are gaps in some services, of adequate numbers of RA sponsors.
- Mobile phone displays difficult to read and use causing incorrect options to be chosen e.g. observations.
- Staff may not be aware of training resources / support materials / Not all areas have SystmOne superusers/ champions
- Agency staff can only access the system by logging into an active SystmOne account
- Scanning not completed in a timely way due to mitigation of internet access being revert to paper records.
- Unconfirmed potential for improvements to be made by updating the handheld devices/phones, from Motorola to Samsung
- In consistent trust wide method of recording bedside observations for patients when Brigid/WIFI not working
- Ward staff access to the physical handsets and/or log in for temporary staff
- Impact of reduced access to systems results in reduced access to nurse in charge alerts
- Handset devices are not of adequate standard / Not enough access to desktops or laptops on wards for when devices are not working.
- Bank/agency staff can login on Brigid using other staff member log in details (safety and legal implications)

Assurances

	Source	Evidence	Assurance Rating
Internal:	Incidents relating to access to IT systems Serious incidents reporting difficulties in access to IT systems	Patient Safety Patient Safety	Amber
External:	CQC inspections/MHA visits	CQC inspection report 2022	Amber
Gaps:			

Actions

Date:	Actions:	Action Owner	Progress:	Status
Provisional October22 date for all actions	• Quantify gaps in RA sponsors across the Directorates and recruit RA sponsors • Identifying champions and super users in clinical areas and do they understand their role • Process for agency staff to identify and access RA sponsors to be clarified and published • Reminders for staff re training resources • Identifying training requirements and support materials / accessibility / format • Supporting agency staff to access training and support materials prior to shift • Agency staff contract management to ensure staff have a smartcard prior to booking a shift • Staff behaviours programme • Process for reviewing SOP for authorisation • LPT IG/DPO to consider review of SystmOne access versus data privacy • Ensure that resolution of access issues mitigates scanning risk • Training information being sent out to staff via CSS. • HIS scoping handset options for Brigid	T. Singh/CSOs by Directorates Csos by Directorates Ops Directors Ops Directors J. Hames and CSOs CSS CSS CSOS/Team Leaders / charge nurses CSS Tirath Singh	• Process is underway to identify extra staff in in-patient services, to be RA Sponsors. List has been submitted to RA team and training is being undertaken. • Trust Wi-Fi project underway to identify areas with low/intermittent/ black spots strength to add a booster • Training information being disseminated • Exploring cost of replacement of handheld devices	Amber

Risk No: 84	Date included	August 2022	Date revised	14/09/2022
Objective: S	High Standards			
Risk Title:	A high vacancy rate for registered nurses, AHPs, HCSWs and medical staff, is leading to high temporary staff usage, which may impact on the quality of patient outcomes, safety, quality and experience.			
Risk owner:	Exec: Director of Nursing, AHPs and Quality		Local: Assistant Director of Nursing & Quality	
Governance:	Quality Forum, SWC/QAC /Board - Monthly Review			

	Consequence	Likelihood	Combined
Current Risk	4	4	16
Residual Risk	4	2	8
Tolerance Level Significant 16-20 (Appetite People-Seek)			

Controls

Description:

- Safe staffing policy
- Revised dynamic risk assessment process for additional staffing requests
- Safer Staffing Board Assurance Framework November 2021
- Weekly safer staffing and safety huddle
- Staff forecasting and quality impact assessments
- Daily operational management processes
- Decision tool and escalation framework for resolution of staff shortages
- Staffing escalation plans for business continuity and surge plans
- Winter plan
- Nurse in charge with clear roles and responsibilities to check staffing meets individual care needs
- Clear induction policy for substantive and temporary staffing including agency staff

Gaps:

- National workforce shortages – particularly in LD, mental health and community nursing
- Continuity of care
- Impact on patient outcomes and experience

Assurances

	Source:	Evidence:	
Internal:	Bank clinical supervision report to the professional standards group with themes and trends for monitoring bank staff induction, support and skills Daily safe staffing huddle, Winter Preparedness 2021 Nursing Safer Staffing BAF November 2021, National safe staffing return Monthly Safe staffing report including monitoring harm / nurse sensitive indicators Reporting to Trust Board and level 1 assurance committee	• Self-assessment complete 4 key themes to enhance assurance, action plan developed • Weekly situational and forecast staffing meeting • Workforce and Agency Reduction Plan to QAC and FPC (August 22)	Assurance Rating Green
External:	• Internal Audit – Agency Staffing due Q3 2022/23 • CQC and regulatory feedback • National reporting – fill rates and care hours per patient day - NHSE		Assurance Rating Amber
Gaps:			

Actions

Date:	Actions:	Action Owner:	Progress:	Status
Feb 23	Project to introduce Schwartz rounds	D Rennie	Task and Finish Group set up, funding agreed and staff identified	Amber
Nov 22	Continue to deliver robust temporary worker induction and undertake a spot check.	L Evans	Spot check audits planned for November 22	
Nov 22	Update actions from the safer staffing Board Assurance Framework –refresh for winter 2022/23	L Evans	Ongoing – refresh due to be drafted Nov 22 and presented to SWC	
March 23	Delivery of the workforce and agency reduction plan (link to risk 85)	Sarah Willis	Scoping in line with model hospital, NQB standards	
Oct 22	Review of wider measures to understand the impact of staffing on quality	E Wallis	Ongoing	
Sept 22	Working group to review support for bank staff and address training compliance	L Evans	Action plan implemented and monthly monitoring of progress	

