Risk No: 59	Date included	29 November 2021	Date revised	07/11/2022
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: Operational Directors and Director of Nursing, AHPs and Quality		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 • DMH pilot programme – new cyclical process for managing and learning from SI's • Initial meeting held with the ICB for PSIRF to determine LLR ICB approach – ongoing engagement within ICB / System • Recruitment of additional clinical governance officers within Directorate to provide further capacity		
	Gaps:	• Capacity within Directorates to achieve trajectories in improvement plans		
Assurances	Internal:	Source • Reports/ minutes from Incident Oversight Group, Incident Review Meeting and Quality Forum and Executive Team. • Quality Summit March 2022 with learning • Monthly Quality Monitoring Report – Patient Safety Incident Investigation Report	Evidence • Directorate improvement plans - monitored via IOG and through to Quality Forum • Early learning from Incident Review Meeting • Reduced rate of complaints from families relating to SIs due to enhanced engagement. • Quality Forum November 2022 – assurance rated amber	Assurance Rating Amber
	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 Green
	Gaps:			

Actions	Date: Dec 22 (ongoing review)	Actions: Delivery of Directorate trajectories re incident closure, complete Sis and closure SI actions	Owner: TH/SL/HT	Progress: • Each Directorate is rated Green on closures within 15 days • Monthly report at Quality Forum showing stability or slightly reducing figures for SI completions

Status: Green

Risk No: 61	Date included	29 November 2021	Date revised	21/11/2022
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

	Source:	Evidence:	
Internal:	• 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	• 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 • Monthly pre-learning report on DPA training • SME report to TED/SWC	Assurance Rating Green
External:			Assurance Rating Green
Gaps:			

Actions

Date:	Actions:	Owner:	Progress - All actions ongoing and anticipated completion dates moved from October 22 to December 22	Status
Dec 22	• New process for amending compliance requirements to position numbers	AOD / Helen Briggs		Green
Dec 22	• Manager compliance and DNA reports live on ulearn	AOD / Helen Briggs		
Dec 22	• Deteriorating Workforce and Sepsis Group to progress and review training and compliance for ILS and BLS	AOD / Helen Briggs		
Dec 22	• Reporting and monitoring of monthly course unutilised spaces and cancelled courses/places	AOD / Helen Briggs		
Dec 22	• new report on DPA training compliance for pre-learning to go to DMT monthly	Sailesh Modhvadia		
	• MHA for Drs reviewed and amended refresh by MHA Governance Delivery Grp accepted by TED	Saquib/AOD		
Dec 22	• New report of Mandatory Training SME and course update logs to TED	Helen Briggs	New report due December 2022	

Risk No: 64	Date included	29 November 2021	Date revised	21/11/2022		Consequence	Likelihood	Combined
Objective: T	Transformation				Current Risk	4	3	12
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.				Residual Risk	3	3	9
Risk owner:	Exec: Director of Strategy and Partnerships			Local: Head of Strategy	Tolerance Level Moderate 9-11 (Appetite Financial-Cautious)			
Governance:	Transformation Committee / FPC / Board - Monthly Review							

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	Assurance Rating Green
	External:	Source: Internal Audit HOIAO Feedback from NHS E/I Feedback from stakeholders (CQC, CCG/ICB & local authorities) Attendance at local authority scrutiny meetings	Evidence: Formal feedback from audit opinion, formal meetings and our stakeholder feedback.	Assurance Rating Green
	Gaps:	Further building of our work with voluntary and community organisations		

	Date:	Actions:	Owner:	Progress:	Status
Actions	Nov 22	Launch of LDA Collaborative	Executive Director of Strategy & Partnerships	Complete and now delivering	Green
	Nov 22	Establishment of Commissioning & Collaborative Committee and first meeting		Provides Assurance on delivery of collaboratives and LPT commissioning functions	

Risk No: 65	Date included	29 November 2021	Date revised	18/11/2022
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	3	12
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:	

