Leicestershire Partnership NHS Trust

H

Trust Board 26 September 2023

Organisational Risk Register

Purpose of the report

The Organisational Risk Register (ORR) contains strategic risks that may prevent us from achieving our objectives. It is presented as part of a continuing risk review process.

Analysis of the issue

There are currently 21 risks on the ORR, of which 11 have a high current risk score. The high-risk profile by strategic objective for the Trust includes the following areas;

High Standards (3)

- Access and use of Technology (risk 83)
- Vacancy Rate (safety and quality) (risk 84)
- Medical capacity in CMHT (risk 86)

Well Governed (3)

- Cyber threat (risk 79)
- High agency usage (finance) (risk 85)
- 23/24 financial position (risk 90)

Environment (2)

- FM Service (risk 87)
- Cleaning Standards (risk 89)

Access to Services (3)

- Waiting lists (risk 75)
- Access to Neurodevelopmental Assessment and Follow Up (risk 91)
- Access to 5-19 Service (risk 92)

Horizon Scanning

Reinforced Autoclaved Aerated Concrete (RAAC)

The risk of RAAC has been evaluated and as there is no known presence of RAAC on the LPT owned or occupied Estate, no risk has been identified for escalation.

Artificial Intelligence

A discussion of the threats and opportunities posed by using Artificial Intelligence are ongoing. Reference to the risk regarding cyber has been included on risk 79 and it has been deemed that a separate risk regarding AI is not currently required.

Changes in August and September 2023

- Risk 66 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.

  The Trust has drafted an estates 5-year plan and with ongoing consultation has negated the risk of not being able to adequately plan for an estates configuration which is fit for delivery high quality care. The FPC approved the closure of this risk.

- Risk 83 Inadequate access to and adoption of new technology hinders staff ability to maximise the advantages of the technology which impacts on the delivery of patient care.

  The residual score has reduced to 9 and clearer actions have been identified to support the mitigation of this risk. This has been subject to a deep dive discussion at our Strategic Executive Board in September 2023.

- Risk 84 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.

  The current risk score for this risk has increased from 16 to 20 due to the recruitment pipeline for preferred candidates. An additional action has been included to identify and deliver improved systems and processes for recruitment.

- Risk 91 Increasing numbers of patients on waiting lists and increasing lengths of delay in accessing diagnostic services for ADHD and ASD and timely follow-up, mean that patients may

  The title has been revised for increased clarity *'There is a risk that CYP and adults within LLR do not receive timely diagnosis and treatment for neurodevelopmental conditions, specifically autism and ASD. Delays result in failure to meet statutory obligations for SEND, as well as adverse psycho-social outcomes for people, including an increase in morbidly and mortality as well as an increased financial cost to the health, education, social care and criminal justice systems'.*

- Risk 93 Lack of emergency preparedness results in major service failure
  This new risk was approved by the Quality and Safety Committee for inclusion onto the ORR.

ORR risks September 2023

No.	Title	SU2G	Initial risk	Current risk	Residual Risk	Tolerance
59	Lack of staff capacity in 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.	High Standards	12	12	8	16-20
61	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.	High Standards	16	12	8	16-20
64	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.	Transformation	12	9	6	9-11
67	The Trust does not have identified resource for the green agenda, leading to non-compliance with the NHS commitment to NHS Carbon Zero.	Environment	12	12	12	9-11
68	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.	Well Governed	16	12	8	9-11
72	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.	Reaching Out	16	12	8	16-20

73	If we don't create an inclusive culture, it will affect staff and patient experience, which may lead to poorer quality and safety outcomes.	Equality, Leadership and Culture	12	9	6	16-20
74	The impact of additional pressures on service delivery may compromise the health and wellbeing of our staff, leading to increased sickness levels.	Equality, Leadership and Culture	9	9	6	16-20
75	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.	Access to Services	16	16	8	16-20
79	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	Well Governed	16	16	12	16-20
83	Inadequate access to and adoption of new technology hinders staff ability to maximise the advantages of the technology which impacts on the delivery of patient care.	High Standards	16	16	9	16-20
84	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.	High Standards	16	20	8	16-20
85	High agency usage is resulting in high spend, which may impact on the delivery of our financial targets for 2023/24	Well Governed	20	20	16	9-11
86	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.	High Standards	20	20	16	16-20
87	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.	Environment	16	16	12	16-20
88	Risk of closed cultures within services that may lead to poor patient, staff and family experience and organisational and reputational risk.	High Standards	12	12	8	16-20
89	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.	Environment	12	16	12	16-20
90	Inadequate control, reporting and management of the Trust's 2023/24 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).	Well Governed	16	16	12	9-11
91	There is a risk that CYP and adults within LLR do not receive timely diagnosis and treatment for neurodevelopmental conditions, specifically autism and ASD. Delays result in failure to meet statutory obligations for SEND, as well as adverse psycho-social outcomes for people, including an increase in morbidly and mortality as well as an increased financial cost to the health, education, social care and criminal justice systems'	Access to Services	20	20	16	16-20
92	Increasing demand and insufficient staffing is resulting in long wait times for the 5-19 service, which may cause harm to our patients and may prevent us from meeting our statutory responsibilities.	Access to Services	20	16	8	16-20
93	To ensure that LPT is able to provide core services in the event of any incident	Well Governed	9	9	6	9-11

