Leicestershire Partnership NHS Trust

Organisational Risk Register
March 2023

Based on the risk appetite matrix produced by the Good Governance Institute

Risk No: 59	Date included	29 November 2021	Date revised	09/03/2023
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:	Quality Forum / QSC / 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:	• Incident reporting policy, centralised SI reporting and oversight process, and approved exec sign off process • Incident investigation training monthly rolling programme • 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 SI investigators and clinical governance officers • Learning lessons community of practice		
	Gaps:	• Resource and workforce challenges due to winter pressures • Short term safeguarding and ANP capacity to input into SI reviews in a timely way • Delivery of trajectories for improvement		
Assurances	Internal:	Source • Reports/ minutes from Incident Oversight Group, Incident Review Meeting and Quality Forum and Executive Team. • Monthly Quality Monitoring Report – Patient Safety Incident Investigation Report • Increased frequency of sign off meetings • Collaboration with the Group learning lesson exchange group • Clinical governance structure • Directorate improvement plans in place monitored via Incident Oversight Group	Evidence • Patient Safety Trust Board reporting includes patent stories to support learning • Directorate improvement plans - monitored via EMB, 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.	Assurance Rating Amber
	External:	Source: • CQC Inspection 2021 • CCG sign off and feedback for SI reporting	Evidence: • CQC feedback The trust must ensure that managers review incident in a timely way, in line with trust policy. (Reg17 (1)) • CCG – number of reports signed off / number returned for additional work	Assurance Rating Green
	Gaps:			

Actions	Date: Mar 23	Actions: Approval of a tailored quality improvement plan	Owner: TH/SL/HT	Progress: Developed – awaiting sign off

Status
Amber

Risk No: 61	Date included	29 November 2021	Date revised	01/03/2023
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 / PCC / 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, Safer staffing policies and guidance
- National and local People Plan
- Mandated clinical supervision
- Role applicable competency framework / Annual training needs analysis
- E rostering in place across inpatient services and community
- Reintroduction of system for bank staff who are unable to book shifts unless they are fully compliant with mandatory training
- On-going recruitment programme / STAR days
- Annual establishment reviews / Winter BAF actions revised and reviewed
- New process for amending compliance requirements to position numbers / Manager compliance and DNA reports live on ulearn
- Deteriorating Workforce and Sepsis Group in place to progress and review training and compliance for ILS and BLS
- Reporting and monitoring of monthly course unutilised spaces and cancelled courses/places / New report of Mandatory Training SME and course update logs to TED
- new report on DPA training compliance for pre-learning to go to DMT monthly
- MHA for Drs reviewed and amended refresh by MHA Governance Delivery Grp accepted by TED

Gaps:

- Elements of mandatory and role essential training compliance for our non-substantive/bank workforce
- Knowledge of the skill set for individual bank and agency staff
- Knowledge of Agency staff skills outside of the on-framework agency
- Clinical matron role for supporting the skills training and clinical supervision for bank and agency staff
- Emphasis on the role of sepsis awareness and deteriorating patient training for all staff

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 • Workforce and safe staffing, tipping points and actions aligned to OPEL levels and governed through SWC • Hotspots identified on Directorate Risk Registers • Weekly safe staffing meeting • Learning from SI's and quality improvements • Monthly clinical education forum • Winter BAF actions reviewed at Winter Committee	• 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 • New PCC discussion on agency compliance	Assurance Rating Green
External			
Gaps:			

Actions

Date:	Actions:	Owner:	Progress	Status
Feb 23	• Increase compliance for ILS, NEWS 2 and sepsis for substantive and bank staff	Helen Briggs	Ongoing	Green
April 23	• ILS training compliance for 113 agency RNs who regularly work in in-patients	Helen Briggs	Meeting held 8.2.23, TNA completed, compliance check to be completed by agency, GAP identified, training to be sourced	Green
April 23	• SWG consider risk and agency compliance	Emma Wallis		
Mar 23	• Increase the cascade of flat lift awareness and competency assessment to use equipment on inpatient wards	Helen Briggs	Ongoing	

Risk No: 64	Date included	29 November 2021	Date revised	01/03/2023
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 Partnerships		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:	• Sufficient oversight of individual service sustainability