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:			

Actions	Date:	Actions:	Action Owner:	Progress:	Status
	Sept/Oct 22	• Staff engagement/ TUPE sessions jointly planned for Sept/Oct	CFO	• All actions complete	Green
	Ongoing	• LPT Workstreams in progress including; Comms; Operational readiness; People; FM delivery model; Supple Chain; CAFM; Finance; Operational Plans; IT; Assets	CFO		
	Sept/Oct 22	• Creating asset information and job plans	CFO/Estates Team		
	Sept/Oct 22	• Commenced recruitment of cleaning staff and contractors			

Risk No: 66	Date included	29 November 2021	Date revised	18/11/2022
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 Estates plan 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: Ongoing March 23 June 23	Actions: • Implementation of Dormitory Eradication programme. • Estates delivery plan • Production of the Trust's estates 5-year plan	Action Owner: Richard Brown Richard Brown Paul Sheldon	Progress: • Dorm scheme. Complex project - remains on plan, reported to NHSE Estates. • In draft – estimated trajectory 6 to 12 months • Being drafted and consulted	Status Amber

Risk No: 67	Date included	29 November 2021	Date revised	18/11/22
Objective: E	Environments			
Risk Title:	The Trust does not have ~~a Green Plan~~ or identified resource for the green agenda, leading to non-compliance with the NHS commitment to NHS Carbon Zero.			
Risk owner:	Exec: Chief Finance Officer		Local: Chief Finance Officer	
Governance:	Estates Committee, FPC / Board - Monthly Review			

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

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

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

Assurances	Internal:	Source: Green plan approved	Evidence:	Assurance Rating Amber
	External:	Source: LLR Green Board Work to share across the Group with NHFT knowledge and experience on sustainability	Evidence: Green Board Committees in Common	Assurance Rating Amber
	Gaps:			

Actions	Date: Dec 22	Actions: Exploring scope of using posts group wide	Owner: CFO	Progress: In discussion	Status Amber

Risk No: 68	Date included	29 November 2021	Date revised	09/11/22
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		

	Date:	Actions:	Owner:	Progress:	Status
Actions	Dec 22	• Restructure of information team	SM	MOC In progress	Green
	Dec 22	• Define data quality training approach	SM	Phase 2 data quality action plan will be presented at December	
	Mar 23	• Delivery of phase 2 of data quality plan – embedding processes & implementing kitemark approach	SM	DQC	

Risk No: 69	Date included	29 November 2021	Date revised	09/11/22
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
	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 amber (FPC - 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:	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		

	Date:	Actions:	Action Owner:	Progress:	Status
~~Actions~~	Dec 22	• Restructure of information team	SM	MOC In Progress	Amber
	Dec 22	• Phase 2 review of information team, including approach to performance framework management	SM	In Progress	
	Feb 23	• Making Data Count training for operational leads	SM	Date to be confirmed	
	Feb 23	• Board development session on making data count & QI journey for ELFT	SM	Date to be confirmed	
	Mar 23	• Finalise 23/24 metrics & performance report	SM		

Risk No: 72	Date included	29 November 2021	Date revised	21/11/2022
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 Partnerships		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	Dec 22	Reaching out delivery plan as part of the Step Up to Great (SUTG) strategy and plan	David Williams	Ongoing	Amber
	Nov 22	Social value framework co-produced	David Williams	Discussions with HACT Re framework and tool taking place and proposal received.	
	Jan 23	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	
	Jan 23	Development of inequalities data in an accessible format	Information Team	Some data complete, exploring with performance how this can be available to all. Local Public health team will provide the analysis.	