Proposal

Ongoing monthly risk review with executive directors and risk leads.

Decision required

Trust board is assured by the risk management process and that the ORR continues to be reflect the risks relevant to the Trust.

Governance Table

For Board and Board Committees:	Trust Board 26 September 2023	
Paper sponsored by:	Kate Dyer, Acting Director of Corporate Governance	
Paper authored by:	Kate Dyer, Acting Director of Corporate Governance	
Date submitted:	18 September 2023	
State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):	None	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e. assured/ partially assured / not assured:		
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	Regular	
STEP up to GREAT strategic alignment*:	High **S**tandards	Yes
	Transformation	Yes
	Environments	Yes
	Patient Involvement	Yes
	Well **G**overned	Yes
	Reaching Out	Yes
	Equality, Leadership, Culture	Yes
	Access to Services	Yes
	Trust wide Quality Improvement	Yes
Organisational Risk Register considerations:	All	Yes
Is the decision required consistent with LPT's risk appetite:	Yes	
False and misleading information (FOMI) considerations:	None	
Positive confirmation that the content does not risk the safety of patients or the public	Confirmed	
Equality considerations:	None	

Leicestershire Partnership NHS Trust

Organisational Risk Register
September 2023

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

Risk No: 59	Date included	29 November 2021	Date revised	04/09/2023
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 • Approved SI sign off process
Gaps:	• Delay due to capacity focussing on clearing the backlog

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. • Trajectories for delivery of the over 15-day incident closure backlog complete and monitored through EMB.	Assurance Rating Amber
External:	Source: • CQC Inspection 2021 • ICB sign off and feedback for SI reporting • Accreditation feedback from SIRAN – positive on quality • Patients and family feedback – improving	Evidence: • CQC feedback The trust must ensure that managers review incident in a timely way, in line with trust policy. (Reg17 (1)) • ICB – number of reports signed off / number returned for additional work	Assurance Rating Green
Gaps:			

Actions

Date:	Actions:	Owner:	Progress:	Status
Ongoing	Directorate and patient safety services working together to clear the backlog of SIs	TH/SL/HT/TW	CHS – reviewed process and prioritisation and seeing a significant improvement in decreasing the backlog and proactive management to ensure SIs do not breach.	Amber
Ongoing	Closure of action plans within timeframes across the directorates.	TH/SL/HT/TW	FYPC – ongoing. Action plan backlog subject to 'scrum and sprint' methodology which is seeing significant improvement	Amber
Ongoing	Moving towards PSIRF	TH/SL/HT/TW	DMH – significant progress in completing the backlog with more robust systems, process and capacity in place to sustain. Approach with Local Authority Public Health Commissioners being agreed.	Amber

Risk No: 61	Date included	29 November 2021	Date revised	04/09/2023
Objective: S	High Standards			
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:	SWG / 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
- Process for amending compliance requirements to position numbers / Manager compliance and DNA reports live on ulearn
- Deteriorating Patient and Resus Group in place to progress and reviews clinical incidents and staff skills, resus drills, Level 3 ILS and Level 2 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
- Reporting on DPA training compliance for pre-learning/new starter goes to DMT monthly
- Level 3 ILS training plan agreed for 113 HRCG agency RNs who regularly work in in-patients, training to be completed by August 2023
- HRCG agency staff compliant with the national skills framework requirements, external audited and compliance reported through the Contract Review meeting
- Bank staff provided with clinical supervision through 0.4wte clinical education leads for bank
- EQIAs for a Trust wide 'hard stop' deployment of Thornbury HCA July 2023.
- Additional training provided by HRCG to regular agency nurses to complete ILS (L3)
- Extra capacity for face-to-face Pressure Ulcer Prevention training

Gaps:

- Elements of mandatory and role essential training compliance for our non-substantive/bank workforce

Assurances

Internal:

Source:	Evidence:	Assurance Rating
• SWC , Directorate Workforce groups , retention working group • Training Education and Development Group (TED) • 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	• Increased compliance for ILS, NEWS 2 and sepsis for substantive staff • Supervision compliance report- monthly • 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 • Managers live view of staff compliance on ulearn • EMB paper from Directorate execs on trajectory to compliance	Green