Assurances	Internal:	Source: Commissioning & Collaborative Committee and first meeting Transformation and QI Committee Joint Working Group (JWG) of LPT & NHFT Executive, board meetings & board development sessions Finance and Performance Committee	Evidence: Transformation Committee will review progress of internal transformational priorities. JWG reviews progress on key joint priorities. Executive, Board meetings and development sessions include a focus on our strategic priorities and transformation. Evidence available in papers, agenda and minutes Business pipeline report	Assurance Rating Green
	External:	Source: Internal Audit HOIAO Feedback from NHS E/I Feedback from stakeholders (CQC, CCG/ICB & local authorities) Attendance at local authority scrutiny meetings	Evidence: Formal feedback from audit opinion, formal meetings and our stakeholder feedback.	Assurance Rating Green
	Gaps:	Further building of our work with voluntary and community organisations		

Actions	Date: Mar 23	Actions: Liaison with Director of Finance and Operational Directors to identify way forward	Owner: Executive Director of Strategy & Partnerships	Progress: ongoing	Status Green

Risk No: 66	Date included	29 November 2021	Date revised	21/03/2023
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 Green
	External:	Source: • CQC Inspection 2021, 2022 • Consideration of NHP expression of interest submitted 2022.	Evidence: • CQC report • NHSEI updated monthly on track.	Assurance Rating Amber
	Gaps:			

Actions	Date:	Actions:	Action Owner:	Progress:	Status
	June 23	• Implementation of Dormitory Eradication programme.	Richard Brown	• Dorm scheme. Complex project - remains on plan, reported to NHSE Estates. [status Green].	Green
	March 24	• Estates delivery plan	Richard Brown	• In draft – estimated trajectory 6 to 12 months	Amber
	June 23	• Production of the Trust's estates 5-year plan	Paul Sheldon	• Being drafted and consulted	Amber

Risk No: 67	Date included	29 November 2021	Date revised	01/03/23
Objective: E	Environments			
Risk Title:	The Trust does not have 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:	• 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 Green NHS Board meets monthly – LPT in attendance • Job Descriptions approved for Head of Sustainability, and Sustainability Manager (potential secondment/development role) • Working with NHFT to deliver across the Group
	Gaps:	• Lack of data on carbon footprint • Lack of historic Sustainable Development Management Plan

Assurances	Internal:	Source: Green plan approved Regular reporting	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: Mar 23	Actions: Recruit to a Head of Sustainability role	Owner: CFO	Progress: In progress.	Status Amber

Risk No: 68	Date included	29 November 2021	Date revised	13/03/23
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	3	12

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
- Local risks reviewed in Data Privacy Committee
- Delivery of phase 1 21/22 data quality work plan
- SEB approved Data Quality Plan Implementation and Campaign on 02/12/22

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
Mar 23	• Trust wide data quality comms campaign	SM	Working with comms team	Green
Apr 23	• Implement priority SNOMED coding areas	SM	Concerns around resource to support implementation	Red
Apr 23	• Trust resource must be agreed for SNOMED implementation (statutory requirement from 01/04/23)	SM	Agreed at SEB as Trust priority now at I, M & T delivery group for milestones & resource agreement	Green
Dec 23	• Continue to implement SNOMED		Clarity for 23/24 resources to be agreed by end of March 23	Amber
Dec 23	• Delivery of phase 2 of data quality plan – embedding processes & implementing kitemark approach	SM SM	Data quality plan approved by DQC in December 2022 & approved by SEB	Green

Risk No: 69	Date included	29 November 2021	Date revised	13/03/23	
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:	EMB / 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.
	External:	Source: • CQC inspection 2021 • External and internal audit	Evidence: • Internal audit review of performance framework 21/22 – significant assurance
	Gaps:	• Fully embedded system (demonstrated once level 2 dashboards are fully implemented) • Trust wide approach to reporting planned post covid performance & capacity	

	Assurance Rating
Internal:	Amber
External:	Green

~~Actions~~	Date:	Actions:	Action Owner:	Progress:	Status
	tbd	• Restructure of information team	SM	MOC on hold	Amber
	tbd	• Phase 2 review of information team, including approach to performance framework management	SM	on hold	Amber
	Feb 23	• Making Data Count training for operational leads	SM	Completed	Green
	Feb 23	• Board development session on making data count	SM	Completed	Green
	Mar 23	• Finalise 23/24 metrics & performance report	SM	Final approval planned for 31/03/23 SEB	Green
	Apr 23	• Agree priority information projects for 23/24, including dashboard & SNOMED implementation	SM	List agreed at 03/03/23 SEB, now at I, M & T delivery group for milestones & resource agreement	