Risk No: 85	Date included	August 2022	Date revised	09/09/22
Objective: S	Well Governed			
Risk Title:	High agency usage is resulting in high spend, which may impact on the delivery of our financial targets for 2022/23			
Risk owner:	Exec: Director of Finance / Director HR		Local: Deputy Director of Finance	
Governance:	EMB/FPC/Board - Monthly Review			

	Consequence	Likelihood	Combined
Current Risk	4	5	20
Residual Risk	4	4	16
Tolerance Level Moderate 9-11 (Appetite Financial-Cautious)			

Controls

Description:

LPT Controls

- DRA process ensures all agency shifts appropriately approved against establishment
- Agency spend separately coded on ledger
- Budget reports show agency spend by cost centre & reviewed by budget holders & management accountants
- Pre-approval process for all non clinical agency staff prior to NHSE approval being sought
- HCL master vend approach ensures agreed rates paid for staff
- Reducing reliance on agency project clearly defined with specific financial target for spend reduction & specific actions
- Agency estimated WTE included on cost centre reports to highlight total level of staffing being used compared to budget

Gaps:

- Off framework agency does not conform to NHSE price caps
- Gaps in establishment in ESR & General ledger reconciliation; staff could be working to different views of the funded establishment
- Operational pressures could lead to higher than planned agency use
- Agency reduction required to deliver 22/23 plan is a material decrease on current usage
- Budget holder training could be out of date/new budget holders may not have received training during Covid

Assurances

	Source:	Evidence:	
Internal:	• Reducing reliance on agency project QI approach & reporting • Operational oversight & management of cost forecasts through Directorate Management Teams • Finance and Performance Committee report includes agency reporting • LLR ICB Finance committee oversight	• Progress reporting to EMB • Workforce and agency reduction plan (presented to QAC and TB development in August 22) • Monthly reports to OEB/SEB/FPC/Board/ICB finance committee on all aspects of delivery against financial plan, including agency • Mitigation plans for revenue to demonstrate requirements for financial plan delivery, including agency targets	Assurance Rating Green
External:	• NHSE monitoring of system delivery against Agency ceiling • 360 Assurance audit for agency staffing planned for Q3		Assurance Rating Amber
Gaps:			

Actions

Date:	Actions:	Action Owner:	Progress:	Status
Sept 22	Conclude reconciliation of establishment in ESR to General ledger	Nicola Ward/Chris Poyser	Ongoing	Green
March 23	Implement actions from the Workforce and Agency Reduction Plan	Sarah Willis	Ongoing	
Ongoing	Stop off framework agency use	Directorates	QI approach – will be monitored through the agency escalation meeting & cessation dates to be agreed for specific staff groups. CHS reduction in off framework spend across all areas Assurance on need is embedded through the DRA process	
Oct 22	Launch budget holder training & 'back to basics' finance engagement programme.	Sharon Murphy	Agreed approach with comms team - timetable developed	

Risk No: 86	Date included	14/09/22 **DRAFT**	Date revised	
Objective: S	High Standards			
Risk Title:	A lack of capacity within the workforce model and a high vacancy rate is reducing our ability to assess and follow up patients in community mental health services in a timely way, impacting on the safety of care and the mental wellbeing for our patients.			
Risk owner:	Exec Lead: Medical Director	Local: Clinical Director – Planned Care		
Governance:	EMB/QAC/ Board monthly			

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

Controls

Description:

- CMHT task and finish group
- A Planned Treatment and Recovery Team rapid response task and finish group
- Skill mix and career pathway task and finish group
- Workforce solutions in recruitment is supported by Trust policies and processes
- Crisis Team joint referral SOP
- Revised Duty System across all CMHTs
- CMHT workforce and risk assessment action plan
- Mental Health multi professional workforce plan
- pathway for overseas recruitment of consultant psychiatrists
- SUTG MH Transformation Programme

Gaps:

- Consultant Psychiatrist vacancies across the AMH planned care teams, the use of locums and the increasing difficulty in recruiting both substantive and locum staff
- Impact of transformation work to move the CMHTs to Planned Treatment and Recovery Teams
- Increased waiting times with repeated cancellations of clinics
- Temporary staff do not always have Approved Clinician status and managing patients on CTOs
- Workforce availability of staff with other skills/ knowledge – NMP's, ACP'S, AC's, Physician Associates, Pharmacists.

Assurances

	Source:	Evidence:	Assurance Rating
Internal:	• Operational risk 5087 Planned Treatment and Recovery Teams Staffing Risk • Review of measures including complaints, incidents and learning from deaths reported monthly through Quality and Safety DMT. • Cancelled clinics and waiting time data reported monthly through performance and finance DMT. • Quality summits – March 22 and September 22	• SEB paper Addressing the Consultant Psychiatrist vacancies in DMH – current issues, plans and next steps 1 July 2022 • CMHT Risk Paper to DMT in August 2022. • Quality Summit briefing to SEB May 2022	
External:			Assurance Rating
Gaps:			

Actions

Date:	Actions:	Action Owner	Progress:	Status
30 Sept 22	Physician Associate recruitment plan	Avinash Hiremath	• 2 posts recruited and further plan in place.	
28 Sept 22	Development of an improvement plan to address risks and support transformation	John Edwards	• A draft plan completed and shared with DMT and Executive Team on 16th Sept.22.	
31 Oct. 22	Present risk and mitigation plans to LLR MH Design Group	Sam Hamer		
31 Oct 22	Risk stratification of current CMHT patients commenced.	Debi O'Donovan		