Risk No: 73	Date included	29 November 2021	Date revised	01/11/2022
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. • Zero tolerance campaign launched		
	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:			

	Date:	Actions:	Owner:	Progress:	Status
Actions	Dec 22	Delivery of Cultural Competency Programme	HA	(Programme underway. Low response rates for 360 assessments. Deadline for completion extended to mid-November.	Amber
	Nov 22	Establishing Equality Objectives within staff appraisals	HA (with Bina Kotecha) HA	Awaiting final sign off by L and D- expected November	

Risk No: 74	Date included	29 November 2021	Date revised	01/11/2022
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

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
	•			
Dec 22	• Codesign review of the anti bullying and harassment policy	Claire Taylor	Progressing	Amber
Dec 22	• Review financial HWB for staff	Amy Huckle	Continuous review	

Risk No: 75	Date included	29 November 2021	Date revised	17/11/2022	
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	Internal:	Source: • 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	Evidence: • Performance dashboards and reporting to DMTs , OEB and Trusts Board • Trajectory for improvement and measurement against trajectory • Transformation plans	Assurance Rating Amber
	External:	Source: • 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	Evidence:	Assurance Rating Amber
	Gaps:			

Actions	Date: ongoing	Actions: Delivery of priority service plans for reducing waiting lists	Owner: Operational Directors	Progress: In progress – ongoing.

Status
Amber

Risk No: 78	Environment / High Standards	Date reviewed:	18/11/2022		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	2	8
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:	

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:			

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
	Nov 22	To develop a service specification for garden cleaning and maintenance	Helen Walton	
	Nov 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	Cleaning forum now scheduled for Dec 22, first reports will be available from Dec 22
	March 23	Reintroduction of annual PLACE inspections	Helen Walton	Amber

Risk No: 79	Date included	29.03.22	Date revised	09/11/22
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
- More sophisticated phishing simulation exercise being planned

Gaps:

- Authentication of identity at service desk contact – implementation of multifactor authentication at all levels of the organisation
- Increase in NHS cyber threats seen in 2022
- Some staff clicked through links from August phishing exercise
- Staff continue to click through, as demonstrated in recent attack - c10% of staff who received the e-mail (similar % to August)

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:
Ongoing	Cyber security working group convened in response to increased risk	Chris Biddle	Ongoing until safe to step down	Green
Jan 23	Consider approach to staff who repeatedly click through links	Chris Biddle		
Jan 23	Consider if more impactful comms are needed	Chris Biddle		

Risk No: 81	Date included	29 April 2022	Date revised	09/11/22
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 ICB medium term capital strategy not yet in place
- LLR ICB 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 c£6.5m deficit
- ICB unmitigated pressure c£33m at month 7 (including LPT's likely forecast deficit)
- ICB risk share final date to be agreed to give organisations certainty around year end targets

ICB highest scored operational finance risks:

- Workforce recruitment and retention (score 16)
- Delivery of 22/23 financial plan (score 20)
- Urgent care pressure (score 16)

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 • Delivery against recovery plan actions will be reported monthly via finance report • LLR ICB Finance committee oversight	Evidence: • Reports & updates from Internal & external auditors • Monthly Director of Finance report to FPC / Trust Board – highlight report assurance rating Red (FPC - 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	Assurance Rating Amber
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 • HFMA checklist audit Q3 22/23	Evidence: • 2021/22 annual accounts unqualified opinion • Significant assurance • Significant assurance • significant assurance • Self assessment against checklist completed by trust, audit reviewing evidence	Assurance Rating Green
Gaps:			

Actions

Date:	Actions:	Action Owner:	Progress:	Status
Dec 22	Define value programme 22/23 in year financial delivery & contribution to deficit reduction	SM	weekly meetings taking place, value & impact on forecast deficit to be confirmed end November	Green
Dec 22	Contribute to LLR ICB capital & financial strategy development	SM	Ongoing	
Dec 22	Revise LPT medium term capital & financial strategy to ensure alignment with ICS strategy	SM	CFOs have discussed approach	
Dec 22	HFMA checklist actions & audit report presented to Audit Committee	SM	Ongoing	
Mar 23	Continued monitoring and management of all aspects of the Trust's delivery of the financial plan, including recovery actions	SM		

