Leicestershire Partnership NHS Trust

Organisational Risk Register
January 2024

Risk Appetite based on the matrix produced by the Good Governance Institute

Risk No: 59	Date included	29 November 2021	Date revised	08/01/2024
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. • Agreed approach with Local Authority Public Health Commissioners
	Gaps:	• Delay due to capacity focussing on clearing the backlog • Capacity to support unclosed incidents

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:
	Ongoing	Directorate and patient safety services working together to clear the backlog of SIs	TH/SL/HT/TW	CHS – significant improvement in written reports FYPC – ongoing. Action plan backlog subject to 'scrum and sprint' methodology which is seeing significant improvement DMH – significant progress in completing the backlog with more robust systems, process and capacity in place to sustain.
	Ongoing	Closure of action plans within timeframes across the directorates.	TH/SL/HT/TW	
	Ongoing	Moving towards PSIRF	TH/SL/HT/TW	

Status
Amber
Amber
Amber

Risk No: 61	Date included	29 November 2021	Date revised	08/01/2024
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	2	8
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
- 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 / 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
- Bank staff provided with clinical supervision through 0.4wte clinical education leads for bank
- EQIAs DRA and break glass criteria in place for the 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
- Reinstatement for bank staff to be compliant before booking shifts to take effect April 2024

Gaps:

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

Assurances

Internal:

Source:	Evidence:	Assurance Rating Green
• Data set for SWG this month – forecasting compliance for priority and safety topics – BLS, ILS, disengagement and safeguarding level 3 • 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 • Learning from SI's and quality improvements • Monthly clinical education forum • Winter BAF actions reviewed at Winter Committee • New report of Mandatory Training SME and course update logs to TED • Monthly safe staffing report	• Compliance reporting thresholds reviewed and agreed • Increased compliance for ILS, NEWS 2 and sepsis for substantive staff • Supervision compliance report- monthly • HRCG agency staff compliant with the national skills framework requirements, external audited and compliance reported through the Contract Review meeting • Directorate risk registers received at DMTs • Quarterly triangulation document to Exec Team with action plan. • Training capacity DNA spaces monitored at TED • 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	

External

Gaps:

Actions

Date:	Actions:	Owner:	Progress	Status
Mar 24 March 24	Options appraisal for clinical induction capacity signed of at EMB. Education and training to implement as required. Introduction of data set forecasting compliance for priority areas	Alison O'Donnell	Completed. Ongoing oversight. SWG January, PCC February	Green

Risk No: 64	Date included	29 November 2021	Date revised	23/01/2024
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 • LPT and NHFT National innovator
	Gaps:	• Sufficient oversight of individual service sustainability across the Trust

Assurances	Internal:	Source: Commissioning & Collaborative Committee 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: April 24 April 24	Actions: Collaborative contract in place Ongoing CIP planning and oversight of fragile services	Owner: Group Director of Strategy & Partnerships Managing Director	Progress: Ongoing Ongoing	Status Green

Risk No: 67	Date included	29 November 2021	Date revised	23/01/2024
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 • 100% renewable energy to be purchased. • New Group Sustainability Committee with NHFT
	Gaps:	• Lack of data on carbon footprint. • Submission of national data returns impacted • Dedicated resource • New Group Sustainability post not approved by Vacancy Control Panel

Assurances	Internal:	Source: EMEC, FPC and Trust Board	Evidence: Green plan	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:	Actions:	Owner:	Progress:	Status

Risk No: 68	Date included	29 November 2021	Date revised	23/01/24
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:

- Collaboratively delivered Q2 Healthy Together KPI submission
- 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
Mar 24	Phase 1 delivery of health inequalities data recording	SM	Implementation plan in place will be reviewed as part of updated DQ Action Plan	Green
Ongoing	Continue to implement SNOMED	SM	Clarity for 23/24 resources agreed with all parties and updated at SEB	Amber
Ongoing	Delivery of phase 2 of data quality plan – embedding processes & implementing kitemark approach	SM	Updated 24/25 plan is being developed for submission to DQG in February with focus on identifying gaps in data quality	Green

Risk No: 72	Date included	29 November 2021	Date revised	23/01/2024
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 • Green Plan • Inequalities data reporting and analysis
	Gaps:	• Resources to develop 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: SLF – inequalities framework (Oct 23) 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: Jan 24	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.	Status Green

