CORPORATE RISK REGISTER

May 2023

Summary Corporate Risk Register May 2023

CRR No.	Nature of Risk	Date added to CRR	Executive Lead	Current Risk Score	Last Reviewed By RMC	Next Review By RMC	Link to LIM Value Stream	Page No.
Workforce Risk								
Workforce Supply Risk							*Cautious*	
CRRW1	Inadequate nurse staffing levels – REMOVED FROM CRR FOLLOWING MAY 2023 MEETING	May 14	Chief Nurse	16	Feb 23	Aug 23		-
CRRW2	Insufficient Medical Staff to deliver service - REMOVED FROM CRR FOLLOWING MAY 2023 MEETING	May 14	Chief Medical Officer	16	Mar 23	Sept 23		-
CRRW4	Insufficient staff to provide treatment, care and services to patients *(New)*	May 23	Director of Human Resources, Chief Nurse & Chief Medical Officer	16	May 23	Nov 23		5-11
Workforce Deployment Risk							*Cautious*	
-	-	-	-	-	--	-	-	
Operational Risk								
Business Continuity Risk							*Cautious*	
CRRO1	Risk of a viral pandemic	May 18	Chief Operating Officer	15	Apr 23	Oct 23		12-13
CRRO2	Power failure/lack of IPS/UPS resilience due to electrical infrastructure	Aug 15	Director of Estates & Facilities	16	Jan 23	Jul 23		14-16
Health & Safety Risk							*Minimal*	
CRRO3	Harm due to clinically related behaviours that challenge linked to organic, mental health or other reasons	May 15	Chief Nurse	16	Dec 22	Jun 23		17-20
CRRO4	Staff absence Health, Safety and Wellbeing	Oct 20	Director of Human Resources	15	Dec 22	Jun 23		21-31
Change Risk							*Cautious*	
CRRO6	Risk relating to commercial pressures arising from delays in delivering the refurbishment of the Generating Station Complex (GSC) at LGI	Oct 18	Director of Estates & Facilities	16	Jan 23	Jul 23		32
CRRO7	Risk of failure to deliver the hospital of the future project.	May 20	Director of Finance	20	Nov 22	May 23		33-39
CRRO8	Risk of failure to deliver the pathology project.	May 20	Director of Finance	16	Nov 22	May 23		40-45
CRRO9	Risk of failure to deliver the LGI Site Development Project	Nov 21	Director of Finance	16	Nov 22	May 23		46-49
Information Technology Risk							Cautious	
CRRO10	Cyber-attack leading to potential loss of IT systems and/ or data	May 22	Chief Digital & Information Officer	16	Apr 23	May 23		50
CRRO11	Insufficient DIT resources to meet demand for DIT led projects	Jan 23	Chief Digital & Information Officer	15	Jan 23	May 23		51
CRRO12	Closure of data centre in December 2023 *(New)*	May 23	Chief Digital & Information	15	May 23	Nov 23		52

