Leicestershire Partnership NHS Trust

Leicestershire Partnership and Northamptonshire Healthcare Group

Board Assurance Framework

LPT and Group Strategic Risks

May 2025

BAF 2025/26 Quick Guide

1. Strategic Risk

The BAF enables the Board to identify and understand the principal risks to achieving its strategic objectives. We have a strategy in common with our Group partner Northamptonshire Healthcare NHS Foundation Trust (NHFT). Our risks are structured around our 'THRIVE' strategy.

This BAF presents strategic risk relating to Leicestershire Partnership NHS Trust, it is owned by the Trust Board and is reviewed by our Strategic Executive Board and our Level 1 Committees. This BAF also contains strategic risk in common with NHFT, presented as Group BAF risks which are owned by both Trust Boards and are reviewed by each board, together in the Group Public Board meetings, each of our Strategic Executive Boards, and our Level 1 Committees.

2. Aligning controls and assurances

The format presents the controls, assurances, gaps and actions together. This means that we can provide assurance over whether existing controls are working. Where they are not, we can be clear about the action required to resolve this. We are also able to clearly identify where additional controls and assurances are required and what actions we need to include.

3. Three lines of assurance model

The Trust uses the three lines of assurance model. The assurance provided on the BAF is split by each of the three lines so that we can be clear which part of the organisation is providing assurance and undertaking mitigating action. This also helps us to identify and rectify any gaps.

4. Cause, Risk and Effect

The cause, risk and effect format allows us to see controls, assurances and actions by the cause and effect of each risk, so that we can be sighted on how we are reducing the likelihood and the consequence. Risk descriptors are written using the cause, risk, and effect model to help shape the way we present risk on the BAF.

BAF 2025/26 Quick Guide

5. Clarity over scoring stages

Scoring terminology is defined as;

- Inherent Score. This is the score of a risk based on there being no controls in place. This would apply if the BAF were to identify that current controls are not working effectively.
- Current score. This is the score considering the controls currently in place, assuming that they are working. This can also be termed as residual risk by some organisations, due to this, we are avoiding the use of this term.
- Target score. This is the score once any new mitigating controls have been put in place; this will need to be within our target appetite or will need to be tolerated and justified as such in the covering risk report.

6. 5x5 multiplication methodology

The Trust uses the 5x5 multiplication scoring methodology.

7. Risk Appetite - Open

The Trust Board has applied an open appetite for each category of risk for 2025/26. This means that we have a willingness to make decisions which may impact on our current business as usual for longer term reward and improvement if appropriate controls are in place. This will require a focus on assurance over the strength of our existing internal control framework, as well as identifying and embedding any new controls.

Appetite	None	Minimal	Cautious	Open	Eager
Appetite tolerance	0-3	4-8	9-12	13-16	17-25

BAF 2025/26 Summary May 2025: Together we THRIVE

BAF No.	Risk Title	Score
Section 1 - T Technology [Finance and Performance Committee Oversight]		
GROUP BAF1.1	If we do not continue to engage in **digital transformation**, we will not be digitally mature. This will affect our ability to deliver safe care to our service users.	16
BAF1.2	If we are not sufficiently prepared, we may be impacted by **digital disruption** which will affect our ability to access our electronic systems and provide safe care to our service users.	12
Section 2 - H Healthy Communities [Finance and Performance Committee Oversight]		
BAF2.1	Ensuring Healthy Communities in LLR requires a reduction in **health inequality**. If we do not work in strong partnerships and build new ones, we will not reduce inequity with our communities..	8
Section 3 - R Responsive [Quality and Safety Committee Oversight]		
GROUP BAF3.1	If we do not engage in **research, quality improvement and innovation**, we will not identify opportunities for improvement which will impact on the quality and design of our services.	12
BAF3.2	Without **timely access** to services, we cannot provide high quality safe care for our patients which will impact on clinical outcomes.	20
BAF3.3	If we do not continue to review and improve our systems and processes for **patient safety**, we may not be able to provide the best experience and clinical outcomes for our patients and their families.	20
BAF3.4	If we do not have appropriate **emergency preparedness**, resilience and response controls in place, we may be impacted by accidents, disruption and system failures affecting our ability to maintain continuity of services.	8
Section 4 – I Including Everyone [People and Culture Committee Oversight]		
BAF4.1	If we do not adequately utilise **workforce** resourcing strategies, we will have poor recruitment, retention and representation, resulting in high agency usage.	20
Section 5 – V Valuing people [People and Culture Committee Oversight]		
BAF5.1	If we do not lead with compassion, we will not promote an **inclusive culture**, resulting in unwanted behaviours and closed cultures.	12
Section 6 – E Efficient and Effective [Finance and Performance Committee Oversight]		
BAF6.1	If we cannot maintain and improve our estate, or respond to maintenance requests in a timely way, there is a risk that our estate will not be fit for purpose, leading to a poor-quality **environment** for staff and patients.	20
BAF6.2	If we do not continue to strive for **sustainability**, we will be impacted by adverse weather events and environmental factors impacting on the health of our population, resulting in poorer health outcomes.	12
BAF6.3	Inadequate **capital funding** for LLR system will impact on LPT's ability to manage financial, quality & safety risks related to estates and digital investment in 2025/26 and in the medium term	20
BAF6.4	Inadequate control, reporting and management of the Trust's **2025/26 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)	16

GROUP BAF **1.1**	If we do not continue to engage in **digital transformation**, we will not be digitally mature. This will affect our ability to deliver safe care to our service users.	
Date	Included 1 April 2025	Last updated 07.05.2025
Strategic Link	THRIVE: **TECHNOLOGY**	
Governance	**GROUP** LPT and NHFT Finance and Performance Committee, Group Strategic Executive Board, Group Trust Board	
Context	Moving from analogue to digital, where digital healthcare becomes the enabling centre of clinical care	

Score	Consequence	Likelihood	Combined
Initial Risk	4	5	20
Current Risk	4	4	16
Target Risk	4	2	8

Risk Appetite – Open (upper limit of tolerance 16)