External

Gaps:

Actions

Date:	Actions:	Owner:	Progress	Status
Sept 23	• SBAR for the reinstatement for bank staff to be compliant before booking shifts	Jane Martin	Reviewed at TED	Green
Sept 23	• Review benchmarking for compliance reporting across the Group and the system	Nicola W/Alison O'D	Follow up paper to EMB September 23	Amber

Risk No: 64	Date included	29 November 2021	Date revised	18/09/2023
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	3	3	9
Residual Risk	2	3	6

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: Sept 23	Actions: Delivery of the national innovator supports new ways of working and LPT's role in the system as a convener and coordinator of services.	Owner: Group Director of Strategy & Partnerships	Progress: ongoing	Status Green

Risk No: 67	Date included	29 November 2021	Date revised	18/09/2023
Objective: E	Environment			
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	4	12

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

Controls	Description:	• Chief Finance Officer is Executive lead • Self-assessment undertaken on the Green Plan requirements, taken through Board Development and Strategic Executive Board • LLR Greener NHS Board authentic representation of the position and request for support made • Job Description drafted for Head of Sustainability, and Sustainability Manager. • 100% renewable energy to be purchased. • New Group Sustainability Committee with NHFT
	Gaps:	• Lack of data on carbon footprint. • Lack of historic Sustainable Development Management Plan. • Chapter leads to be confirmed • Job Descriptions awaiting banding and funding approval • New Joint Sustainability post not approved by Vacancy Control Panel

Assurances	Internal:	Source: • Green plan approved	Evidence: Board and committee meetings	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: Sept 23	Actions: • Set out action plan based on existing resource and without recruiting to Sustainability post	Owner:	Progress: Post not approved by LPT Vacancy Control Panel	Status Amber

Risk No: 68	Date included	29 November 2021	Date revised	15/09/23
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	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
- Accessible data for front line clinical teams
- Recorded demographic data does not support the health inequalities agenda, and could delay Trust understanding & action in this area
- Incomplete demographic data could impact on LLR system's ability to understand & manage Population Health Management for LPT patients
- SNOMED recording at point of care - non-compliance from 01/04/23; action plan & oversight group in place, team in dialogue with NHSE.
- Provision of late or inaccurate KPI data could lead to contractual penalties, leading to reputational impacts for the Trust, particularly in Health Together service

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 2023
- 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 23/24 360 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

Actions

Date:	Actions:	Owner:	Progress:	Status
Oct 23	• Collaboratively deliver Q2 Healthy Together KPI submission	IIT/FYPC	Project plan in place	Green
Dec 23	• Phase 1 delivery of health inequalities data recording	SM	Implementation plan in place	
Dec 23	• Continue to implement SNOMED	SM	Clarity for 23/24 resources agreed with all parties and updated at SEB	Amber
Dec 23	• Delivery of phase 2 of data quality plan – embedding processes & implementing kitemark approach	SM	Data quality plan approved by DQC in December 2022 & approved by SEB	Green

Risk No: 72	Date included	29 November 2021	Date revised	18/09/2023
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 • Board development programme • Social Value Charter • Inequalities data reporting and analysis
	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 • Social Value Charter

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.		

Actions	Date: Oct 23	Actions: Presentation to Directorate Meetings, Strategic Exec Board and Senior Leadership Forum of the Inequality data	Owner: David Williams	Progress: Presented to MH senior leadership team, date requested for SLF. Expected presentation to SEB October	Status Amber

Risk No: 73	Date included	29 November 2021	Date revised	18/09/2023
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
- Group TAR programme of work

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) • WRES / WDES staff survey results reviewed at EDI groups • WRES EDI reviewed at SEB June 23	Assurance Rating Green
External:	Source: • System wide EDI Taskforce established and identified seven priority areas for implementation • National scoring 0.7 out of 4	Evidence: • EDI Taskforce – highlight report assurance rating • CQC feedback • WRES and WDES metrics have improved in most areas.	Assurance Rating Amber
Gaps:			

Actions

Date:	Actions:	Owner:	Progress:	Status
Sep 23	Self-assessment against the National EDI delivery framework and refresh WRES WDES action Plans	Haseeb A	Complete – going to TB September 2023	Green
Ongoing	Delivery of annual action plans (including learning from NHSE ET ruling)	Haseeb A	Ongoing	Amber
March 24	Delivery of Group (LPT/NHFT) EDI programme	Chris Oakes	Ongoing	Amber
Jan 24	Task and Finish Group for the WDES programme – reasonable adjustments and equipment – 6 months starting July 2023	Sarah W	Ongoing – Group set up, meeting monthly for 6 months, to be reviewed in Jan 24	Green

