Risk ID	Date Ris	Risk Title	Risk Description	Exec Lead	Senior Resp	Controls	Gaps in Controls	Assurances	Gaps in Assurance	Current R	Target Ri	Target Da
ICB007	06/10/23	High levels of Oral Health issues (Dental Caries) and the longer time to recover from COVID means patients are having difficulties in accessing routine dental access or specific services to manage oral health issues.	Actual Risk There is a risk that the prevalence of dental caries (tooth decay) and the underlying level of oral health disease will deteriorate putting additional pressures on access to routine dental care and other dental services available in primary and secondary care. Trigger The level of dental caries within areas of high deprivation across the ICB remains high, affecting cohorts of patients whose access to dental services and whose self care dental regime has historically been lower than average. There has also been a shift in the oral health disease burden across the wider patient population largely caused by reduced access to dental services during COVID, that has led to patients requiring far more invasive procedures when accessing dental services. Outcome 1.Dental practices were not able to see and treat the same number of patients during the pandemic as each patient was taking more clinical time and a greater number of appointments to make them orally fit. 2.Dental practices were not able to achieve their full levels of contracted activity, which led to punitive contract sanctions and in turn reduces the sustainability of the dental practice, leading to an increase in contract 'hand backs' in the 12 month period after the pandemic. 3.NHS Dental contracts and their limited flexibility for developing services to specifically manage more effectively oral health issues. 4.The provision of NHS Dental clinicians providing services under the NHS Dental contracts is reducing due to the increased pressure on the clinical teams and recruitment and retention issues.	Craig Harris	David Armstrong	1. Dental Access and Oral Health Improvement Plan, focusing on 5 key themes (Investment Framework/Outcome Measures; Pathways; Communications; Contracting and Workforce) developed and implemented 2. Two year Dental Investment Plan approved and implemented and progress reviewed on a regular basis 3. Commissioning intentions for 2024/25 approved in April 2024 4. Approved to pay for activity up to 110% in 2024/25 for top 5 priority Local Authority areas 5. National Dental Recovery Plan 2024/25: - minimum UDA rate increased to £28 for 28 contracts - 88% of L&SC practices opted in to New Patient Premium Scheme - 14 posts funded under Dental Recruitment Incentive Scheme 6. Pathway 1 (Urgent Care) commissioned until 31.3.25 7. Pathway 3 (priority patients) commissioned until 31.3.25 8. Child Access and Oral Health Improvement Pathway commissioned until 30.8.26 9. Regular monitoring of the commissioning pathways occurs on a monthly basis. 10. Regular meetings with the Local Dental Network and Local Dental Committee are scheduled. 11. 3.12.24 BI team are now providing some support but this is still to be developed 12. 10.4.25 - Dental Access and Oral Health Improvement 5 Year plan has received Board Approval	Information is at system level and there is no dedicated BI resource to presently support more detailed analysis. National contracting constrictions are restricting the ICBs ability to invest and support the providers to become more resilient and sustainable. Ongoing national reform programme is not moving at a pace required to better support practices, this is resulting in more applications to re base contracts nationally.	1. Dental Access and contract performance is routinely reviewed by dental contract manager and reported to the Primary Dental Services Group 2. Local Dental Network has a system wide overview of service delivery and access 3. Performance metrics are reported into PCCC and F&P on a monthly basis 4. Dental activity and access is steadily improving and moving towards pre-pandemic levels. 5. Dental Access and Oral Health Improvement 5 Year plan is now being mobilised	Delivery of Pathway provision is voluntary there are some geographies where patients may have to travel further than others to access provision.	16 - C4 x L4, High	8 - C4 x L2, Medium	31/03/26
ICB009 (recommended for closure)	23/04/24	GP contract 2024/25 dispute – collective action	GP partners/contractors in England voted in favour of collective action following 99.2% of their GP and GP registrar members having rejected the 2024/25 contract changes which have subsequently been nationally imposed from 1st April. The British Medical Association (BMA) have urged GP partners/contractors to start taking part in collective action from 1 August 2024. The BMA has produced a GP practice survival toolkit: GP contract 2024/25 changes (bma.org.uk) which identifies 12 potential actions for practice decisions and have urged GP partners/contractors to undertake take at least one of the 12 actions detailed. Practices across L&SC are participating in the collective action but due to the nature of the collective action it is unclear as to which practices are taking which actions, and practices