Control	Control Gaps	Sources of Assurance	Assurance gaps	Actions	Progress
Cause: Lack of capacity, resources and commitment to support all Trust Digital needs					
• LPT Digital plan • National Digital plan • Digital maturity assessment • Digital Prioritisation Process • ICB Digital plan/Strategy • Local, system and national efficiency plans limit staff availability to digital delivery across our organisation. • Joint LPT / NHFT digital lead and LLR ICB CIO	• Lack of capital funding for Digital • Capacity and resources • Ability to recruit and retain Digital workforce. • Digital not always committed to as an organisational priority • Effectively supporting digital reasonable adjustments for staff • Availability and quality of data for reporting & analysis • Lack of funding for digital solutions to improve data & productivity	**1st Line:** The capital planning committee decides the level of digital capital spending by evaluating investments in technology infrastructure and initiatives, such as new equipment and system upgrades, alongside other non-digital capital programs. The committee ensures that this capital spending is aligned with the Trust's long-term strategic goals and system partners. **2nd Line:** The Information Management & Technology Committee ensures the relevance of the Digital Plan & commitment to delivery on behalf of the Trust Finance & Performance Committee in line with the Trust's strategic priorities and system partners. The Committee ensures that mechanisms are in place to assure the operational delivery of the Digital Plan for the Trust through robust reporting and monitoring arrangements. The Committee provides the strategic approval of IM&T systems, projects, and work programmes to which Trust resources (financial and staffing) are to be committed. **3rd Line:** The Finance and Performance Committee are provided with a copy of the Digital Plan and the LHIS annual report to offer assurance on the strategic direction and execution of digital initiatives. By receiving these documents, the committee can assess whether digital investments align with organisational goals, are delivered within budget, and have achieved the expected results. This oversight allows the committee to provide feedback, ensure accountability, and confirm that digital initiatives contribute to the organisation's long-term objectives	Additional capacity to further develop the LPT digital strategy and deliver its implementation. Clear timeline for the delivery of digital transformations.	• Deliver the Group Digital Transformation plan. **Joint Director of Digital (as SRO) 2025/26 with quarterly updates.** • Clear timelines for delivery of digital transformation. **Joint Director of Digital June 2025.** • Gap analysis of capacity to deliver plan. **Joint Director of Digital June 2025.**	LPT Digital transformation group in place to oversee delivery with AAA report into FPC. Potential inclusion within Group Trust Board workplan.
Effect: Unable to support service transformation.					
• Digital transformation programme. • Digital Transformation Group • Digital Prioritisation Process	• Finance • Capacity • Digital engagement	**1st Line** The digital prioritisation Process will ensure that the most impactful initiatives receive the focus and resources required. This process is owned by the Trust's PMO (Project Management Office), which works closely with the various directorates to score and evaluate digital projects based on factors such as local and national strategic alignment. By collaborating with the directorates, the PMO ensures that priorities reflect organisational goals and the directorate's needs. **2nd Line** The scored digital prioritisation will be regularly reported to the Transformation Committee to provide oversight and ensure that the Trust can make informed decisions, monitor progress, and adjust priorities to keep Digital transformation on track **3rd Line** Clinical Focus and Engagement: The Trust considers clinical engagement and involvement in decisions to be an essential element of its governance arrangements. As such, the Trust's integrated governance approach aims to mainstream clinical governance into all planning, decision-making, and monitoring activities.	Prioritisation process to undertake retrospective scoring & become BAU Lack of clinical leadership	Prioritisation **process Joint Director of Digital June 2025.** to be presented to LPT digital transformation group and assurance to FPC. Gap analysis of clinical leadership to deliver plan. **Joint Director of Digital June 2025.** to be presented to LPT digital transformation group and assurance to FPC.	LPT Digital transformation group in place to oversee delivery with AAA report into FPC. Potential inclusion within Group Trust Board workplan.

BAF **1.2**	If we are not sufficiently prepared, we may be impacted by **digital disruption** which will affect our ability to access our electronic systems and provide safe care to our service users.
Date	Included 1 April 2025. Last updated 07.05.2025
Strategic Link	**T**hrive **TECHNOLOGY**
Governance	**LPT** Finance and Performance Committee, Strategic Executive Board, Trust Board
Context	Access to electronic systems, configuration is fit for purpose, cyber attack

Score	Consequence	Likelihood	Combined
Initial Risk	4	4	16
Current Risk	4	3	12
Target Risk	3	3	9

Risk Appetite – Open (upper limit of tolerance 16)

Control	Control Gaps	Sources of Assurance	Assurance gaps	Actions	Progress
Cause: Lack of capacity and resources to mitigate sources of digital disruption					
• HIS provide a small team of qualified Cyber security experts with the required accreditation • Multiple technical counter measures including firewalls, honeypots, InterceptX, IDS/IPS, anti-malware, etc. • Microsoft MDE is active on all endpoints and servers • Only privileged user accounts are able to install or run programmes • MDM in use on all mobile devices • Back-up procedure in place and regularly checked • Patches automatically deployed to all devices • Quarterly penetration tests undertaken by LHIS • Have access to the ICB CISO for advice and guidance • MFA enabled on user accounts • VPN are monitored and restricted	• **Lack of capital funding for Digital and Cyber** • **Capacity and resources provided to HIS** • **There is no SIEM (security information and event management) solution** • **No pro-active management of security outside core business hours (no cyber on call)** • **There are times we are reliant on EOL software to run systems outside of our control (ESR)**	**1st Line:** The capital planning committee decides the level of digital capital spending by evaluating investments in technology infrastructure and initiatives, such as new equipment and system upgrades, alongside other non-digital capital programs. The committee ensures that this capital spending is aligned with the Trust's long-term strategic goals and system partners.	Group (LPT/NHFT) level Digital committee, Plan, Road map.	• Implement InTune as the new Trust MDM • Complete DSPT/ CAF submission for 24/25 • Replace end of support mobile devices • Review NHSE offerings to identify opportunities to improve the Trust's level of security • Collaboration with cyber security teams across LLR. • Adoption and deployment of strategic cyber security solutions.	• Pillar under the new Digital Transformation Group in place to review Cyber opportunities • DSPT CAF being worked on and evidence provided • Reviewing SIEM solution from NHSE • Cyber Group being formed across LLR/NICB byt eh ICB CISO • Mobile phone replacement programme being started along with rollout of InTune.
		2nd Line: DSPT Compliance and quarterly audit and penetration test with executive summary and action plan provided to the Data Privacy group. LHIS is ISO27001 accredited which provides assurance that the Information Security Management System (ISMS) operates effectively. Audited twice yearly. Routine reporting, review and escalation of cyber security threat/risk through Data Privacy Group (DPG). Incident reporting to DPG, including root cause and lessons-learned reviews. NHSE monitoring of our environment and MDE reporting	• **Assurance of security posture/compliance from core IT service suppliers.**		
		3rd Line: Training is provided to staff to raise cyber awareness as well as regular communications and events. NHSE Board level cyber training provided by external provider Feb 2024	Impact of training and phishing campaigns		
Effect: unable to access electronic systems which are fit for purpose					
• Data Privacy Group • Trust CDIO/ HIS Cyber team • NHSE best practice (DMA) to have NED assigned as the cyber lead -Chair of the FPC receives annual update as part of committee workplan.	• Finance • Capacity • Cyber awareness / training	**1st Line** The annual penetration test enables resources to be focused on areas of high and medium impact to the trust and address those issues as a matter of priority.		Raise at the capital management committee when appropriate with ongoing oversight **Joint Director of Digital throughout 2025/26**	Escalation of capital limitations impacting on delivery of digital agenda to EMB
		2nd Line Capital has been obtained from NHSE in previous years for key cyber security requirements as well as the new ICB CISO role.	Capital might not be sufficient and there are no ring fenced finances for Cyber		
		3rd Line Systems monitored by HIS and NHSE teams via MDE, MDM and secure boundary services LHIS re-accreditation of secure email system [ISO27000] and Cyber Essentials Consultancy			