Risk No: 72	Date included	29 November 2021	Date revised	01/03/2023
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 / 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:	• 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 Reaching out delivery plan as part of the Step Up to Great (SUTG) strategy and plan	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	Mar 23	Social value framework co-produced	David Williams	Ongoing	Amber
	Mar 23	Further agreement on our approach and calculating impact and value	David Williams	Internal assessment underway	Amber
	Mar 23	Development of inequalities data in an accessible format	David Williams/ Information Team	Some data complete, exploring with performance how this can be available to all. Local Public health team will provide the analysis.	Amber

Risk No: 73	Date included	29 November 2021	Date revised	01/03/2023
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 / PCC / 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:	• 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 • Equality Objectives within staff appraisals • Cultural Competency Programme		
	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	Mar 23	Feedback and impact review of the cultural competency programme for 22/23	Haseeb A		Amber
	April 23	Review outputs of staff survey	HA and KB		Amber

Risk No: 74	Date included	29 November 2021	Date revised	01/03/2023			
Objective: E	Equality, Leadership, Culture						
Risk Title:	The impact of additional pressures on service delivery may compromise the health and wellbeing of our staff, leading to increased sickness levels.						
Risk owner:	Exec: Director of HR & OD		Local: Deputy Director of HR and OD				
Governance:	SWC / PCC / 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 • Rolling programme of health and wellbeing roadshows		
	Gaps:	- Impact of financial pressures on health and wellbeing		
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 • Staff side – feedback • Action plan reporting through SG AND ICC • People plan • HWB Guardian update to Board	Assurance Rating Green
	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: Mar 23 Ongoing March 23	Actions: • Task and finish group review financial HWB for staff • Operational directorate focus on sickness levels over winter period • SWG deep dive on sickness absence / consider the impact of strike action / Staff Survey results	Action Owner: DN, KB and AH SL, HT and TH CT	Progress: Progressing with continuous review Ongoing	Status Green Green

Risk No: 75	Date included	29 November 2021	Date revised	01/03/23
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:	Access Delivery Group / 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 • Recurrent funding for non recurrent solutions • 23/24 access priorities to be agreed

Assurances	Internal:	Source: • Executive Management Board – Performance reviews • Directorate level deep dives. • 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, EMB and Trust 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 • National benchmarking data • Quality / Contract Monitoring with ICB • LDA	Evidence: NHSE QRSM LDA regional oversight board delivery plan / metrics	Assurance Rating Amber
	Gaps:	• Access Delivery Group to be established (replaces Improving Access Committee)		

	Date:	Actions:	Owner:	Progress:	Status
Actions	Ongoing	Delivery of priority service plans (22/23) for reducing waiting lists FYPCLD – Comm Paeds / Audiology/ CAMHS Eating Disorders/CAMHS Access/SALT. Plans in place DMH – CMHT/ ADHD/memory assessment / TSPPD / CBT/DPS. Plans in place CHS – CINNS, Continence. Plans in place	Operational Directors	In progress – ongoing. Trajectories being determined and discussed at a newly convened Access Delivery Group and oversight at EMB	Amber
	Mar 23	Signed off plans for priority areas by end March 2023 DMH/CHS/FYPC			Amber

Risk No: 79	Date included	29.03.22	Date revised	13/03/23
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/ 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:

- Multiple tiers of controls including ongoing assessment and scanning of boundaries, geo-blocking and supporting information security policies
- Governance controls – reporting to Data Privacy and IM&T Committee on Cyber and Information Security / SIRO Structure / mandatory training / bespoke training
- Audits on Information Security Management System (ISMS), ISO, DSPT – with significant assurance
- Continuity Planning and Disaster Recovery – exercises and reviews. Business Continuity Plans for all services incl loss of IT systems in accordance with the EPRR Policy
- 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
- Regular One Minute Brief messages and communications reminding staff how to recognise a potential Phishing email or request for credentials
- Increased collaborative working with other NHS organisations to share intelligence and learning
- 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
- Home working risk assessment includes confidentiality clauses and accessing clinical systems, which requires signature of staff member
- Phishing simulation exercise August 2022 enabled assessment of Trust's vulnerability – further 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)
- Audit and assurance regarding the testing of Business Continuity Plans - feeding into the 2023/24 planning process for internal audit plan