			Officer					
Clinical Risk								
Infection Prevention & Control Risk							*Minimal*	
CRRC1	Healthcare acquired infection	Mar 19	Chief Nurse	16	Nov 22	May 23		53-58
Patient Safety & Outcomes Risk							*Minimal*	
CRRC3	Patient harm – falls and hospital acquired pressure ulcers	Mar 21	Chief Nurse	16	Feb 23	Aug 23		59-60
CRRC4	Failure to achieve Emergency Care Standard	May 14	Chief Operating Officer	20	Jan 23	Jul 23	ED LGI	61-64
CRRC5	18-week RTT target non-compliance	May 14	Chief Operating Officer	20	Mar 23	Sept 23	Ophthalmology / Cardiac Surgery	65-68
CRRC6	62-day cancer target	May 14	Chief Operating Officer	16	Dec 22	Jun 23	MDT & Pancreatic Breast Only	69-73
CRRC7	Failure to achieve 28 day cancelled operations target	May 14	Chief Operating Officer	16	Mar 23	Sept 23	Cardiac	74-76
CRRC8	Patients waiting over 52 & 78 weeks for treatment across a range of services.	Oct 18	Chief Operating Officer	16	Dec 22	Jun 23	Neurosciences	77-82
CRRC9	Patients waiting longer than 6 weeks following referral for diagnostics tests	May 14	Chief Operating Officer	16	Jan 23	Jul 23	Breast cancer	83-84
Capacity Planning Risk							*Cautious*	
CRRC10	High occupancy levels and insufficient capacity and flow across the health and Social care system causing impact on elective activity, unplanned care and diagnostic ability to meet the needs of our patients.	Sept 15	Chief Operating Officer	20	Feb 23	Sept 23	MMPS	85-88
CRRC12	Airedale Hospital Infrastructure: potential risk re transferring patients to LTHT	Feb 22	Chief Operating Officer	16	Nov 22	May 23		89
Financial Risk								
Financial Management & Waste Reduction Risk							*Cautious*	
CRRF1	Failure to deliver the financial plan 2023/24	May 14	Director of Finance	20	Jan 23	May 23		90-92
CRRF2	Reduction in operational capital allocation *(New)*	May 23	Director of Finance	16	May 23	Nov 23		93-94

Corporate Risk Register - Key

Risk Type	
Risk Category (*Colour coded for risk appetite level)*	
CRR 1	Individual risks

Risk Appetite Scale

Averse - Avoidance of risk and uncertainty is key objective
Minimal - Preference for safe options that have a low degree of inherent risk
Cautious - Preference for safe options that have a low degree of residual risk
Open - Willing to consider all options and choose one that is most likely to result in successful delivery
Eager - Eager to be innovative and to choose options that suspend previous held assumptions and accept greater uncertainty

Risk Score

Initial Score	The score before any controls (mitigating actions) are put in place.
Current Score	The score after the risk has been mitigated (by controls) but with gaps in controls (things we are not able to do) identified.
Target Score	The score at which the risk management committee would be comfortable in removing the risk from the corporate risk register (CSU or corporate function).

CRRW4: Insufficient staff to provide treatment, care and services to patients	C = 4 L = 4	16	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
									Target Score					Current Score	Initial Score	

Risk Description:
Inability to recruit to staff vacancies across all professional groups and support workers, caused by a local and or national shortage of qualified and experienced staff, exacerbated by the general workforce shortage post the coronavirus (COVID-19) pandemic where the market for staff is hyper competitive. Resulting in a potential failure to provide safe care and treatment to patients and to protect staff from psychological and physical harm (burn-out): loss of stakeholder confidence and/or material breach of CQC conditions of registration.

Executive Leads
Chief Nurse, Chief Medical Officer & Director of Human Resources and Organisational Development

Date Added to CRR: May 2023
Last reviewed: May 2023
Next Review: November 2023

Committee reviewed at:
Workforce Committee
Risk Management Committee

Controls	Gaps in Control	Further Mitigating Actions
NURSING, MIDWIFERY AND AHP's - Lead Chief Nurse		
Nurse staffing risks – controls and mitigating actions documented on Chief Nurse Risk Register		
Ongoing Deep dives into Nursing & Midwifery Recruitment and retention .	Inability to reduce vacancy gap due to decrease in supply of staff regionally and nationally. Significant vacancies nationally for specialist roles. For some roles, the private sector offers better pay and incentives (e.g., no on-call) Cost base review being undertaken to reduce staffing levels	System wide large scale recruitment events working at place with system providers. New entry routes created for those 'new to care' through apprentice CSW and trainee CSW routes. Launch of Excellence in Practice programme for unregistered workforce Learning Practitioner programme Focus on 'growing our own' through in-house courses and apprenticeships. Development of new roles and alternative workforce models. Use learning from Exit Interviews to improve