Risk No: 74	Date included	29 November 2021	Date revised	18/09/2023	
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
- Ongoing deep dives on absence across the Directorate
- Mental Health First Aid Training internal offer to support health and wellbeing approved

Gaps:

- The ongoing NHS challenging environment and economic situation may impact on staff 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 Sickness deep dive received at SWG

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:	Actions:	Action Owner:	Progress:	Status
Ongoing	Deep dive reviews of sickness management	Claire Taylor	Ongoing	Green
Sep 23	Create an action plan with KPIs to be monitored through workforce groups and SWG	CT	Ongoing	Green
Sept 23	Health and wellbeing outcome from culture and leadership programme – team time out September 2023	Kamy Basra		Green

Risk No: 75	Date included	29 November 2021	Date revised	04/09/23
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:	EMB / 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 • Access Group • 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 • Approaches in services to reduce risk of harm while waiting by supporting service users with appropriate information • Agency locum sessions • Waiting list initiatives and extra sessions • Clinically led review of CHS waiting lists and targets – agreed approach with the ICB
	Gaps:	• Capacity and resources • FYPC recurrent funding for non-recurrent solutions • 23/24 access priorities to be agreed • Impact of industrial action by medical staff

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 • System performance monitoring • National benchmarking data • Quality / Contract Monitoring with ICB • LDA Collaborative	Evidence: NHSE QRSM LDA regional oversight board delivery plan / metrics	Assurance Rating Amber
	Gaps:			

	Date:	Actions:	Owner:	Progress:	Status
Actions	Ongoing	Delivery of Medical workforce plan	Ops Directors	In progress – ongoing.	Amber
	Ongoing	Delivery of priority service plans and associated trajectories; FYPCLD – Comm Paeds / Audiology/ CAMHS Eating Disorders/CAMHS Access/SALT/CYP Physio/Adult Autism Diagnostic Service. (ND separate risk 91) DMH – CMHT/ ADHD/memory assessment / TSPPD / CBT/DPS/SMI physical health checks . CHS – CINNS/ Continence/SALT/MSK.		Plans being delivered – next touchpoint August 2023 Overseen by Access Delivery Group and oversight at EMB Agreement by ICS to change waiting time targets in line with clinically agreed timelines. DMH weekly performance meetings	Amber
	Ongoing	Extension of virtual ward offer where appropriate to facilitate quality access.			Amber

Risk No: 79	Date included	29.03.22	Date revised	15/09/23
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 / 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
- Guidance is to be published into LPT, at the earliest opportunity, to ensure staff seek approval and authorisation before AI/LLM platforms are used within LPT services.

Gaps:

- Authentication of identity at service desk contact – implementation of multifactor authentication at all levels of the organisation
- Increase in NHS cyber threats seen affecting suppliers that the NHS uses
- 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 fed into the 2023/24 planning process for internal audit plan
- The use of public Artificial Intelligence (AI) /Large Language Model (LLM) services within LPT has the potential to place personal/patient information at risk of unauthorised/uncontrolled disclosure. Information input into the public platforms (e.g. ChtGPT) is available to all users with the concomitant risk to confidentiality

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 & testing of disaster recovery and business continuity processes in response to real world testing Cyber metrics reported through DPC Dashboard Reporting of incidents NHFT/LPT group EPRR business continuity workplan including co-production of response plans for cyber risks	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 22/23 DSPT submission – standards met 22/23 External scrutiny at multiple levels – Police Cyber resilience, National Cyber Security Centre (NCSC), BitSight assessment, NHS Secure Boundary scanning and reporting 360 Assurance Cyber security governance Audit 22/23	Accreditation report Audit reports / 360 substantial assurance NHS Digital submission Significant assurance	Assurance Rating Green
Gaps:	The Trust is reliant on Business Continuity plans of suppliers being adequately able to respond to cyber attacks in a timely manner		

Actions

Date:	Actions:	Owner:	Progress:	Status:
Aug 23	Data Privacy Committee consider trust wide comms around use of AI/Chat GPT	SM	Comms issued to Trust - complete	Green
Mar 24	Multi Factor authentication will be mandated by NHS Digital for NHS mail accounts	HIS	Working group set up priority areas identified e.g.	Green
Mar 24	IT Business continuity plan for prolonged downtime part of 23/24 internal audit plan	SM	finance/procurement	Green

Risk No: 83	Date included	August 2022	Date revised	18/09/2023
Objective:	High Standards			
Risk Title:	Inadequate access to and adoption of new technology hinders staff ability to maximise the advantages of the technology which impacts on the delivery of patient care.			
Risk owner:	Exec Lead: Group Director of Strategy and Business Development | Local Lead: Group CDIO / Director of LHIS			
Governance:	IMTC, EMB & FPC			