Assurances

	Source:	Evidence:	
Internal:	Cyber security working group 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 Business Continuity plans Mandatory training compliance reports	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 External scrutiny at multiple levels – Police Cyber resilience, National Cyber Security Centre (NCSC), BitSight assessment, NHS Secure Boundary scanning and reporting	Accreditation report Audit report Audit Report – substantial assurance NHS Digital submission	Assurance Rating Green
Gaps:			

Actions

Date:	Actions:	Action Owner:	Progress:	Status:
Mar 23	Joint exercise with HIS to test plans in the event of a cyber security breach	EPRR Lead / HIS	Approach agreed at DQC	Green
Jun 23	Multi Factor authentication will be mandated by NHS Digital for NHS mail accounts	HIS	Working group set up	Green
Mar 24	IT Business continuity plan for prolonged downtime part of 23/24 internal audit plan	SM	Audit plan to be agreed at March Audit & risk committee	Green

Risk No: 81	Date included	29 April 2022	Date revised	13/03/23
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:	EMB / FPC / Board monthly			

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

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
- 2023/24 planning guidance states that capital allocations will be based on delivery of either break even or NHSE agreed deficit positions

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£2.9m deficit
- Operating costs of the Beacon Unit significant exceed the cost per case income secured.
- ICB unmitigated pressure c£20m at month 9 (including LPT's likely forecast deficit)
- ICB risk share final date to be agreed to give organisations certainty around year end targets
- 2023/24 planning risks emerging around workforce bureau, health & wellbeing hub & winter capacity funding from the ICB which could impact on Q1 if LPT is not able to quickly enact mitigations
- Draft 2023/24 financial plan had £20m deficit for LPT & £158m for LLR ICB

ICB highest scored operational finance risks:

- Elective care backlog (score 20)
- Urgent care pressure (score 16)

- Financial risk has reduced to 9, following agreement of 2022/23 deficit value with NHSE

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
- 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
- MHOST safer staffing review completed for Beacon ~~(to Trust Board in Jan 23~~

Assurance Rating Green

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
- 360 Assurance review complete, report issued & presented to Dec Audit Committee

Assurance Rating Green

Gaps: If the Trust moves to a deficit, it will break the in year duty to break even, but the statutory duty is to deliver break even "taking one financial year with another". The Trust will have a 2 year period to return to surplus to ensure that the statutory duty can still be achieved.

Actions

Date:	Actions:	Owner:	Progress:	Status
Mar 23	Contribute to LLR ICB capital & financial strategy development	SM	Ongoing	Green
Mar 23	Revise LPT medium term capital & financial strategy to ensure alignment with ICS strategy	SM	Will be drafted alongside 23/24 plan	Green
Mar 23	Continued monitoring and management of the Trust's delivery of the 2022/23 financial plan, incl recovery actions	SM	Ongoing – Board approved a change in Forecast outturn on 13/12/22	Green
Mar 23	Review contractual arrangements for the Beacon Unit	HT		Green
Mar 23	Continue to mitigate draft 2023/24 financial plan risks & reduce deficit	SM		
Mar 23	Submit final 2023/24 Financial plan	SM	Board sign off planned 28/03/23	

Risk No: 83	Date included	August 2022	Date revised	01/03/2023
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
Mar 23	• Quantify gaps in RA sponsors across the Directorates and recruit RA sponsors	T. Singh/CSOs by Directorates	• Progress revised to March 2023 for further review next month	Amber
Mar 23	• Identifying champions and super users in clinical areas and do they understand their role	Csos by Directorates		
Mar 23	• Process for agency staff to identify and access RA sponsors to be clarified and published	Ops Directors		
Mar 23	• Reminders for staff re training resources	Ops Directors		
Mar 23	• Identifying training requirements and support materials / accessibility / format	J. Hames and CSOs		
Mar 23	• Supporting agency staff to access training and support materials prior to shift	CSS		
Mar 23	• Agency staff contract management to ensure staff have a smartcard prior to booking a shift	CSS		
Mar 23	• Staff behaviours programme	CSOS/Team Leaders / charge nurses		
Mar 23	• Process for reviewing SOP for authorisation	CSS		
Mar 23	• LPT IG/DPO to consider review of SystmOne access versus data privacy	Tirath Singh		
Mar 23	• Ensure that resolution of access issues mitigates scanning risk			
Mar 23	• Training information being sent out to staff via CSS.			
Mar 23	• HIS scoping handset options for Brigid			