Risk No: 83	Date included	August 2022	Date revised	21/11/2022
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

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

Actions

Date:	Actions:	Action Owner	Progress:	Status
Feb 23	• Quantify gaps in RA sponsors across the Directorates and recruit RA sponsors	T. Singh/CSOs by Directorates	• 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
	• Identifying champions and super users in clinical areas and do they understand their role	Csos by Directorates		
	• Process for agency staff to identify and access RA sponsors to be clarified and published	Ops Directors		
	• Reminders for staff re training resources	Ops Directors		
	• Identifying training requirements and support materials / accessibility / format	J. Hames and CSOs		
	• Supporting agency staff to access training and support materials prior to shift	CSS		
	• Agency staff contract management to ensure staff have a smartcard prior to booking a shift	CSS		
	• Staff behaviours programme	CSOS/Team Leaders / charge nurses		
	• Process for reviewing SOP for authorisation	CSS		
	• LPT IG/DPO to consider review of SystmOne access versus data privacy	Tirath Singh		
	• Ensure that resolution of access issues mitigates scanning risk			
	• Training information being sent out to staff via CSS.			
	• HIS scoping handset options for Brigid			

Risk No: 84	Date included	August 2022	Date revised	07/11/2022
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
- Direct support programme with NHSE for reducing HCA vacancies
- Nursing and midwifery self assessment tool – NHSE / workforce leads
- Enhanced training programme for Bank staff

Gaps:

- National and local workforce shortages – particularly in LD, mental health, medical mental health workforce, AHPs (OT and Physiotherapy) and community nursing
- Increased pressure on staffing capacity winter/covid

Assurances

Internal:	Source: 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	Evidence: • 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 • National reporting – fill rates and care hours per patient day - NHSE		Assurance Rating Amber
Gaps:			

Actions

Date:	Actions:	Action Owner:	Progress:	Status
Feb 23 Dec 22	Project to embed Schwartz rounds - ongoing Delivery of the Trust Wide workforce, recruitment and agency plan link to (risk 85).	D Rennie Sarah Willis	Task and Finish Group set up, funding agreed and staff identified Spot check audits planned for November 2022 Delivery of plan update due December 2022	Amber
March 23	Delivery of actions from the Nursing and midwifery self assessment tool	L. Evans	Self assessment completed Sept 2022. Action plan being developed and will feed into SWC (Jan 23) Matrons forum session November 2022.	

Risk No: 85	Date included	August 2022	Date revised	09/11/22
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
- Establishment control approach put in place to reconcile finance and HR information through ESR and arrive at an accurate staffing picture
- Recruitment plans in place to address administration HCA/HCSW vacancies to zero, and reduce vacancies in other high agency usage workforces

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
- Agency spend is not decreasing fast enough to deliver LPT 22/23 plan value £23m & is contributing to the Trust's forecast deficit

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
March 23	Implement actions from the Workforce and Agency Reduction Plan	Sarah Willis	QI approach – will be monitored through the agency escalation meeting & cessation dates to be agreed for specific staff groups.	Green
Ongoing	Stop off framework agency use	Directorates	CHS reduction in off framework spend across all areas	
Dec 22	Recruitment of additional capacity in recruitment	Sarah Willis	Assurance on need is embedded through the DRA process	
Nov 22	Launch budget holder training & 'back to basics' finance engagement programme.	Sharon Murphy	Trust wide comms; roadshows & training started; collating feedback	

Risk No: 86	Date included	14/09/22	Date revised	18/11/22
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

Internal:	Source: • 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	Evidence: • 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	Assurance Rating Amber
External ..	Source:	Evidence:	Assurance Rating Amber
Gaps:			