	Consequence	Likelihood	Combined
Current Risk	4	4	16
Residual Risk	3	3	9

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

Controls

Description:	• 24 hour on-call availability of HIS • Online training on SystmOne available to all SystmOne users • Business Continuity Plans in every service to ensure continuity • Constant Cyber protection from HIS, with reinforcement of local awareness for all staff • Operating policies for virtual appointments • LPT digital plan • LLR Care Record • Heat maps of wifi coverage across buildings and wards • Digital Maturity Assessment • HIS escalation route for staff
Gaps:	• Access and usability of the system • Staff knowledge, training and culture

Assurances

Internal:	Source: • Incident reporting • Monthly Directorate meetings with HIS contacts • IMT Delivery Group • IMT Committee	Evidence: Report summaries and regular meetings DMT meetings Minutes and actions from the meetings Minutes and actions form the meetings	Assurance Rating Amber
External:	Source: • CQC inspections/MHA visits • LLR Digital Strategy and Delivery meetings	Evidence: CQC inspection report 2022 Notes from the meetings	Assurance Rating Amber
Gaps:			

Actions

Date:	Actions:	Action Owner	Progress	Status
Oct 23	• Development of a Training SOP for SystmOne	Julia Bolton	In consultation	Amber
Oct 23	• Development of Digital Maturity Assessment and Digital Plan action plan	Gareth Jones	Action Plan and prioritisation in consultation with clinical staff	

Risk No: 84	Date included	August 2022	Date revised	18/09/2023
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 HR and OD		Local: Assistant Director of Nursing & Quality	
Governance:	Quality Forum and SWC / QSC / Board - Monthly Review			

	Consequence	Likelihood	Combined
Current Risk	4	5	20
Residual Risk	4	2	8

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

Controls

Description:

- Revised dynamic risk assessment process for additional staffing requests
- 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
- Direct support programme with NHSE for reducing HCA vacancies
- Nursing and midwifery self-assessment tool – NHSE / workforce leads
- 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
- Transition preceptorship programme and two WTE education and pastoral support nurses – accredited with the pastoral quality award
- Weekly vacancy control panel (includes nurse representation).
- Daisy Award
- Preceptorship quality mark application
- Flexible working as part of the People Promise Exemplar Programme
- Recruitment Risk Summit (September 2023) – managing the risk as an incident with 2xs weekly gold calls and action log chaired by the Director of HR
- Workforce and agency reduction plan in line with NHS Long Term Workforce Plan –
- Schwartz Rounds

Gaps:

- Capacity due to national and local workforce shortages
- Increased demand
- Significant delays in recruitment pipeline

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 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 – advisory incl recommendations for improvement • National reporting – fill rates and care hours per patient day - NHSE – improving reporting accuracy to reflect all additional skill mix roles. Need evidence in the national submission to flow through.		Assurance Amber
Gaps:			

Actions

Date:	Actions:	Owner:	Progress:	Status
March 24	Embedding of Development of QI collaborative improvement plans	JM, EW, MCS	All three QI collaborative groups have been established and being delivered within the SUTG plan. Touchpoint in August 2023	Green
March 24	Delivery of the recruitment and agency plan link to (risk 85) including medical workforce Plan	Sarah Willis	Delivery on track. Touchpoint in March 2024	Green
Dec 2023	Implementation of the Foundations for Great Nursing Care Programme	E. Wallis	On track. Held synthesis event and now consulting on the nursing care principles and delivery outputs .	Amber

Risk No: 85	Date included	August 2022	Date revised	15/09/23
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 2023/24			
Risk owner:	Exec: Director of Finance		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.
- Refresh of workforce and Agency Reduction Plan following system ops plan and increased CIP
- Establishment control process in place
- Stopped off-framework agency use for HCA (break glass process in place)

Gaps:

- Off framework and some on framework agencies do not conform to NHSE price caps
- Agency reduction required to deliver 23/24 plan is a material decrease on current usage
- Increased system pressures re workforce growth and CIPS could impact on agency use

Assurances

Internal:	Source: • 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	Evidence: • 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 • Agency reduction group bi weekly meetings • Deep dive on plan at EMB June	Assurance Rating Amber
External:	• NHSE monitoring of system delivery against Agency ceiling • 360 Assurance audit - agency staffing	Advisory review – no assurance rating provided	Assurance Rating Amber
Gaps:			