BAF **2.1**	Ensuring Healthy Communities in LLR requires a reduction in **health inequality**. If we do not work in strong partnerships and build new ones, we will not reduce inequity with our communities.	
Date	Included 1 April 2025.	Last updated 07.05.2025
Strategic Link	THRIVE: **HEALTHY COMMUNITIES**	
Governance	**LPT** Finance and Performance Committee, Strategic Executive Board, Trust Board	
Context	Healthy Communities are essential to the delivery of our system strategy, preventing ill-health and reducing demand on NHS services	

Score	Consequence	Likelihood	Combined
Initial Risk	4	5	20
Current Risk	4	2	8
Target Risk	4	2	8

Risk Appetite – Open (upper limit of tolerance 16)

Control	Control Gaps	Sources of Assurance	Assurance gaps	Actions	Progress
Cause: **Not working closely with our community**					
• Services working in partnership across LPT and from LPT with the VCSE and other stakeholders • Organisational monitoring of system meetings • Named executive leads attending place-based meetings • LLR ICB and ICS meetings • East Midlands Alliance • Learning Disability and Autism Collaborative • Mental Health Collaborative • National Provider Collaborative Innovator	Changes in other organisations impact on system ability to deliver plans	**1st Line**: Discussions in Strategic Executive Board and other internal LPT formal meetings . Leadership support within Collaboratives / DMT oversight Directorate delivery plans	Consistent feedback from system meetings	Self-assessment / gap analysis SMART actions / KPIs Success reporting (longer term). Action learning within directorates to identify opportunities using DNA data to improve equity. **update to be provided August 2025 Director of Strategy** Work to implement high impact actions for LeDeR to reduce premature age of death in people with LDA **update to be provided August 2025 Director of Strategy**	Strong progress in LDA, and Mental Health through our collaboratives. Good engagement and emerging LPT leadership support to CYP, including SEND. Strong engagement in system working in UEC. Exec representation at LMNS LPT representation at Caring Together Conference 18.3.2025
		2nd Line: Assurance and discussions in the integrated care board meetings, in our system quarterly review meetings with NHS England and the outcomes from the collaboratives we are involved with Collaborative and Commissioning Delivery Group Transformation Committee / engagement in formal ICB meetings - feedback into the Strategic Executive Board.	Self-assessment / gap analysis SMART actions / KPIs Success reporting Effectiveness of Collaborative, Commissioning and Contracting Delivery Group / Escalation via SEB		
		3rd Line: Feedback from our well-led review, the CQC and other organisations; Shadow Mental Health Collaborative Joint Project Engagement meetings with CQC, NHS England, ICB Regional & national recognition of effective joint working 3rd Line: Feedback from our well-led review, the CQC and other organisations; Shadow Mental Health Collaborative Joint Project			
Effect: **Limited contribution to social value, and providing place-based care**					
• Social Value Charter • LLR Green Plan • People Plan • Social Value Community of Practice • NHSE national policy on integrated care • Social value charter • LLR ICB 5-year strategy • LPT strategy • Co-production programme	• Evidencing the impact of learning • Evidencing the impact of the social value charter • Directorate plans for 24/25 • Transformation plans	**1st Line :** Individual programmes of work identified to support new workforce into the organisation, health inequalities actions and the development of training through greater partnerships with our universities.		Alignment of directorate delivery plans and the Trust transformation programme with the ICB 5-year strategy **Director of Strategy – April 2025**	Action Plan being developed to progress the roll out of Inequalities App across all Directorates.
		2nd Line Group social value programme in place with development meetings. Reporting into our annual report. Updates at Strategic Executive Board and the Joint Working Group.	Success reporting (longer term)		
		3rd Line LLR Health Inequalities Meetings			

GROUP BAF **3.1**	If we do not engage in **research, quality improvement and innovation**, we will not identify opportunities for improvement which will impact on the quality and design of our services.		
Date	Included 1 April 2025. Last updated	28.04.2025	
Strategic Link	THRIVE: **RESPONSIVE**		
Governance	**GROUP** LPT and NHFT Quality and Safety Committee, Group Strategic Executive Board, Group Trust Board		
Context	Innovation, research for new treatments, redesign of care delivery models with a focus on patient outcomes and experience		

Score	Consequence	Likelihood	Combined
Initial Risk	4	4	16
Current Risk	4	3	12
Target Risk	4	2	8

Risk Appetite – Open (upper limit of tolerance 16)