Risk No: 84	Date included	August 2022	Date revised	09/03/2023
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 and SWC / QSC / 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 / induction policy for substantive and temporary staffing including agency staff • 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 • Decision tool and escalation framework for resolution of staff shortages • Staffing escalation plans for business continuity and surge plans • Winter plan • Direct support programme with NHSE for reducing HCA vacancies • Nursing and midwifery self assessment tool – NHSE / workforce leads • Enhanced training programme for Bank staff • International nursing and AHP recruitment programme and comprehensive induction in place • LLR AHP faculty – short term funding to support recruitment and retention – recruitment video for AHPS and support worker career and appraisal tool
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 • Additional support and supervision in practice during transition period for internally recruited staff • Impact of work resulting from the QI collaboratives focusing on pressure ulcers, mental health observations and the deteriorating patient

Assurances

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 New PCC	Assurance Rating Green
External:	• Internal Audit – Agency Staffing due Q4 2022/23 • National reporting – fill rates and care hours per patient day - NHSE		Assurance Amber
Gaps:			

Actions

Date:	Actions:	Owner:	Progress:	Status
August 23	Embedding of Schwartz Rounds	D Rennie	On track with launch for August 2023.	Green
Sept 23	Development of QI collaborative improvement plans	JM, EW, MCS	All three QI collaborative groups have been established. Programmes are embedded within SUTG 2023/24 strategic plan.	Amber
Sept 23	Delivery of the recruitment and agency plan link to (risk 85). Specific Medical workforce Plan	Sarah Willis	On target for 0 Healthcare Support worker vacancies for July 2023.	Amber
August 23	Delivery of actions from the Nursing and midwifery self assessment tool	E. Wallis	Recruited a HCSW clinical lead to support the trajectory. SWC update in March 2023	FFGPC Amber
May 2023	Implementation of the Foundations for Great Nursing Care Programme and Daisy award celebrating excellence in nursing care	E. Wallis	FFGPC group established, engagement events booked for May and June 23 DAISY Project group established and signed agreement with launch date 11 May 2023	Daisy Green Amber

Risk No: 85	Date included	August 2022	Date revised	01/03/23
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:

- 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
- Budget holder training & 'back to basics' finance engagement programme.

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 – fortnightly meeting addressing all aspects of agency reduction plan • 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 including deep dive in December 22 • Workforce and agency reduction plan received at the new PCC • 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 Q4 – ToR approved		Assurance Rating Amber
Gaps:			

Actions

Date:	Actions:	Action Owner:	Progress:	Status
March 23	Implement actions from Workforce and Agency Reduction Plan	Sarah Willis	All actions progressing	Green
Ongoing	Stop off framework agency use	Directorates	"	Green
Mar 23	Recruitment of additional bank capacity in recruitment	Sarah Willis	"	Green
Mar 23	Review RRP schemes available to substantive and bank staff	SW	"	Green
Ongoing	Implement new rolling programme of bank recruitment	SW	Review progress March 2023	Green

Risk No: 86	Date included	14/09/22	Date revised	01/03/23
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/QSC/ Board – Monthly Review			

	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
- Revised level 2 Waiting Times Delivery Group chaired by interim Medical Director

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 • Caseload reviews progressing – not yet concluded • CMHT workforce and risk assessment action plan	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
Mar 23	Physician Associate recruitment plan	Saquib Muhammad	• Ongoing recruitment progressing – review in March	Amber
Mar 23	Delivery of an improvement plan to address risks and support transformation	John Edwards	• Ongoing delivery – review in March	Amber

Risk No: 87	Date included	18 November 2022	Date revised	01/03/2023
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 • Staffing 60% vacancies in Cleaning Team.

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		

	Date:	Actions:	Action Owner:	Progress:	Status
Actions	Ongoing	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
	Ongoing	Appointments to senior team and onboarding of new staff from January	Paul Sheldon	Progressing	Amber
	Ongoing	Compliance and safety testing	Paul Sheldon	Ongoing – no finish date. Work started and becoming business as usual	Amber

Risk No: 88	Date included	29/11/22	Date revised	08/03/23
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/QSC/ 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:

- 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
- Focussed quality & safety reviews (example of Langley ward in March 2023)

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:	Action Owner	Progress:	Status
Mar 23 Mar 23	• Quality & Safety review paper presented at QAC in December 2022 • Delivery of recommendations from Quality & Safety review reported to QAC/EMB/FFHS	James Mullins	• Q&S review reported to SEB & QAC • Recommendations and governance paper reported to QAC in February 2023 and SEB in March 2023	Amber