Actions

Date:	Actions:	Action Owner:	Progress:	Status
Nov 23	Stopping off framework for nursing by 31 Oct in FYPC/LD & DMH	Sarah Willis	Agreed at agency reduction meeting, EQIA approved	Green
Oct 23	Agree approach to stopping RN off framework in CHS	Sarah Willis	2 weekly agency reduction meeting	Amber
Oct 23	Agree approach to next step agency rate reduction with HCRG	Sarah Willis	2 weekly agency reduction meeting	Amber
Mar 24	Delivery of the workforce and agency reduction plan.	Sarah Willis	Monthly touchpoint review.	Amber

Risk No: 86	Date included	14/09/22	Date revised	18/09/23
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
- Specific medical workforce plan developed with 9 workstreams to support recruitment, retention, health and wellbeing and career development
- International medical graduate in post June 23 / five arriving in Q4 23/24
- Three ST6's able to be appointed substantively as either an NHS Locum or into a substantive medical consultation role during 23/24
- Proactively supporting trainees to apply for posts within the Trust as substantive medical employees

Gaps:

- Consultant Psychiatrist vacancies across the AMH planned care teams, the use of locums and the difficulty in recruiting substantive 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 • Monthly meeting with senior medical leadership team and CEO	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 • Workstreams that support medical workforce plan reported to SWG	Assurance Rating Amber
Externa –	Source:	Evidence:	Assurance Rating
Gaps:			

Actions

Date:	Actions:	Action Owner	Progress:	Status
Ongoing	Physician Associate recruitment plan	Saquib Muhammad	• Awaiting agreement with RSP and GMC re governance – to be discussed by Clinical Executives August 2023.	Amber
Mar 24	Medical workforce plan developing with 10 key workstreams – set within workforce and agency reduction plan. Monthly updates to SEB.	SMuh/ Sarah Willis	• Ongoing progression	Amber

Risk No: 87	Date included	18 November 2022	Date revised	18/09/2023
Objective: E	Environment			
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 • Performance metrics with full data availability in development from 1 November 2022
	Gaps:	• Inherited and unquantified unknown issues

Assurances	Internal:	Source: 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 • Estates 5 Year Plan (Archus)	Evidence: • CQC report	Assurance Rating Amber
	Gaps:	• Missing historical data from previous FM provider		

	Date:	Actions:	Action Owner:	Progress:	Status
Actions	Ongoing	Review of financial implications of backlog maintenance and reactive repairs	CFO	Initial review to EMEC before reporting to FPC Ongoing – no finish date. Next touchpoint August 2023	Amber
	Ongoing	Compliance and safety testing	CFO	Good progress, compliance increasing	Amber

Risk No: 88	Date included	November 2022	Date revised	18/09/23
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:	QF/QSC/ Board			

	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
Ongoing	• Delivery of recommendations from Quality & Safety review reported to QF/Q&S every 6 months, Update to FFHS monthly	James Mullins	• Action to report to QF and Q&S every 6 months with monthly updates to FFHS	Amber

Risk No: 89	Date included	28/02/23	Date revised	18/09/23
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	4	16
Residual Risk	4	3	12

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
- IPC and Estates environment audit programme
- Paper based audits still available – electronic auditing data being reviewed re suitability and report format.

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
- Appropriately trained staff and records to evidence

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 Assurance Group – on target for full implementation of cleaning standards • Regular performance reports – no full set of cleaning scores available yet. • PLACE report	• IPC BAF • Cleaning report • Waste report • IA reporting • IPC walk arounds • Incident reporting • Implementation of national standards of healthcare cleanliness including training of both facilities and clinical staff	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:
Sept 23	Substantive recruitment	Helen Walton/ HR	Currently utilising agency or framework agreements	Amber
Oct 23	Develop and implement training records via uLearn	AoD	FM staff ESR records not pulled through to Ulearn which is impacting on training and appraisals.	Amber

Risk No: 90	Date included	April 2023	Date revised	15/09/23
Objective: G	Well Governed			
Risk Title:	Inadequate control, reporting and management of the Trust's 2023/24 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	4	4	16
Residual Risk	4	3	12

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
- UEC collaborative tasked with identifying £17m savings to close planning gap

ICB highest scored operational finance risks:

- Urgent Care Pressure (score 20)
- 23/24 Financial plan delivery (score 20)
- Workforce, recruitment & selection (score 16)
- Delivery of financial strategy (score 16)
- Transformation & efficiency schemes (score 20)

Gaps:

- Breakeven plan submitted in May - £37m of quantifiable risk highlighted in plan – 8% of expenditure
- Operating costs of the Beacon Unit significantly exceed the cost per case income secured.
- Trust wide safer staffing, recruitment & agency reduction assumptions need to be delivered
- Significant efficiency savings - £16m 4% required for break-even plan- not fully identified currently
- LLR ICB medium term capital strategy not yet in place
- LLR ICB medium term revenue strategy not yet in place
- LLR ICB Risk/gain share unlikely to be agreed for 23/24 –specific organisational ownership of solutions to UEC risk & financial consequences outstanding
- LLR ICB May plan position was £10m deficit - ICB-break even, UHL-deficit related to urgent & emergency care unfunded costs (£10m)
- In year delivery of system wide plan at high risk as at month 5