Risk No: 73	Date included	29 November 2021	Date revised	08/01/2024
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) • EDI Policy (including how to potentially refuse treatment to patients who racially abuse staff). • 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 and third cohort completed. Fourth 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 / gender pay gap and diversity metrics • Embeddedness of WRES/ WDES/ Together Against Racism action plan/ NHSEI high impact actions (Inclusive talent management implementation) • Elimination of racist behaviour from patients towards staff members

Assurances	Internal:	• Annual action plans signed off • 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: • ICB Self-assessment against the National EDI delivery framework – November people board • 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 Green
	Gaps:	We need data output to illustrate that metrics show equity in the workforce		

Actions	Date: Ongoing March 24	Actions: Delivery of annual action plan / Delivery of Group EDI / Together Against Racism programme Task and Finish Group for the WDES programme – reasonable adjustments and equipment – 6 months starting July 2023	Owner: Haseeb A Chris Oakes Sarah W	Progress Ongoing Group development session January 2023 Ongoing – Due to finish this month but open for review, may be extended	Status Green Green Green Green

Risk No: 74	Date included	29 November 2021	Date revised	08/01/2024
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
- Team Time Out launched
- Sickness monitoring format developed. SPCC charts to reviewed on a quarterly basis through SWG.

Gaps:

- The ongoing NHS challenging environment and economic situation may impact on staff wellbeing

Assurances

Internal:

- SWG highlight report to PCC include action plan and KPIs
- 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
- IA Health and Wellbeing Q3/Q4 2023/24

Evidence:

- NHSI benchmarking reports
- Attendance at external NHSI wellbeing workshops
- MHWB hub data

Assurance Rating Green

Gaps:

Action

Date:	Actions:	Action Owner:	Progress:	Status
Jan 24	LPT audit of sickness management processes to SWG	Claire Taylor	PCC signed off a quarterly SPC chart reporting for sickness and patterns	Green

Risk No: 75	Date included	29 November 2021	Date revised	15/01/24
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 • Directorate 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 • Minimising harm while waiting briefing. • Approval to restart children's ADHD medication now they are available.
	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 • Global shortage of adult ADHD medications

Assurances	Internal:	Source: • Access Group oversight of Directorate performance and risks • 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 • Regular papers on delivery of medical workforce plan to exec team and SWG, PCC	Assurance Rating Amber
	External:	• 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	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 – long term elements for delivery. Plans being delivered and overseen by Access Delivery Group and oversight at EMB Accountability Framework Meetings	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.			Amber
	Ongoing	Extension of virtual ward offer where appropriate to facilitate quality access.			Amber

Risk No: 79	Date included	29.03.22	Date revised	23/01/2024
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
- LPT well represented at system wide NHSE run LLR ICS Cyber Incident Response Exercise, October 2023.
- 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
- Guidance published 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 2022 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 Group 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:
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	23/01/2024
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 QSC for oversight			

	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 • Training programme and SOPs • Acute mental health inpatient wards using paper forms for mental health observations – using Brigid for physical health observations
	Gaps:	• Access and usability of the Brigid system • Staff knowledge, training and culture

Assurances	Internal:	Source: • SEB paper on responding to emerging AI technology • Monthly Directorate meetings with HIS contacts • IMT Delivery Group • IMT Committee • Establishing task and finish group led by Deputy CEO	Evidence: Report summaries and regular meetings DMT meetings Minutes and actions from the meetings Minutes and actions from the meetings Minutes and actions from 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: Jan 24	Actions: • Brigid deep dive at EMB to determine appropriate actions	Action Owner Executive Directors	Progress	Status Amber

Risk No: 86	Date included	14/09/22	Date revised	15/01/24
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
- Relaunch of community caseload reviews has commenced.
- Recruitment and Retention Premium scheme introduced for the medical workforce.