		retention. Working with WYAAT on attraction, recruitment and retention.
Utilisation of Nursing International recruitment	Further pastoral Support and supervision to be provided to international recruits after 1 years' service	Recruitment of 578 WTE international nurses through Health Education England (HEE) Global Further cohorts of international recruits to join the Trust in June 2023 Use of international recruitment agencies. HR/Nursing/Medics working together to develop approach to pastoral support
Safer staffing guidance and escalation pathway to ensure operational oversight and appropriate mitigation in safe deployment of staff. This includes the out of hours, assessment, assurance and escalation for safe nurse staffing guidance.	Variance in practice across CSU's in relation to roster governance and management. Impacts on safer staffing returns (Hard Truths) and timely release of vacant shifts to bank and agency. Available workforce to support opening of surge capacity in response to Covid pandemic or operational pressure, including ESA escalation.	Safer staffing resources, escalations and safer staffing policy available on the Trust intranet. All safer staffing documentation reviewed and monitored through the Nursing, Midwifery, AHP Workforce Group (NMAWG) Temporary wards (seasonal and surge capacity) included in external safer staffing return once opened for full roster period of six weeks.
Programme of quality Framework reviews and nursing quality reviews with CSUs	Variance in results of quality and safety reviews. Not all CSU's have received a review as yet.	Bi annual meetings for quality reviews with CSU's of concern meet more frequently Corporate support for areas of concern.
MEDICAL and SCIENTISTS - Chief Medical Officer		
Medical staffing risks – controls and mitigating actions documented on Chief Medical Officer Risk Register		
Utilisation of International Medical recruitment	Further pastoral Support and supervision to be provided to international recruits after 1 years'	Use of international recruitment agencies. HR/Nursing/Medics working together to develop approach to pastoral support

	service	
Ongoing Deep dives into Medical Recruitment and retention .	Inability to reduce vacancy gap due to decrease in supply of staff regionally and nationally. Significant vacancies nationally for specialist roles. Inability to recruit in some specialties due to national shortage of suitable applicants Increase in numbers of junior doctors choosing to work less than full time Potential inability to fill gaps with locums due to rates of remuneration being lower than other organisations Low morale and burnout in medical staff as indicated by results of staff survey Issues around HOLT Agency and the need for 3 years references prior to employment Risk of consultants reducing PA's or retiring early due to risk of high pension tax liability	Focus on 'growing our own' through in-house courses and apprenticeships. Development of new roles and alternative workforce models. Working with WYAAT on attraction, recruitment and retention. Paper prepared for Discussion at LETC Papers prepared for Executive Committee to discuss pay rates Medical Staff wellbeing strategy which will look at ways to ensure medical staff feel valued and recognised for their work Work underway to identify the impact of the change Development of a consultant retention strategy to include pension planning, flexible working and other key actions
Guardians of Safe Working, Junior Doctor Forum, Exception Reporting results and subsequent response from specialty.	Reporting processes in the current Covid pandemic were disrupted but are now back on track	The Trust has improved rest facilities for trainees following funding from the BMA (£30,000), and for the third-year running has appointed a number of Wellbeing Champions.
A global control for Health Care Scientists (HCS) workforce is the new structure for HCS leadership. This has named Leads for each of the main themes, Physical, Physiological and Life sciences as well as Bioinformatics. Under this leadership team is a HCS organisational structure that	Concerns over staffing levels in audiology esp. paediatric audiology. Raised with clinical effectiveness and outcomes group. Still pressures from AQP competition,	Local audit and external audit completed, and no errors issues identified but national review of paediatric audiology following Lothian review.