may decide to take different actions at different times over the days, weeks and months ahead. These may be permanent subject to negotiations with the new Government and there may be phases of increasing impact. There is a risk that the collective actions may: - further result in reduced levels of service and impact on patients' ability to access healthcare via their GP practice. -reduce the number of patient contacts by GP practice clinicians -result in practices not engaging with Advice and Guidance or referral management-type systems -see GPs handing back work to secondary care which they feel should have been undertaken by secondary care services i.e. requests for fit notes, prescribing, tests. -result in practices not engaging in other work, including attending meetings and similar, that they consider to be unfunded. -result in practices ceasing to provide services that are subject to additional (locally enhanced) funding in some parts of LSC but not others, and/or funded in other places but not LSC. There is a risk that the above actions would impact on secondary care and other services (increasing referrals, investigations, activity urgent care attendances, prescribing administration tasks and patient enquiries), and relatedly could create additional financial pressures in the System.	Craig Harris	Peter Tinson	EPRR governance and previous GP Collective Action meeting structures can be scaled up and down as required – these are currently stood down but will resume if required. Regular updates provided to Committees and Executive Management Team as required. Regular scheduled meetings with the LMC which facilitate discussions regarding general practice issues, this includes the implementation of the new LES services, interface issues and pathway concerns. Primary Care Secondary Care interface work is supporting the relationships between general practice and Trusts and working to reduce inappropriate asks and areas of frustration – System Forum and Place based groups established in all Places. Phased roll out of the new LTC LES from 1 Aril 2025 and commencement of the Routine LES and New Medicines Optimisation LES from 1 May 2025. Whole system GP engagement (via letter, newsletters updates, meetings and webinars) to provide updates regarding consistent commissioning approach and new LESs implementation and associated agreed funding (next GP webinars are 7th May – General LES update, 14th May – Medicines optimisation update). General practice contract and performance monitoring.	No guidance received from NHSE regarding 'grey areas' of the GP contract and what services are considered core Lack of System resources to support and administer Primary Care Secondary Care Place based interface meetings	Updates to ICB Executives Updates to PCCC	-	16 - C4 x L4, High	8 - C4 x L2, Medium	31/03/25
ICB013	09/05/24	Ability of the ICB to effectively identify and respond to quality concerns for Primary Care.	There is a risk that the ICB is not sighted on and managing effectively the quality of care delivered by Primary Care. This could adversely impact patient safety, experience, outcomes, clinical effectiveness and the ICB's ability to meet its statutory responsibilities in relation to quality oversight.	Sarah O'Brien	Kathryn Lord, Peter Tinson, Andrew White	• Close working relationship between ICB Quality, Medicines Optimisation, Primary Care and other ICB teams to ensure that emerging issues are identified and effective escalation pathways are in place to respond. However workload pressures create constraints on all teams to maintain and optimise relationships effectively. • Any emerging concerns in relation to quality in primary care services are escalated via established reporting mechanisms to ICB Primary Care Quality Group, Quality and Outcomes Committee and Board. • Primary Care Quality Group is established. This Group is a formal subgroup of Quality Committee and is the governance route for formal escalation. • ICB core Terms of Reference for reactive visits have been written but are bespoke, dependent on visit focus. These serve to support practice quality visits and articulate the approach and expectation should concerns be raised. • Relationship with the LMC to optimise information sharing and access to support. • Reporting arrangements have been mapped that reflect the interface between key forums. • Primary Care Assurance Framework annual submission submitted by ICB to NHSE which was also subject to MIAA auditing to test robustness. • Work has taken place to ensure the PCCC's Groups align their risk process to the ICB's risk management framework and ensure a consistent approach to identifying, managing and reporting risks relating to the work of the Groups. The PCCC has visibility of risk through the sub groups escalation reports. • Soft intelligence process in place, work ongoing to review centralised reporting system and data triangulation approach. The process includes input from medicines management colleagues. • CCPLs for Primary Care engaged with pilot work for proactive support visits. • Process documentation and SOPs in place for supported proactive visits. Revisions required to reflect the learning