Control	Control Gaps	Sources of Assurance	Assurance gaps	Actions	Progress
Cause: **Not engaging in research and innovation**					
• Group Programme • University Hospitals Teaching Status • Leicestershire Academic Health Partners Board (LAHP) • Health Innovation East Midlands • ICB Research Strategy Group • Nursing & Midwifery AHP&P Cabinet • Research Policy – hosting conducting & collaborating • LPT integration with system and • LAHP partnership working	• Research Strategy and delivery plan • Funding for academic posts • Clarity over remit for Group roles • Funding for research projects • Funding for Innovation (Dragon's Den) • Capacity of the LPT research team to support succession planning	**1st Line:** Participant Research Experience Survey (PRES) Research activity and income **2nd Line:** Joint Working Group oversight of Group research and innovation programme Research programme to Quality and Safety Committee Local clinical research network Oversight of LAHP papers at SEB **3rd Line:** University Led Non-Executive Director	Assurance over uptake and PRES survey outcomes Assurance over success rate for attracting high quality commercial trials	• Research Strategy and delivery plan **Medical Director June 2025** • Group Joint Roles with clinical/AHP research element – 'Principal Investigators' **Medical Director June 2025** • Assurance over uptake and PRES survey outcomes **Medical Director June 2025 tbc** • Review LPT R&D team establishment needs **DMD Ongoing**	Generation of New Knowledge Workstream – 1st meet 25.9.2; 2nd meet 18.10.24 (NHFT, UoL Partners) Oversight of research participant recruitment numbers to form part of reporting to AFM
Effect: **Quality and Design of Services**					
• QI programme • Transformation Programme • Directorate objectives aligned to strategy • Deputy Medical Director for R&D	• Innovation strategy • Success measures	**1st Line** QI programme uptake and feedback Learning boards **2nd Line** QI and Transformation Committee AAA report to Finance and Performance Committee and the Strategic Executive Board **3rd Line** CQC inspection feedback and ratings	Impact of learning from research into service redesign	• Develop and deliver Innovation Strategy **Medical Director & Director of Strategy** October 25 • Innovation paper approved by SEB Dec 24 – to be submitted to operational planning round 25-26 **Medical Director & Director of Strategy March** 25 • Success measures and measuring impact to be determined **Medical Director tbc**	DMD for R&D recruited Sept 24 Ongoing discussions with Health Innovation East Midlands re translating national projects to local needs.

BAF **3.2**	Without **timely access** to services, we cannot provide high quality safe care for our patients which will impact on clinical outcomes.
Date	Included 1 April 2025. Last updated 28.04.2025
Strategic Link	THRIVE: **RESPONSIVE**
Governance	**LPT** Quality and Safety Committee, Strategic Executive Board, Trust Board
Context	Minimising harm while waiting, improving access to diagnosis and treatment, best clinical outcomes

Score	Consequence	Likelihood	Combined
Initial Risk	5	5	25
Current Risk	5	4	20
Target Risk	5	3	15

Risk Appetite – Open (upper limit of tolerance 16)

Control	Control Gaps	Sources of Assurance	Assurance gaps	Actions	Progress
Cause: **timeliness of access to services**					
• Access Policy • Performance Management Framework • Urgent and Emergency Care Framework • Medical Workforce Plan • LLR ICB 5-year strategy and LPT strategy / Annual Plan	• National strategy for neurodiversity demand • Local commissioning plans for addressing significant increases in neurodiversity demand	**1st Line:** Directorate attendance at Access Group and AFM WL trajectories and initiatives by service Operational risk profile AFM/EMB	Linkage of health inequalities to access group actions Clarity over policy compliance measures and rates	• Health Inequalities work to support Access Group actions. Update by **31 March 2025 Director of Strategy** • Policy compliance with Access policy **– Director of Nursing / Medical Director update by 31 March 2025** • Raising awareness of neurodiversity demand at system level through System Execs and regionally through regional MH oversight group (RMHOG) and through Quarterly system review meetings (QSRM) – **Director of FYPCLDA ongoing – update 31 March 2025** • Keeping Safe Whilst Waiting meeting taking place **Jan 25 DoN & MD** • Close monitoring NHS111/2 activity and performance in directorate and shadow MH collaborative meetings **Director of FYPCLDA ongoing – update 31 March 2025**	
		2nd Line: • Access Group with AAA to AFM/EMB			
		3rd Line: • Internal Audit – Patient Observations 24/25 significant assurance • Internal Audit – Remote Consultations March 2023 significant assurance • CQC feedback and ratings	ADHD Solutions closure – reduction in support across LLR Significant increase in NHS111/2 activity since Oct 2024 Global shortage of ADHD medication		
Effect: **Clinical Outcomes**					
• Reducing Harm Whilst Waiting Policy • Clinical Outcome performance measures • PSIRF • Incident reporting	Full implementation of PSIRF	**1st Line** Directorate attendance at Access Group and AFM for escalation	Clarity over policy compliance measures and rates	• Review of RHWW policy Compliance measures **Interim Director of Nursing –** review to ADG March 25. • Development of quality dashboard for testing **Interim Director of Nursing** – in progress review at 31 March 2025 • Implementation of PSIRF **Interim Director of Nursing. 2024/25 review at 31 March 2025**	Quality dashboard delivery framework developed (3-year programme)
		2nd Line Monthly performance report with clinical outcomes measures to Quality and Safety Committee and AFM	• Comprehensive quality dashboard focusing on outcome measures, including those attributed to waiting		
		3rd Line Internal audit patient experience August 2022 significant assurance Coroner feedback	External review of waiting times on patient safety		

BAF **3.3**	If we do not continue to review and improve our systems and processes for **patient safety**, we may not be able to provide the best experience and clinical outcomes for our patients and their families.
Date	Included 1 April 2025. Last updated 28.04.2025
Strategic Link	THRIVE: **RESPONSIVE**
Governance	**LPT** Quality and Safety Committee, Strategic Executive Board, Trust Board
Context	PSIRF, Just Culture, Prevention of harm, learning

Score	Consequence	Likelihood	Combined
Initial Risk	5	5	25
Current Risk	**5**	**4**	**20**
Target Risk	5	2	10

Risk Appetite – Open (upper limit of tolerance 16)