mirrors the Trusts structures including a Resource management group. This forum helps identify and manage workforce risks through shared experience and provides an escalation route outside of the normal CSU route as needed.	national review of audiology. Staffing risk of 50% vacancies. Only have capacity to train 1 paediatric audiologist a year. Annual staff establishment pattern. For several roles in the Trust recruitment is heavily dependent on graduate leavers. As such there is a spike in recruitment from September, spiking in November. But throughout the year these declines. The effect is that for about 2/3s of the year staffing levels are well below the average annual level. National shortage across Medical Physics. Clinical engineering - have made good progress in filling vacancies but have another group of retirements on the horizon. Difficulty recruiting in haematology, blood transfusion high pressure and are so not attractive job Genetics shortage. service expansion faster than university trained students. The impact of CDCs on the workforce is unknown. The teams are actively working with colleagues in the Trusts and ICS to gain better understanding through the Operational team.	Using February for setting staffing levels is not the best time as levels are well below the annual level at this time. Better to use the level in September otherwise this introduces another pressure into the workforce. To be discussed within RMG Working with HEE etc for more training across all areas. Apprentice scheme highly successful for engineering, although lag due to training period. Unknown at present as impact still evolving

ADMINISTRATION PROFESSIONAL, NON-REGISTERED AFC STAFF – Director of HR AND OD		
WORKFORCE ISSUES GENERIC TO ALL STAFF GROUPS – Director of HR and OD		
Each CSU has a Workforce Plan CSU workforce plans – reviewed by Deputy Director of HR and ADOPs	Further work required on Workforce plans to ensure focus on Retention and to improve links to finance.	Workforce planning template to be reviewed to assist CSUs
Resource Management Group meets bi-monthly to lead, support and report on activities related to resource management. Workforce Committee receives a deep dive into workforce issues 3 times per year		
Structured approach to Exit interviews	Exit interviews are not completed for all staff	Development of an electronic Exit Interview form to assist in understanding why people are leaving the organisation
Regular review of absence management data with Tri team / HRBPs / Operational HR /CSUs with actions agreed.	Tri teams and operational managers may not be confident in the actions that they can take locally. Tri-teams/Operational HR need to develop standard work to review short term and long-term absence. Organisational focus on operational pressures, managing the pandemic and the operational response to reset and recovery, resulting in a lack of remaining capacity to effectively manage sickness absence.	Optimal Attendance Management project established with project plan further detailed is contained within CRR04.
Roster management tools for staff groups.	Roster management not embedded consistently across the organisation	Work on going as part of the Finance Mitigation project to support 5 key CSUs with effective Roster management. A review is also planned to consider ROI of this work.

Continued focused recruitment to professional staff groups and support roles with development of new roles to support workforce: • Apprentice programme • Advanced Practitioners • Physician Assistants • Volunteer programme	New role with limited evidence base on patient outcomes. PAs not yet regulated	Adherence to best practice and safer staffing guidance. Nursing Associate deployment reference group commenced to support governance and assurance of new role. It has been agreed that the GMC will regulate. Deputy DME overseeing PA undergraduate placement program at LTHT. Future You programme implemented to create workforce plan, recruitment and retention strategy for the Nursing Associate role. Progress reviewed through NMAWG and RMG.
Use of temporary workforce (bank and agency), including specialist agencies to provide observation, supervision and safe care to patients	Ability to respond to increase in demand as part of operational pressures and winter planning.	Monitoring of staffing requirements through daily staffing meeting.
Locally agreed payment rates for staff, process for escalation, review and approval (Executive Director)	Inconsistencies in application, local CSU agreement.	Focus on increasing recruitment to the staff bank and promotion of new bank pay rates. Escalation of bank and agency rates monitored through the finance mitigation meeting chaired by the Director of HR.
Retention is one of this year's annual commitments Staff survey results	Plan required to develop a systematic approach to retention	Project plan to be developed by Organisational Development and Culture and progress reported through Staff Engagement Group
Specific clinical service risks described in CSU risk registers; risk scores 10 and above reported to Risk Management Committee in line with annual work plan, including nursing, medical staff, specialist radiographers, radiographers, sonographers, operating department practitioners, medical physics, healthcare scientists (pathology), dental nurses, estates and ancillary staff.	Further work required on Workforce Plans to ensure focus on Retention Significant vacancies nationally for specialist roles. For some roles, the private sector offers better pay and incentives (e.g. no on-call) Failure to attract candidates for some roles.	Development of an electronic Exit Interview form to assist in understanding why people are leaving the organisation. Focus on 'growing our own' through in-house courses and apprenticeships. Development of new roles and alternative workforce models. Use learning from Exit Interviews to improve retention.