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.
- Impact of industrial action

Assurances

	Source:	Evidence:	Assurance Rating
Internal:	• Operational risk 5087 Planned Treatment and Recovery Teams Staffing Risk • Review of measures including complaints, incidents and learning from deaths reported monthly through Quality and Safety DMT. • Cancelled clinics and waiting time data reported monthly through performance and finance DMT. • Quality summits – March 22 and September 22 • Caseload reviews progressing – not yet concluded • CMHT workforce and risk assessment action plan • Monthly meeting with senior medical leadership team and CEO	• 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, February 2023, November 2023 • Workstreams that support medical workforce plan reported to SWG	Amber
External			

Gaps:

Actions

Date:	Actions:	Action Owner	Progress:	Status
Ongoing	Physician Associate recruitment plan	Bhanu Chadalavada	• Regular meeting in place reviewing the use of existing staff	Amber
Mar 24	Medical workforce plan linked to workforce and agency reduction plan.	BC/ Sarah Willis	• Ongoing progression	
Jan 24	Use MAST – programme to determine caseload and planning	Sam Hamer	• Being procured	Amber

Risk No: 88	Date included	November 2022	Date revised	15/01/24
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: • Development of early warning dashboard – stakeholder consultation • 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 • Consideration of training film around closed cultures	James Mullins	Progressing	Amber

Risk No: 89	Date included	28/02/23	Date revised	23/01/24
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) • LPT estates rep sits on/reports into IPC Group (cleaning/water/waste/decontamination) • 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 • 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
	Gaps:	• Circa 40 vacancies with delays in recruitment and onboarding

Assurances	Internal:	Source: • Estates Committee (Soft FM report to EMEC (FPC) and IPC (QAC) • IPC Bi-Annual report to Trust Board • EMEC • Waste management meetings • DMTs	• IPC BAF • Cleaning report • Waste report • IPC walk arounds • Incident reporting • PLACE 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: Ongoing	Actions: Substantive recruitment	Action Owner: Helen Walton/ HR	Progress Progressing. Currently utilising agency or framework agreements	Status: Amber

Risk No: 90	Date included	April 2023	Date revised	23/01/24
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	3	12
Residual Risk	4	2	8

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 – none identified

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
- LLR ICB medium term capital strategy not yet in place
- LLR ICB medium term revenue strategy not yet in place
- LPT recovery plan mitigations now sufficient to confirm break even plan will be delivered.
- NHSE letter 'Addressing the significant financial challenges created by industrial action in 2023/24, and immediate actions to take' 22/11/23 submission shows LPT at breakeven, ICB & UHL are both in deficit
- Deficit ICS plan discussed with NHSE national DoF - further actions required as a system to close the deficit & reduce 23/24 exit run rate

Assurances

Internal:

Source:	Evidence:	Assurance Rating
• Audit Committee • Operational oversight & management of cost forecasts through Directorate Management Teams • Capital Management Committee's oversight of capital delivery and agreed governance processes; • Finance and Performance Committee report includes I & E, cash & capital reporting • Delivery against recovery plan actions will be reported monthly via finance report • LLR 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	Green

External:

Source:	Evidence:	Assurance Rating
• KPMG audit of 2022/23 annual accounts and value for money conclusion • 2022/23 Internal audit - Financial systems - 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	• 2022/23 annual accounts unqualified opinion • Significant assurance • 360 Assurance review complete, report issued & presented to Dec 2022 Audit Committee. Actions continue to be monitored.	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
Q3 23	• Contribute to LLR ICB capital & financial strategy development	SM	In progress	Green
Q3 23	• Revise LPT medium term capital & financial strategy to ensure alignment with ICS strategy	SM	In progress	Green
Jan 24	• 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	In progress	Green

Risk No: 91	Date included	April 2023	Date revised	08/01/24
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 ADHD. 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 / Oversight at QSC			

	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 / Access Delivery Group
- Waiting list management and SOPs 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
- Non-recurrent funding for AAADs and Community Paediatrics
- Local Authority funding for ADHD over 3 years
- System QIA for the unsuccessful business case for CYP ND & System Risk Profile and mitigations overseen by ICB Medical Director and ND Programme Board
- Engagement of ICB Clinical Executive, CYP Partnership and CYP Collaborative /Senior Leaders Group in system wide risk profiling and mitigation
- CYP ND Programme and ICB leads co-developing new guidance on second opinions, private diagnosis, service access criteria and expediting cases
- Group AHDH workshop with NHFT to share learning – June 2023. EMHSAN innovation in CYP ND Programme business case and mitigation design
- Benchmarked autism services against national framework for Autism diagnosis and action planning in ND Programme and AAAS
- FYPCLDA agreed performance trajectories
- CYP ND Programme Board within FYPCLDA SUTG includes all three LAs, PCFs/EBEs and ICB colleagues and regularly reports into the LPT Transformation & QI Group
- CYP ND Programme secured access to comprehensive online training resource for all LLR residents
- Refreshed CYP Business Case submitted for review by the ICB – phased and segmented to mitigate financial challenge to the system.
- System expression of interest for Partnership for Inclusion of Neurodiversity in Schools submitted in association with LPT co-lead for SEND & AP change programme
- New system clinical group to risk assess and jointly manage with GPs and Mental Health Services available ADHD medications according to clinical priority