Control	Control Gaps	Sources of Assurance	Assurance gaps	Actions	Progress
Cause: Patient safety systems, processes and governance improvement & learning, CQC outcomes					
• Quality Account • Standard Operating Procedures • Policies • External validation • Service safety checks/huddles & escalation • CQC mock inspections & quality visits • Safety Forum • Monthly patient safety improvement programme board	• Workforce disruption (Safeguarding Team)	**1st Line:** Patient Safety Improvement Programme – phase 2 of RIPB; Executive Service Visits & feedback; NED Board Walks; Compliance Team visits	• Consistent use of PSIRF templates & methodology	• Delivery of Patient Safety Improvement Programme, including consistent use of PSIRF templates & methodology **Director of Nursing, monthly update to PSIP with any escalations to EMB – ongoing in 2025/25** • Suicide prevention work & training **Director of Nursing, update 31 March 2025**	• Safeguarding ICB overview • Staff booked onto STORM training
		2nd Line: SEB/Q&S Committee, Safety Forum. Recruited substantive Head of Safeguarding	- Suicide prevention training		
		3rd Line: External reporting (ICB); HOSCs; CQC Visits & outcomes; MHA Visits & reports, including ICB deep dive workshops (*safeguarding).			
Effect: Poor outcomes for patients, carers, families					
• Incident reporting systems & processes • PSIRF • Access & patient flow • Patient experience • Reputational risk • Patient Safety Team • Quality/CQC Compliance/IPC monitoring	• Consistency in incident reporting • Trust wide Discharge Policy	**1st Line:** Directorate oversight of local quality & safety systems and processes.	Family liaison specialist Learning from NHCT	• Notts HC Section 48 - sharing & embedding learning improvements via directorate governance & T&F Group **Director of Nursing, update 31 March 2025** • Quality Dashboard development **Director of Nursing, update 31 March 2025**	• Notts HC Section 48 T&F Group set up in progress
		2nd Line: Patient Safety Improvement Programme, Family Liaison Officer recruited.	Comprehensive oversight of quality measures		
		3rd Line: Coronial feedback/NHSE oversight; HOSCs			

BAF **3.4**	If we do not have appropriate **emergency preparedness**, resilience and response controls in place, we may be impacted by accidents, disruption and system failures affecting our ability to maintain continuity of services.	
Date	Included 1 April 2025.	Last updated 30.04.25
Strategic Link	THRIVE: **RESPONSIVE**	
Governance	**LPT** Health and Safety Committee, Quality and Safety Committee, Strategic Executive Board, Trust Board	
Context	Maintain organisational resilience. External factors, social, environmental and economic impact	

Score	Consequence	Likelihood	Combined
Initial Risk	4	5	20
Current Risk	4	2	8
Target Risk	4	2	8

Risk Appetite – Open (upper limit of tolerance 16)

Control	Control Gaps	Sources of Assurance	Assurance gaps	Actions	Progress
Cause: **A lack of Emergency Preparedness, Resilience and Response Controls**					
• EPRR Policy • EPRR Group Collaborative • EPRR business continuity workplan including co-production of response plans for cyber risks • LPT representation at the Local resilience forum – feedback back into LPT governance • LPT representation at the Local health resilience partnership - feedback back into LPT governance		**1st Line:** Task letter return logs & actions	EPRR policy compliance	• EPRR policy compliance **Dan Adamson Group EPRR Lead June 2025** • Developing LPT winter plan to feed into LLR winter plan to be agreed by NHSE later in the year**. Managing Director – LPT winter plan for approval at EMB in July 2025.**	Joint EPRR lead in place and in process of reviewing all related policies
		2nd Line: • Oversight at Audit and Risk Committee and the Finance and Performance Committee • LPT Business Continuity Management System (BCMS) Audit • Post Incident /Exercise Reports • Joint EPRR Lead in post			
		3rd Line: • ICB and system assessment against NHS England EPRR Core Standards • IA audit 24/25	LLR winter plan 25/26 – yet to be agreed by NHSE		
Effect: **Continuity of Services**					
• Business continuity plans • Disaster recovery exercises • Industrial Action plans • Director on Call arrangements • Training of strategic, tactical and operational responders • ICC assurance flow via EMB • System wide countermeasure and mass casualty plans • LPT participation in National, regional and local exercises • Checks via on call directors		**1st Line** Business Continuity plans reviewed & agreed within EPRR Group Operational Hub	Completeness and robustness of trust wide continuity plans	• Ongoing review of continuity plans, reported into EPRR Group with an escalations to the Health and Safety Committee. **Managing Director ongoing 2025/26** • Preparation for EPRR core standards assessment 2025/26	Taken part in industrial action audit for national review.
		2nd Line: Training oversight and management	Preparation for EPRR core standards assessment for 2025/26		
		3rd Line • Internal Audit – Business Continuity August 2022 Significant Assurance			

BAF **4.1**	If we do not adequately utilise **workforce** resourcing strategies, we will have poor recruitment, retention and representation, resulting in high agency usage.	
Date	Included 1 April 2025.	Last updated 28.04.2025
Strategic Link	THRIVE: **INCLUDING EVERYONE**	
Governance	**LPT** People and Culture Committee, Strategic Executive Board, Trust Board	
Context	Talent management, OD, growth and retention	

Score	Consequence	Likelihood	Combined
Initial Risk	5	4	25
Current Risk	**5**	**4**	**20**
Target Risk	5	3	15

Risk Appetite – Open (upper limit of tolerance 16)