Actions

Date:	Actions:	Action Owner	Progress:	Status
Dec 22 Dec 22	Physician Associate recruitment plan Delivery of an improvement plan to address risks and support transformation	Saquib Muhammad John Edwards	• Ongoing recruitment progressing. • A draft plan completed and shared with DMT and Executive Team on 16th Sept.22.	Amber

Risk No: 87 DRAFT	Date included	18 November 2021 DRAFT	Date revised	18/11/2022
Objective: E	Environments			
Risk Title:	Following the establishment of a new FM service, there is a risk of unknown issues based on historical maintenance resulting in the Trust not meeting its quality standards or requirements.			
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:	• 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 • New in-house senior team • Performance metrics with full data availability in development from 1 November 2022
	Gaps:	• Inherited and unquantified unknown issues

Assurances	Internal:	Source: FM Oversight Group Estates and Medical Equipment Committee FPC Estates risk register	Evidence: • In house data (from 1 November 2022) • Ongoing review of audit actions • Monthly estates updates including health and safety reviews • FPC estates updates	Assurance Rating Amber
	External:	Source: • CQC inspection 2021	Evidence: • CQC report	Assurance Rating Amber
	Gaps:	• Missing historical data from previous FM provider		

Actions	Date:	Actions:	Action Owner:	Progress:	Status
	January 2023	Process for regular oversight of performance metrics as data is collated from 1 November 2022	Paul Sheldon	EMIC – PS (review of first 3 months data)	Amber
	January 2023	Appointments to senior team and onboarding of new staff from January	Paul Sheldon		
	Ongoing	Compliance and safety testing	Paul Sheldon	Ongoing – no finish date. Work already started, the work will become business as usual	

Risk No: 88 DRAFT	Date included	DRAFT NOVEMBER 2022	Date revised	18 November 2022			
Objective: S	High Standards						
Risk Title:	Risk of closed cultures within services that may lead to poor patient, staff and family experience and organisational and reputational risk.						
Risk owner:	Exec Lead: Director of Nursing, AHPs and Quality		Local: Group Director of Patient Safety				
Governance:	EMB/QAC/ Board monthly						

	Consequence	Likelihood	Combined
Current Risk	4	3	12
Residual Risk	4	2	8
Tolerance level Significant 16-20 (Appetite Quality-Seek)			

Controls	Description:	• Governance processes and systems (Board to Ward) • Recruitment and HR processes • NHS staff survey • Complaints & PALS processes • Patient safety investigations, human factors and learning lessons processes • Freedom to speak up processes and culture • Cultural change workstream • Ongoing work to reduce restrictive practices such as seclusion and long-term segregation • Audits, practice and application of the Mental Health Act, Mental Capacity Act and Deprivation of Liberty Safeguards. This includes application, where required, of Gillick competency and Fraser Guidelines. • Practice and application of safeguarding processes • Advocacy support to service users and families • Community Education Treatment Reviews in Learning Disability Services • External scrutiny and visits from commissioners, regulators and local authority safeguarding • Service led self-assessment and quality assurance processes and accreditation programmes • Service visits by Executive team, Non-Executive Directors, and Governors • Quality summits and associated improvement programmes within directorates
	Gaps:	• Recognition of closed cultures is not built into staff induction and training, including for bank & agency staff. • Output of recommendations from Quality & Safety review

Assurances	Internal:	Source: • Trust governance (committees, sub-committees, directorate level) • Patient safety, patient experience & safeguarding groups • Self-assessment & accreditation processes	Evidence: • Minutes from governance meetings and committees	Assurance Rating Amber
	External:	Source: • CQC/MHA visits • Commissioner/LA safeguarding visits	Evidence: • CQC reports • Commissioner feedback/Safeguarding reviews	Assurance Rating Amber
	Gaps:			

Actions	Date:	Actions: • Quality & Safety review paper being presented at QAC in December 2022 • Delivery of recommendations from Quality & Safety review	Action Owner Anne Scott James Mullins	Progress:	Status Amber