		Working with WYAAT on attraction, recruitment and retention. Raising our advertising profile - using INDEED for some roles. Capitalising on social media campaigns linked to Saving Lives in Leeds Documentary. Reviewing entry requirements for some roles.

CRRO1: Risk of a viral pandemic	C = 5	15	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
	L = 3								Target Score				Current Score		Initial Score	

Risk Description:
There is a risk that the Trust may have to invoke its Emergency Response Arrangements due to a viral pandemic (e.g. influenza or COVID-19) causing the absence of significant numbers of Trust staff and large increase in demand which could overwhelm the Trust's ability to deliver routine care and result in potential fatalities and significant financial loss.

Executive Lead: Chief Operating Officer

Date added to CRR: May 2018
Last reviewed: Sept 2022
Next Review: April 2023

Committee reviewed at:
Risk Management Committee

Controls	Gaps in Control	Further Mitigating Actions:
Pandemic Plan	Pandemic Influenza plan last reviewed in January 2020,Continue to wait for new national guidance. However, due to delay in national guidance decision made to develop a Pandemic plan. Pandemic plan currently out for consultation.	Work undertaken to manage COVID, resulted in a raft of practices that remain in place, including IPC measures, PPE, testing, and capacity planning.
CSU Business Continuity Plans	Not all CSU Business Continuity Plans are up to date.	Work continues to support CSUs update their BCPs and an increasing number are being reviewed and updated.
Infection Control procedures (including Personal Protective Equipment) Training for 'donning' and 'doffing'		FFP3 fit testing programme has been brought up to date during the COVID-19 pandemic. On-going messaging and monitoring of compliance with PPE usage.
Leeds Outbreak Plan	Plan due a review January 2020. Since last review changes to NHS organisational structure. Awaiting confirmation from Leeds Council if plan has been reviewed.	Organisational action cards.
Operational Response Guidance (ORG)		Was reviewed in preparation for Winter 22/23
Arrangements in place to deal with current COVID-19		Arrangements that were in place during the

pandemic		periods of high COVID 19 numbers, such as Tactical Group, CAG, Silver and Gold meetings, can be stood up again quickly if the need arises.

CRRO2: Power Failure due to Electrical Infrastructure/lack of IPS/UPS resilience	C = 4	16	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
	L = 4		1	2	3	4	5	6	8	9	10	12	15	16	20	25
						Target Score								Current Score	Initial Score	

Risk Description: There is a risk of power failure at a Trust site (ward or clinical area)

Due to failure to comply with HTM 06 01 caused by outdated electrical infrastructure and the absence of complete IPS/UPS resilience in Clinical Category Grade A : Life support/complex surgery (Risk to patient due to loss of supply) or Grade 1 : Medical support services (Risk to business continuity due to loss of supply) locations

May result in a poor patient experience; a failure to protect patients or staff from serious harm or fatality; loss of stakeholder confidence; and/or a material breach of CQC conditions of registration or HSE prosecution

Executive Lead: Director of Estates & Facilities

Date added to CRR: August 2015
Last Reviewed: January 2023
Next Review: July 2023