Assurances

	Source:	Evidence:	
Internal:	• 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 • Completion of NHSE controls checklist Sept 23, 80% actions in place, actions clear for 20%	• 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 EMB/SEB/FPC/Board/ICB finance committee on all aspects of delivery against plan • Recovery plan weekly meetings & ongoing reporting to SEB, FPC & Trust Board • NHSE checklist results shared with EMB, SEB & LLR Finance committee • Ongoing review of HFMA 22/23 checklist actions at Audit & Risk committee	Assurance Rating Green
External:	Source: • KPMG audit of 2022/23 annual accounts and value for money conclusion • 2022/23 Internal audit - Financial systems - focusing on budget setting, reporting and monitoring • HFMA checklist audit Q3 22/23 • NHSE national & regional leads undertook deep dive into LPT financial plan & agreed it was robust and included real & clearly identified risk. • NHSE Checklist audit for LLR system by internal audit in Q3	Evidence: • 2022/23 annual accounts unqualified opinion • Significant assurance • 360 Assurance review complete, report issued & presented to Dec Audit Committee	Assurance Rating Green

Gaps: Following the 2022/23 deficit position, the Trust will have a 2 year period to return to surplus to ensure that the statutory duty to break even 'taking one year with another' over a 3 year rolling period an still be achieved.

Actions

Date:	Actions:	Owner:	Progress:	Status
Sept 23	• Close outstanding planning gap – c £2.5m & forecast deficit as at month 5	SM	Recovery plan work ongoing	Amber
Q2 23	• Contribute to LLR ICB capital & financial strategy development	SM	In progress	Green
Q2 23	• Revise LPT medium term capital & financial strategy to ensure alignment with ICS strategy	SM	In progress	Green
Dec 23	• Develop medium term recovery plan, using value in healthcare approach	SM	In progress	Green
Mar 24	• Continued monitoring and mgt of the Trust's delivery of 2023/24 financial plan, incl recovery actions	SM	Ongoing	Green

Risk No: 91	Date included	April 2023	Date revised	04/09/23
Objective: A	Access to Services			
Risk Title:	There is a risk that CYP and adults within LLR do not receive timely diagnosis and treatment for neurodevelopmental conditions, specifically autism and ASD. Delays result in failure to meet statutory obligations for SEND, as well as adverse psycho-social outcomes for people, including an increase in morbidly and mortality as well as an increased financial cost to the health, education, social care and criminal justice systems			
Risk owner:	Exec: Medical Director		Local: Director of DMH and FYPCLDA	
Governance:	EMB / FPC / 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:	• Access Policy • Waiting list management approaches and Standardised Operational Processes applied to waiting lists including application of acceptance criteria, patient tracking lists and demand capacity modelling • Service pathway re-design including triage, pre-assessment screening, digital contacts and skill-mix • System planning (design groups) established to identify system risks and investment required • Approaches in services to reduce risk of harm while waiting by supporting service users with appropriate information • Managing patient expectation through sharing approximate waiting times • Access Delivery Group • Non-recurrent funding for AAADs and Community Paediatrics • Local Authority funding for ADHD over 3 years • System QIA for the unsuccessful business case • Group AHDH workshop with NHFT to share learning – June 2023 • Benchmarked autism services against national framework for Autism diagnosis • FYPCLDA agreed performance trajectories • Regular reporting into the Transformation Committee • Refreshed CYP Business Case submitted for review by the ICB
	Gaps:	• Capacity and resources • No investment in 23/24 for business cases for CYP ND, AAADs – confirmed by ICB on 6 June 2023

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 in CAMHS • Directorate level risks relating to AADS, CYP ND and ADHD waiting times • Transformation and QI Group	Evidence: • Performance dashboards and reporting to DMTs, EMB and Trust Board • Business case setting out the case of need for CYP • Business case setting out case of need for adults with Autism • Re-designed pathways • Directorate Risk, actions and mitigations	Assurance Rating Amber
	External:	Source: • System ND Pathfinder Group • Regional ND summit – Q3 • CYP design Group / LLR LDA Collaborative • ND Board • LLR Mental Health Collaborative / LLR ND System Partnership Meeting	Evidence: • Meeting minutes and action logs • QIAs reviewed through system quality group • System risk register • System ND transformation group to be established to identified and support areas of risk.	Assurance Rating Amber
	Gaps:			