Control	Control Gaps	Sources of Assurance	Assurance gaps	Actions	Progress
Cause: **Not utilising workforce resourcing strategies**					
• National and local People Plan • Recruitment Pipeline Management • Medical Workforce Plan • Recruitment and retention premium scheme for medical workforce • International recruitment • Nursing Recruitment & Retention High Impact Actions • LLR AHP faculty & Council • L2 Committee Workforce Development Group in place • Benchmarking against workforce metrics	• High vacancies with supply issues • Vacancy Control • Link to transformation planning • Structure of NHS pay award	**1st Line:** Operational risk profile for staffing – oversight at AFM and EMB/SEB; Recruitment weekly Gold Calls; Agency reduction Group **2nd Line:** Workforce Development Group; Directorate Workforce groups & HCA Retention Working Group Strike Action Group (as required) including organisational debriefs; People & Culture Committee **3rd Line:** System people and culture board System CPO meetings	• Directorate objectives and planning linked to workforce plan – awaiting planning guidance • Actions resulting from recent staff survey findings when available • Impact of band 2/3 HCSW changes • Delivery of the medical workforce plan • Delivery of the workforce and agency reduction plan • Jobtrain effectiveness including time to hire rates	• Directorate Objectives and Planning linked to workforce plan**. Operational Directors 31 March 2025** • Staff Survey action plan to be approved by **31 March 2025 – Director of HR/OD** • Band 2/3 HCA workstream impacts analysis – **Director of HR/OD to PCC April 2025** • Additional workstreams for delivery within the updated Medical Workforce Plan **Medical Director – update to PCC April 2025** • Delivery of the workforce and agency reduction plan 24/25 **– update to PCC Director of HR/OD at each meeting** • Jobtrain/time to recruit monitoring & user satisfaction to be reviewed – benefits realisation to report to AFM EMB WDG & **PCC Aug 25 Director of HR/OD** • WDG to monitor time to hire from **Jan 25 Director of HR/OD** • Directorate level time to hire reports starting **Dec 24 Director of HR/OD**	Engagement with the NHSE price cap work for medical agency costs commenced Feb 2025 People Dashboard launched through PCC
Effect: **High Agency Usage**					
• Agency Reduction Plan	None	**1st Line** EQIAs DRA and break glass criteria to stop deployment of Thornbury HCA **2nd Line** Agency reduction group AAA to People & Culture Committee **3rd Line** • LLR People Programme Delivery Group • Internal Audit Agency Staffing April 2023 Advisory (no high-risk actions) • Internal Audit Supporting Timely Recruitment April 2023 Limited Assurance	 Delivery of the workforce and agency reduction plan	• Delivery of the workforce and agency reduction plan 24/25 **Director of HR/OD – update 31 March 2025**	• No off-framework usage outside of break glass • THP numbers reducing • Bank incentives stopping agreed subject to EQIA

BAF **5.1**	If we do not lead with compassion, we will not promote an **inclusive culture**, resulting in unwanted behaviours and closed cultures.	
Date	Included 1 April 2025	Last updated 28.04.25
Strategic Link	THRIVE: **VALUING PEOPLE**	
Governance	People and Culture Committee, Strategic Executive Board, LPT Trust Board GROUP PUBLIC BOARD	
Context	Innovation, research for new treatments and redesign of care delivery models with a focus on patient outcomes and experience	

Score	Consequence	Likelihood	Combined
Initial Risk	4	4	16
Current Risk	**4**	**3**	**12**
Target Risk	4	2	8

Risk Appetite – Open (upper limit of tolerance 16)

Control	Control Gaps	Sources of Assurance	Assurance gaps	Actions	Progress
Cause: **Not leading with compassion**					
• Accountability Framework • EDI policy • People Plan • WRES and WDES • Cultural competency programme • Group TAR programme (including PCREF) • Culture of Care • Staff Safety in the workplace • L2 Workforce Development Group	None	**1st Line:** Appraisals with wellbeing element, speak up process, sickness management	Civil unrest	Cultural work to address civil unrest and wider including; • Anti racism listening events / TAR actions by **31 March 2025 Director of HR/OD** • Leadership Development Conferences delivery of 24/25 programme by **31 March 2025 Director of HR/OD** • Delivery of the Our Future Our way Programme of work & 4 priorities & leadership behaviours embeddedness by **31 March 2025 Director of HR/OD** • Campaign to embed leadership behaviours commenced 2.7.24 – to run throughout 24/25 by **31 March 2025 Director of HR/OD** • Developing a medical leadership programme **update by 31 March 2025 Medical Director** Staff Survey 24-25 – actions & implementation of priority areas Development of reasonable adjustments framework – Maple & ND Staff Networks Reasonable adjustment clinics & meetings established	Anti racism listening events & FAQS following civil unrest/racist riots Workplace Safety & Security Sessions planned in Medical Trainees Inductions December 24 Leadership Programme for medics - planning underway Team Time Out year 2 launched
		2nd Line: • F2SU Guardian, NED F2SU role • Learning from speaking up and sickness review • Workforce Development Group; People and Culture Committee • Schwartz Rounds • Group programme reporting to SEB every month for oversight	• Staff survey Oct 24 • Meeting reasonable adjustment requirements		
		3rd Line: • Internal Audit Freedom To Speak Up October 2023 significant assurance • Internal Audit Fit and Proper Persons Test due Q2 2024/25 • Health & Wellbeing 360 Audit rated significant assurance			
Effect: **Unwanted behaviours and closed cultures**.					
• Our Future Our Way • Leadership Behaviours Framework • Wellbeing, sickness management policy • Counselling service • Anti bullying harassment and advice service • Occupational health service wellbeing strategy	• Training on leadership and culture on induction • Closed cultures training	**1st Line** • Annual staff survey results • Deloitte staff survey and focus group feedback	• Delivery of recommendations from quality and safety review • Closed cultures not currently in staff inductions • Impact of leadership development	• Delivery of recommendations from quality and safety review**. Interim Director of Nursing 2024/25** • Closed cultures to be covered in staff inductions – ongoing - **Interim Director of Nursing / Director of HR & OD 2025/26** Leadership Conferences – focussed on psychological safety & speaking up within the 24/25 programme by **31 March 2025 Director of HR/OD** Reverse Mentoring cohort 6 launch Jan 25 OFOW output to come to PPC **April 25**	• 4 Leadership Conferences taken place during 2024 • Jan 25 Team Leadership Conference
		2nd Line • Mental health and Wellbeing Hub • Health and wellbeing champions and wellbeing NED role • Health and Wellbeing Lead • People and Culture Committee			
		• **3rd Line** • CQC inspection findings • System mental health HWB hub	Audit outturn 24/25 CQC reports		