Gaps:

- Capacity and resources: over 6000 CYP currently waiting for ND assessment in FYPCLDA
- No investment in 23/24 for business cases for CYP ND, AAADs – confirmed by ICB on 6 June 2023
- Inclusion of ADHD within MHIS in 2024/25 tbc

Assurances

	Source:	Evidence:	
Internal:	• Mental Health/ADHD transition group • 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	• 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 • LPT leadership of SEND, ND and LDA system responses • CYP system risk profiling within ND Programme	Assurance Rating Amber
External:	• System ND Pathfinder Group • Regional ND summit – Q3 • CYP design Group / LLR LDA Collaborative • ND Programme Board reporting to ICB Clinical Exec on refreshed risk profiling • LLR Mental Health Collaborative / LLR ND System Partnership Meeting	• Meeting minutes and action logs • QIAs reviewed through system quality group • CYP ND System risk profile • LPT led system ND sub-group established to support development • Minutes of Clinical Executive, CYP Partnership, Collaborative and ND Programme Board	Assurance Rating Amber
Gaps:			

Actions

Date:	Actions:	Owner:	Progress	Status
Closed	Review performance trajectories for 23/24 in DMH for new patients for assessment (treatment trajectories dependent on availability of ADHD medication supply chain).	Directors	Task and finish group supporting clinical management of patients re medication supply issues. Some medication is more readily available now and new patients can start on this medication. Still impacting on those areas where medication is not readily available. The backlog will need to be cleared.	Amber
Feb 24	Recruit to all non-recurrently funded vacancies and secure and act on ICB agreement for early recruitment to CYP ND roles within business case Adult ADHD and CYPND business case to ICB for approval	Directors	Partial recruitment outstanding – next touchpoint Feb 24	

Risk No: 92	Date included	May 2023	Date revised	08/01/24
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	3	12
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 patient • 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 • Completed Induction periods of new starters • Appointment of a Practice Development Nurse, now onboarded
	Gaps:	• Timely health assessment for LAC (5-18yrs) • Workforce supply and band 6 alternative career pathways • Sufficient resource to meet increasing numbers of unaccompanied asylum seekers

Assurances	Internal:	Source: Safeguarding Assurance Group and Safeguarding Committee FYPC/LDA DMT Trajectories included in TB paper Accountability framework meetings Finance and Performance Committee Introduction of a monthly PTL and exception reporting, initial meeting has occurred	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 ICS Looked After Strategic Health Group Place based Corporate Parenting Boards	Evidence: CYP Collaborative – monthly update Quarterly report to designated nurse – RAG rating RED for Review Health Assessment Approved business case	Assurance Rating Amber
	Gaps:			

	Date:	Actions:	Owner:	Progress	Status
Actions	Mar 2024	Continue to recruit and onboard to agreed clinical model in BC	JS	x2 B6 / x2 B5 / x0.6 B4 – ongoing review in Mar 24	Amber
	Mar 2024	Mobilise enhanced LAC 5-18 service	JS	Ongoing – review in Mar 24	Amber
	Feb 2024	System level discussion regarding unaccompanied asylum seekers	JK	Delayed to Feb 24	Amber

Risk No: 93	Date included	August 2023	Date revised	23.01.2024
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
Q3 23/24	Review of evacuation procedures across all sites	Jean Knight	Green
Q3 23/24	Agree the system wide countermeasure and mass casualty plans	JK	
Q3 23/24	Undertake preparation for EPRR standards review within LPT	JK	
Q3 23/24	Strengthen Group Collaborative	JK	

Risk No: 94	Date included	October 2023	Date revised	08/01/24
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 delivery of our financial targets for this year.			
Risk owner:	Exec: Director of HR and OD		Local: Assistant Director of Nursing & Quality	
Governance:	Parent Committee - Workforce Lens: Strategic Workforce Group and People and Culture Committee Quality and Safety Lens: Quality Forum and Quality and Safety Committee Finance Lens: Finance and Performance Committee Overview: Executive Management Board and fortnightly Agency Reduction Meeting			