	Date:	Actions:	Owner:	Progressing – next touchpoint September 2023	Status
Actions	Oct 23	Re-establish Mental Health/ADHD transition group	Directors		Amber
	Sept 23	Agree revised performance trajectories for 23/24 in DMH	"		
	Sept 23	Recruit to non-recurrently funded vacancies	"	Partial recruitment outstanding	
	Sept 23	Deliver the ND transformation plan	"	Transformation committee - on track	

Risk No: 92	Date included	May 2023	Date revised	04/09/2023
Objective: S	Access to Services			
Risk Title:	Increasing demand and insufficient staffing in the Looked After Children nursing team is resulting in long wait times for LAC (5-18), which may cause harm to our patients and may prevent us from meeting our statutory responsibilities			
Risk owner:	Exec: Helen Thompson		Local: Janet Harrison	
Governance:	SEB / QSC / 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
- Standard operating procedure – ongoing review to address new clinical pathways
- Prioritisation model
- Service specification
- Use of bank staffing
- Approved Business Case (April2023) for additional funding for team members
- Social worker as corporate parents (LA) with 6 monthly review (inc. face to face)
- Approved skill-mix model
- New models of working agreed including virtual RHAs with inclusion criteria
- New starters onboarded (2.6 wte)

Gaps:

- Timely health assessment for LAC (5-18yrs)
- Current substantive WTE availability
- Sufficient resource to meet increasing numbers of unaccompanied asylum seekers

Assurances

Internal:	Source: Safeguarding Assurance Group and Safeguarding Committee FYPC/LD DMT Trajectories included in TB paper	Evidence: Regular reporting Minutes and improvement plan Feature on LAC at Trust Board in August 2023	Assurance Rating Amber
External:	Source: CYP Collaborative oversight (monthly) Designated nurse for LAC at ICB – oversight	Evidence: CYP Collaborative – monthly update Quarterly report to designated nurse – RAG rating RED for Review Health Assessment Approved business case	Assurance Rating Amber
Gaps:			

Actions

Date:	Actions:	Owner:	Progress	Status
Oct 2023	Continue to recruit and onboard to agreed clinical model in BC	JS	Ongoing – awaiting 3 WTE to start.	Amber
Oct 2023	Mobilise enhanced LAC 5-18 service	JS	Timescales dependent on staffing.	Amber
Nov 2023	Develop a practice development nurse role within the team	JS	Signed off at FYPCLDA DMT September 2023 - to start recruitment	Amber
Nov 2023	LLR LAC Summit	DN, NN LAC	Due for November	Amber
Nov 2023	Introduce a monthly PTL and exception reporting	JS		Amber
	System level discussion regarding resource for unaccompanied asylum seekers	JK		Amber

Risk No: 93	Date included	August 2023	Date revised	04.09.2023
Objective:	Well Governed			
Risk Title:	Lack of emergency preparedness results in major service failure			
Risk owner:	Exec: Managing Director, AEO		Local: Managing Director, AEO	
Governance:	EMB / QSC / Board - Monthly Review			

	Consequence	Likelihood	Combined
Current Risk	3	3	9
Residual Risk	3	2	6

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

Controls	Description:	EPRR Policy and plans in place System wide EPRR training attended Health and Safety Committee Director and Manager on-call pack Director/senior manager training/exercising Business continuity plans in place and tested Increased visibility of EPRR function across the Trust EPRR core standards return On-call training schedule Consistent review of BC planning Industrial action plans and processes EPRR Workplan LPT Training Needs Analysis for EPRR
	Gaps:	• Systemwide countermeasure and mass casualty plans

Assurances	Internal:	Source: Self-assessment against NHS England EPRR Core Standards Bi-monthly reports to Health and Safety Committee On-going training of strategic, tactical and operational responders Regular review of operational hub activities and escalation via AEO to EMB in line with agreed governance protocols Delivery against EPRR Workplan EPRR Group collaborative LPT Business Continuity Management System (BCMS) Audit Post Incident /Exercise Reports	Evidence: Outcome to Board Minutes Health and Safety Committee Training records Evidence of discussion in Executive Board	Status
	External:	Source: ICB and system assessment against NHS England EPRR Core Standards LHRP EPRR Governance structure and meetings Health Emergency Planning Operational Group(HEPOG)	Evidence: Assessment against standards Minutes of meetings	
	Gaps:			

Actions	Date:	Actions:	Owner:	Status
	Q2	Review of evacuation procedures across all sites	Jean Knight	Green
	Q2	Agree the system wide countermeasure and mass casualty plans	JK	
	Q2	Undertake preparation for EPRR standards review within LPT	JK	
	Q2	Strengthen Group Collaborative	JK	

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