BAF **6.1**	If we cannot maintain and improve our estate, or respond to maintenance requests in a timely way, there is a risk that our estate will not be fit for purpose, leading to a poor-quality **environment** for staff and patients
Date	Included 1 April 2025. Last updated 07.05.2025
Strategic Link	THRIVE: **EFFICIENT AND EFFECTIVE**
Governance	**LPT** Finance and Performance Committee, Strategic Executive Board, Trust Board
Context	Therapeutic, fit for purpose, meet standards, agile working

Score	Consequence	Likelihood	Combined
Initial Risk	4	5	20
Current Risk	**4**	**5**	**20**
Target Risk	4	3	12
Risk Appetite – Open (upper limit of tolerance 16)			

Control	Control Gaps	Sources of Assurance	Assurance gaps	Actions	Progress
Cause: **Unable to maintain and improve our estate**					
• Estates Strategy and Delivery Plan • Group Strategic Estates Plan • Accommodation & Space Policy • Estates Annual Plan 24-25 • Statutory Compliance continues to be maintained during 24-25 • Capital prioritisation process embedded	• Lack of capital funding • Aging estate with limited options for improvement • Having adequate space for clinics and supervision and training	**1st Line**: Capital Prioritisation process **2nd Line:** Estates and medical equipment group **3rd Line:** System estates groups, Capital prioritisation criteria , CQC engagement meetings and inspection feedback	Clinical representation at Strategic Property Group	• Identify alternative sources of capital Engagement internal to prioritise estates safety **Chief Finance Officer – August 2025** • Medical Directorate rep at relevant Estates meetings to be identified – **Medical Director**	Space Utilisation Study started Sept 24 – Feb 25 full completion – awaiting sign off
Cause: **Unable to respond to maintenance requests in a timely way**					
• Maintenance Logging System • Performance monitoring (soft & hard FM) data (12 months) • Jobs logged monitored & tracked monthly – monthly reports to DMTs breaking down outstanding jobs	Financial constraints – capital and revenue	**1st Line:** Feedback and use of the maintenance logging system **2nd Line:** KPIs in place for soft FM **3rd Line:** CQC feedback		Oversight of financial constraints ongoing – **Chief Finance Officer and Director of Finance via SEB and Trust Board**	Continued reduction in number of outstanding maintenance jobs
Effect: **Poor quality environment**					
• Environmental checklist • Operational risk management • Environmental checklist • Operational risk management • Health & Safety inspections • Estates Annual Plan	• Governance oversight of all quality and risk issues relating to environment • Regulatory standards for buildings	**1st Line:** Directorate Management Teams for escalation and oversight of risk **2nd Line:** Estates and Medical Equipment Committee; Estates log **3rd Line:** CQC feedback	Adherence to systems and processes (detailed in actions) for identifying and logging environmental concerns	• Governance route escalations • EMEG – review risks & escalate • AFM clarified escalation process • Annual Estates Plan approved • Escalation of Health & Safety issues • Oversight of estates risks on Ulysses • Review building compliance standards with DoN **Chief Finance Officer – August 2025**	Ongoing CRR/ directorate risk reviews taking place

BAF **6.2**	If we do not continue to strive for **sustainability**, we will be impacted by adverse weather events and environmental factors impacting on the health of our population, resulting in poorer health outcomes.
Date	Included 1 April 2025. Last updated 07.05.25
Strategic Link	THRIVE: **EFFICIENT AND EFFECTIVE**
Governance	Finance and Performance Committee, Strategic Executive Board, LPT Trust Board
Context	

Score	Consequence	Likelihood	Combined
Initial Risk	4	3	12
Current Risk	**4**	**3**	**12**
Target Risk	4	3	12
Risk Appetite – Open (upper limit of tolerance 16)			

Control	Control Gaps	Sources of Assurance	Assurance gaps	Actions	Progress
Cause: adverse climate change and sustainability factors					
• Green Plan 2022-25 • Estates Strategy and Delivery Plan • Partnerships Manager as resource for Green Plan oversight	• Green Plan for upcoming three-year period in line with ICB plan in draft. • Oversight of climate change and sustainability factors impacting on our population	**1st Line:**	• Plans to start Group Sustainability Forum July 25	• To present refreshed green plan (for upcoming three-year period) with the Trust Board for approval and publish on Trust website. **Chief Finance Officer July 2025** • To share revised green plan with NHSE and DHSE. **Chief Finance Officer July 2025** • To draft the Trust's response to the TCFD and include within annual report 2025/26. **Chief Finance Officer May 2025** • Gap analysis of available funding and impact of any resource gap on delivery of the revised green plan. **Chief Finance Officer July 2025**	• Funding secured for solar panel installations at Hinkley & Bosworth and Loughborough
		2nd Line: Finance & Performance Committee Estates & Medical Devices Group, SEB	• Specific sustainability group for oversight of draft revised green plan and oversight of climate change and sustainability factors • Green plan refresh to receive board level approval July 25 and then be published on the Trust's website.		
		3rd Line: CQC feedback NHSE oversight of green plans	• Revised green plan yet to be shared with NHSE and DHSC. • Provision of information to support the Task Force on Climate related financial disclosures (TCFD)		
Effect: Poorer health outcomes due to climate change and sustainability factors					
Green Plan	Understanding the impact of climate change and sustainability on our local population	**1st Line**	• Plans to start Group Sustainability Forum July 25	Review of governance for oversight of green plan delivery for providing assurance into FPC on a bi-monthly basis. **Chief Finance Officer and Director of Governance July 2025**	
		2nd Line Finance & Performance Committee Estates & Medical Devices Group, SEB	Specific sustainability group for oversight of impact of green plan delivery on our local population, and oversight of key climate change and sustainability factors impact on population health.		
		3rd Line NHSE and DHSC oversight of green plan and TCFD			

BAF **6.3**	Inadequate **capital funding** for LLR system will impact on LPT's ability to manage financial, quality & safety risks related to estates and digital investment in 2025/26 and in the medium term	
Date	Included 1 April 2025.	Last updated 01.05.25
Strategic Link	THRIVE: **EFFICIENT AND EFFECTIVE**	
Governance	LPT Finance and Performance Committee, Strategic Executive Board, Trust Board	
Context	Delivery within available capital resources. Estates, digital regulatory, constitutional and legal requirements.	