	Consequence	Likelihood	Combined
Current Risk	4	5	20
Residual Risk	4	4	16
Tolerance Level Significant 16-20 (Appetite Quality-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
- 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 / EQIAs
- Nursing and midwifery self-assessment tool – NHSE / workforce leads
- International nursing, AHP and medical recruitment programme and comprehensive induction in place
- Workforce and agency reduction plan in line with NHS Long Term Workforce Plan, System Ops Plan and increased CIP
- 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
- Establishment control approach put in place to reconcile finance and HR information through ESR and arrive at an accurate staffing picture
- Establishment control process in place
- Stopped off-framework agency use for HCA (break glass process in place). Actions in place to implement similar approach for Registered Nursing

Gaps:

- Capacity due to increased demand and national and local workforce shortages
- 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
- Potential impact on delivery of continuity of care / person centred care
- In year increases of staffing requirements e.g. new beds being opened

Assurances

Internal:

- SUTG high standard priorities – reported quarterly
- National safe staffing return
- Monthly Safe staffing report including monitoring harm / nurse sensitive indicators
- Operational oversight & management of cost forecasts through DMTs
- Finance and Performance Committee report includes agency reporting
- LLR ICB Finance committee oversight
- Self-assessment complete 4 key themes to enhance assurance, action plan developed
- Weekly situational and forecast staffing meeting
- Progress reporting to EMB including Workforce and Agency Reduction Plan (also received at PCC)
- Monthly reports to OEB/SEB/FPC/Board/ICB finance committee on all aspects of delivery against financial plan, including agency

Assurance Rating Green

External:

- Internal Audit – Agency Staffing – Advisory (no opinion)
- NHS England Direct Support monthly meetings – reducing to zero HCSW vacancies

Assurance Amber

Gaps:

Actions

Date:	Actions:	Owner:	Progress:	Status
March 24	Implementation of the Foundations for Great Nursing Care Programme and high impact interventions for nursing retention (QSC)	Anne Scott	On track Ongoing	Green Green
March 24	Delivery of the Workforce and Agency Reduction Plan (PCC)	Sarah Willis	Ongoing	Amber
March 24	Delivery of the Medical Workforce Plan (PCC)	Medical Director	Ongoing	Amber
March 24	Delivery of the Financial Plan for 2023/24 (FPC)	Sharon Murphy		

Risk No: 95	Date included	October 2023	Date revised	08/01/24		Consequence	Likelihood	Combined
Objective: S	Equality, Leadership, Culture				Current Risk	4	5	20
Risk Title:	The backlog in the recruitment pipeline could lead to delays in onboarding new staff, or the withdrawing of candidates during the recruitment process				Residual Risk	4	4	16
Risk owner:	Exec: Director of HR and OD		Local: Dan Norbury, Deputy Director HR					
Governance:	Strategic Workforce Group and People and Culture Committee				Tolerance Level Significant 16-20 (Appetite People-Seek)			

Controls	Description:	• Safe staffing policy / induction policy for substantive and temporary staffing • Establishment control process in place • Increased forward planning of required candidate attraction events to meet required demand • Additional recruitment officers in place • Onboarding officer roles in place and embedded to support candidate experience • Twice weekly command and control incident management gold log • Weekly review of induction capacity • Actions being taken within existing available technology to streamline processes e.g. use of MS Forms to prevent duplication of data entry and help flow of processes • Engaged management stakeholders and procuring integrated end to end recruitment system to streamline all recruitment processes. Currently at contract mobilisation stage. • Recruitment checklist in place to ensure that candidates are signed off as compliant against required checks		
	Gaps:	• Capacity and skills to clear the backlog • Capacity of employee services to ensure pay is delivered on time for new starters • Capacity of education and training to induct and train before candidates start • Capacity in team to mobilise new recruitment system • Do not have control of demand on the service, and volumes of recruitment are very high at current time		
Assurances	Internal:	Report to SEB, EMB, SWG and PCC	• Monthly report	Assurance Rating Green
	External:	• Monthly report regarding healthcare support workers to NHSE		Assurance Green
	Gaps:			

Actions	Date: Ongoing Mar 24	Actions: Delivery of actions recorded on the gold call log Procurement and mobilisation of new recruitment system	Owner: Sarah Willis Sarah Willis	Progress: Ongoing 3-9 month programme which will impact on risk due to change and double running
				Status 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