from the pilot pro active visits. • Lancashire and South Cumbria formulary launched and almost at completion. • Pro active visits support with mitigating risks, before they materialise. • Weekly soft intelligence reporting being produced that is indicative of issues resulting from collective action, this includes discharges. Reports are being shared with Primary Care Associate Directors. • With effect from 01/04, the ICB has revised governance arrangements. Primary Care Commissioning Committee has been dis established and a Primary Care Contracts Sub-Committee established to oversee the review, planning and procurement of primary care services. • There are established roles that support reactive response to concerns raised in relation to quality. Contractual monitoring is in place which allows for oversight of operational delivery.	• Governance processes between Primary Care and Quality Assurance Team are still maturing. The new ICB delivery model is awaited, expected end of April 2025. • A challenging and complex operating environment for Primary Care in relation to finances, quality, estates, resources and ongoing service demands. • Limited ICB resource to maintain adequate quality oversight which allows for identification of early warning signs of emerging quality concerns. This results in a reactive rather than proactive response. • Ongoing conversations with LMC to refine the shared understanding of responsibility in relation to ICB quality oversight • ICB only has sight of a small proportion of patient complaints regarding Primary Care. • Despite the soft intelligence reporting system being live, there is potential challenge to respond to demand due to existing ICB resource levels. • Lack of process in relation to oversight arrangements for FTSU for Primary Care. The ICB is awaiting guidance regarding ICB responsibilities for primary care. • Limited estates related capital investment opportunities. • Fixed term staff in quality assurance roles impact on long term improvement. A fixed term band 7 post is now vacant in the Quality Assurance team, the post holder has secured alternative employment. • ICB Primary Care team at 'place' are struggling with the capacity to conduct practice visits and maintain relationships with practices. This lack of capacity makes it difficult to engage with GPs and practice managers effectively. It is recognised that, without regular visits, practices may perceive visits as a sign of concern rather than support. Visits support data intelligence to assess practice performance, quality and patient safety. • Quality oversight is focused almost entirely on general practice at this time, due to capacity and expertise.	• ICB governance pathways in place to Quality Committee, Primary Care Quality Group and Primary Care Commissioning Committee. • Dedicated ICB senior leadership roles for Quality Assurance, Medicines Optimisation and Primary Care. • Escalation pathway in place to Regional Quality Group. Quality now linked into regional colleagues, to optimise and learning and best practice efficiently • Monthly Primary Medical Services, Dental, Pharmacy and Optometry groups in place and escalation to PCQG agreed. • Lancashire and South Cumbria Medicines Management Group and Integrated Medicines Optimisation Committee are in place. • NHSE led regional complaints oversight group. • Five proactive GP Quality Support Visits have been undertaken so far and as part of the pilot, which commenced on 10th October 2024. These visits offer assurance that the approach is effective in identifying any support requirements and mitigating potential issues. • Integrated performance report is being produced and shared with PCQG.	• Gaps in assurance about aspects of prescribing practices in Primary Care. • FTSU arrangements in Primary Care. • Low incident and/ or near miss reporting on LFPSE. • Reduced ability for the sharing of learning due to resource challenges with the ICB QA Team and capacity to monitor. • Lack of maturity with triangulating intelligence in relation to different data streams on dashboards. • Limited capacity to ensure complaints identify learning, it is implemented and leads to improvement. • A challenging and complex operating environment for Primary Care in relation to finances, quality, estates, resources and ongoing service demands. There is inter-dependency between this and the anticipated ICB operating model, due end of April 2025. • Lack of patient safety oversight due to PSIRF not yet being implemented across practices, this is not a statutory requirement. Currently, patient specific safety concerns are, at times, being escalated via the soft intelligence reporting process. • ICB reconfiguration planning and requirements to reduce programme and running costs by 47%, has commenced and will impact on quality assurance, primary care and medicines optimisation oversight, depending on the operating model and staffing resource allocation as well as change in functions. These functions may be retained, adapted or transferred depending on decision making. Impact is currently unknown due to lack of clarity around organisational structure.	16 - C4 x L4, High	8 - C4 x L2, Medium	30/09/25