Risk No: 89	Date included	28/02/23	Date revised	08/03/23
Objective: S	Environment			
Risk Title:	Following the transfer of soft FM service, there are potential gaps in the sustainability of compliance with national cleaning standards and waste regulation which may impact on healthcare acquired infections and patient outcomes.			
Risk owner:	Exec Lead: Chief Finance Officer		Local: Associate Director of Estates and Facilities	
Governance:	IPCC / QSC / 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:	• National standards of healthcare cleanliness • Contract management with NHSPS 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 6 monthly report to Trust Board • SOPs in place to describe key responsibilities • Audit programme – national standards cleaning audit, IPC audit including cleaning, environmental audits by FM team, pre-acceptance waste audit, internal waste audits • On outbreak wards staff aligned to task for whole shift • Rapid response team • IPC operational meeting • Environmental checklist in Matron quality and safety checks • Quality accreditations / 15 steps / boardwalks • PLACE - patient led assessment of the care environment
Gaps:	• Recruitment. On transfer of services into LPT approximately 20% vacancy rate unfilled by any other sources. • Clearly defined roles and responsibilities for clinical staff re cleaning • On transfer – national standards of healthcare standards had not been implemented (including cleaning and auditing) – current gap with plan to implement. • Availability of technical cleaning audit performance • Appropriately trained estates team in place – still recruiting to management functions

Assurances

Internal:	Source: • Estates Committee (Soft FM report to EMEC (FPC) and IPC (QAC) • IPC Bi-Annual report to Trust Board • PLACE reporting – EMEC • Waste management meetings • DMTs • Internal audit programme	• IPC BAF • Cleaning report • Waste report • IA reporting • IPC walk arounds • Incident reporting	Assurance Rating Amber
External:	Source: • CQC inspections including MHA visits • PLACE – patient and carer led assessments	Evidence: Good PLACE scores – awaiting benchmark data CQC feedback has not escalated cleaning as an issue	Assurance Rating Green
Gaps:			

Actions

Date:	Actions:	Action Owner:	Progress	Status:
31 Mar 23	Implementation of national standards of healthcare cleanliness including training of both facilities and clinical staff	Helen Walton/HoN/IPC	Agreed with IPC team. Roll out programme to be determined.	Amber
Sept 23	Substantive recruitment (currently utilising agency or framework agreements)	Helen Walton	6 month programme – update due Sept 23	Amber
Sept 23	Reinstatement of PLACE	Helen Walton	Ongoing	Amber
Mar 23	Implement IPC and Estates environment audit programme	Amanda Hemsley / Helen Walton	Ongoing	Amber
April 23	Implement cleaning and efficacy audit programme	Helen Walton	Ongoing	Amber

Risk Scoring and Appetite

Leicestershire Partnership NHS Trust

Risk Scoring Matrix

The following matrix is used to grade risk
The scores obtained from individual consequence and likelihood risk scoring are assigned grades as follows;
1 Very Low (green)
2 Low (yellow)
3 Moderate (Amber)
4 High (red)
5 Significant (red)

The following matrix is used to grade **combined** risk scores. Risk scoring = consequence x likelihood (C x L)

	Likelihood				
Consequence	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

Risk Appetite and Tolerance Level

Risk type	Appetite level	Appetite Descriptor	Tolerance	Tolerance Descriptor
Financial	Cautious	We are prepared to accept the possibility of limited financial risk. However, VFM is our primary concern.	Moderate 9-11	Preference for sage delivery options hath have a low degree of residual risk and only a limited reward potential.
Regulatory	Cautious	We are prepared to accept the possibility of limited financial risk. However, VFM is our primary concern.	Moderate 9-11	Preference for sage delivery options hath have a low degree of residual risk and only a limited reward potential.
Quality	Seek	We will pursue innovation wherever appropriate. We are willing to take decisions on quality where there may be higher inherent risks but the potential for significant longer-term gains.	Significant 16-20	Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk).
Reputational	Cautious	We are prepared to accept the possibility of limited financial risk. However, VFM is our primary concern.	Moderate 9-11	Preference for sage delivery options hath have a low degree of residual risk and only a limited reward potential.
People	Seek	We will pursue innovation wherever appropriate. We are willing to take decisions on quality where there may be higher inherent risks but the potential for significant longer-term gains.	Significant 16-20	Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk).

Based on the risk appetite matrix produced by the Good Governance Institute