Score	Consequence	Likelihood	Combined
Initial Risk	5	4	20
Current Risk	**5**	**4**	**20**
Target Risk	5	2	10

Risk Appetite – Open (upper limit of tolerance 16)

Control	Control Gaps	Sources of Assurance	Assurance gaps	Actions	Progress
Cause: **Inadequate Internal Control**					
• SFIs / SORD • Scheme of delegation • Capital bid approval process	• None	• **1st Line:** Capital management committee management of capital plan; Clear capital bid approval process; SEB & Board approval of capital opening plan & subsequent revisions • Draft 2024/25 accounts – CRL delivered	• Ensure adequate senior clinical representation in prioritisation meetings	• Policy compliance audit and oversight **Director of Finance and Performance.**	
		2nd Line: Accounting policies / SFIs and SORD [Audit and Risk Committee]	Policy compliance		
		3rd Line: External Audit 2023/24 annual accounts unqualified opinion	24/25 annual accounts audit	• External audit of 24/25 accounts **Director of Finance and Performance.**	Audit will commence in May 2025
Cause: **Inadequate reporting and management**					
• Monthly finance report with exec level oversight • Capital management committee 3A report • ICS capital Committee		**1st Line**: Capital management committee triple A report		Appropriate escalation of specific LPT risks via EMB **Medical Director – starting February 2025**	In progress
		2nd Line: Monthly corporate report EMB/SEB/FPC and oversight at the System Finance Meeting & system capital committee	Escalation of risk		
		3rd Line: 2024/25 system wide capital audit completed; 3 low risk findings across all partners			
Effect: **Breach of Statutory Duty (CDEL)**					
• National guidance	• None	• **1st Line** monthly finance report assurance on CDEL delivery year to date & forecast	Approval of medium-term capital plan	Develop medium term capital plan, aligned to ICS plan **Sharon Murphy, DoF / March 26**	
		2nd Line			
		3rd Line KPMG 2024/25 annual accounts and VFM conclusion			
Effect: **Non achievement of capital strategy (LPT and System)**					
• National planning guidance – LPT & ICS delivery plan	• LLR ICB medium term capital strategy	• **1st Line:** ICS Capital committee reviews organisational delivery & ICS Finance committee		• LLR infrastructure 10 year, ; LPT 25/26 & 5 year plan • Manage Trust's capital plan **DoF / March 26** • Policy compliance audit and oversight **Director of Finance and Performance.**	In progress
		2nd line:			
		3rd line:	24/25 annual accounts audit	• External audit of 24/25 accounts **Director of Finance and Performance.**	Audit will commence in May 2025

BAF **6.4**	Inadequate control, reporting and management of the Trust's **2025/26 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)
Date	Included 1 April 2025. Last updated 01.05.25
Strategic Link	THRIVE: **EFFICIENT AND EFFECTIVE**
Governance	**LPT** Finance and Performance Committee, Strategic Executive Board, Trust Board
Context	Delivery within available financial resources. Use of resources, productivity and value for money–Performance measures, constitutional and legal requirements.

Score	Consequence	Likelihood	Combined
Initial Risk	4	5	20
Current Risk	**4**	**4**	**16**
Target Risk	4	2	8

Risk Appetite – Open (upper limit of tolerance 16)

Control	Control Gaps	Sources of Assurance	Assurance gaps	Actions	Progress
Cause: **Inadequate Internal Control**					
• SFIs / SORD • Treasury Mgt policy • Scheme of delegation • Code of conduct • Declarations of interest	None	**1st Line:** Expenditure control forms for all relevant non pay spend over £150; vacancy control process; DRA agency approval process; No PO no pay policy; segregation of duties in finance teams • Draft 2024/25 accounts – break even plan delivered	Additional Belvoir decant costs Reducing cash balances Supplier challenge of contract awards	• DMH to manage private provider costs **Director of DMH June 2025** • Enhanced cash reporting • Ensure transparent & compliant contract awards • Policy compliance audit and oversight **Director of Finance and Performance tbc** • External audit of 24/25 accounts **Director of Finance and Performance**	Ongoing 25/26 finance report Review processes Being scheduled Audit will commence in May 2025
		2nd Line: Accounting policies / SFIs and SORD [Audit and Risk Committee]	Policy compliance		
		3rd Line: External Audit 2023/24 annual accounts unqualified opinion	24/24/25 annual accounts audit		
Cause: **Inadequate reporting and management**					
• Monthly Reports with exec level oversight • Value Programme to deliver local efficiencies	CIP programme	**1st Line**: Directorate finance reports; bi-monthly DoF service level run rate reviews; Enhancing value CIP delivery review	CIP plan not fully identified Plan gap c£7m	• CIP – identify & deliver CIP programme **Director of Finance and Performance ongoing** • Close plan gap **– Director of Finance and Performance** • Deep dive reporting **Director of Finance and Performance ongoing** • DoF/service financial escalation meetings • Include agreed I & I improvement actions in 25/26 plan **Director of Finance and Performance ongoing**	Ongoing Workforce controls work prioritised As required As required Completed
		2nd Line:	Beacon Unit viability; non recurrent CIP; In year overspends & funding gaps.		
		3rd Line: Annual Internal Audit – scheduled Q3 2025/26			
Effect: **Breach of Statutory Duty**					
• National guidance	None	**1st Line** monthly finance report assurance on break even delivery year to date & forecast	Approval of medium-term recovery plan	Medium term recovery plan, using value in healthcare approach **Sharon Murphy, DoF / March 26**	
		2nd Line			
		3rd Line KPMG 2024/25 annual accounts and VFM conclusion	24/25 annual accounts audit		
Effect: **Non achievement of financial strategy (LPT and System)**					
• LPT financial strategy & plan	• LLR ICB revenue strategy • 24/25 non delivery of ICB plan	• **1st Line:** Organisational reports to ICS Finance Committee	• In year LLR plan delivery materially off plan	• LLR ICS financial strategy - Mitigate ICS financial delivery **Director of Finance ongoing** • Manage delivery of 2025/26 financial plan **DoF / March 26**	Via recovery & Sustainability Committee
		2nd line: System wide internal audit of financial systems			
		3rd line: Internal Audit – System wide financial controls & NHSE submissions	Audit outturn – all partners		