Committee reviewed at: Finance and Performance Committee

Controls	Gaps in Control	Further Mitigating Actions
Emergency generator power provision across all sites. Dual electrical supplies to most clinical areas.	Emergency Generators take on average 20 to 30 seconds to start and supply power, clinical areas without UPS provision **will be without power for this period**. Not all patient bedheads have interleaved electrical supplies which is an HTM requirement. This could result in the loss of electrical supplies to individual bed heads upon a local electrical failure.	When Wards and clinical areas are refurbished in the future interleaved electrical supplies should be installed to each bedhead and all clinical category Grade A areas should have full UPS/IPS support fitted in-line with HTM 06-01.
Medical Physics have fitted independent battery back-up to some life support equipment in clinical areas.	This is not consistent across all areas of the Trust resulting in confusion when power supplies are disrupted	Theatre upgrade programme - no Capital funding available in 2022/23 or 2023/24 to upgrade theatres. £1.5m in 2024/25.
Complete assessment of telephony switchboard resilience in terms of UPS protection and autonomy (up to 4 hours)	Not all Information Technology systems are supported by UPS with the required autonomy to maintain a service upon loss of supplies.	
Estates Handbook updated for emergency plans with detailed processes and regular review.	This handbook provides the Estates on-call team with information of what can be	The handbook is reviewed annually.

	done when power interruptions occur but does not assist with the shortcomings of the installed systems.	
Increased interleaving of circuits in Clarendon Wing i.e. there is now more flexibility as to where power to wards/departments is directed from, increasing resilience.	This interleaving work has improved the resilience in Clarendon at Ward/Department level but not improved the local bedhead interleaving provision.	When Wards/Departments are refurbished in the future local interleaving should be carried out as per HTM 06-01.
Comprehensive review across the Trust with completed documentation detailing precise location of all key electrical infrastructure equipment	The detailed electrical review information is stored in hard copy at both Silver Command positions but would require in-depth electrical knowledge to fully understand.	Reviewed annually and updated as resilience is improved.
HTM's are not retrospective and areas were designed to comply with best guidance at the time of design and construction	Although HTM's are not retrospective HTM 06-01 was introduced in 2007 but work to move the Trust towards full electrical compliance is slow due to shortage of decant facilities and Capital shortages to carry out wholesale Ward/Department/Theatre improvements.	
A UPS/IPS infrastructure was installed to support Geoffrey Giles Theatres 1 to 8 and Recovery in 2017. Theatres 1-8 have been connected to the system in 2020/21. Theatre 9 has UPS but is not connected to the central system and is scheduled to be connected before it is due for lifecycle replacement.	Although the UPS/IPS infrastructure has been installed (£600,000) to support Geoffrey Giles Theatres 1 to 8 and Recovery the final connection and rewiring of Theatre 9 & Recovery is still required. If there is a power failure within these theatres the only system with inbuilt battery back-up are the Operating Lights.	Capital investment is required to connect the available IPS/UPS infrastructure Theatre 9 & Recovery in Geoffrey Giles Theatres. Not completed in 2021/22-due to access restrictions. Now in 22/23 plan, but access has not been allowed to either area.
Some areas (e.g. J54) are fitted with the required UPS provision but not fitted with Isolated Power Supplies (IPS).	Several clinical category Grade A areas are not fitted with IPS as required by HTM 06-01 to safeguard the patient from the risk	IPS should be installed to all clinical category A areas in-line with HTM 06-01 when areas are refurbished. Awareness of the electrical

	of electric shock and provide increased local electrical resilience.	shortfalls in UPS and IPS provision in clinical category Grade A areas is required, electrical action cards have been provided by Estates to Clinical, this will be reviewed 6-monthly.
UPS/IPS systems have been installed in a number of clinical category A locations including those detailed above in Geoffrey Giles (theatres 1-8); Cath Labs 3 & 4; Jubilee Wing MRI; 2no. Clarendon Wing B Floor NHS MRIs; Theatre 17 Jubilee Wing; Theatres 1 & 2 CAH. L43 Neonates (Clarendon Wing); Maternity Theatres & Recovery (Gledhow Wing) and ARCU (Gledhow Wing) were upgraded and fitted with compliant UPS/IPS systems in 2021. IPS was installed in J1 (Neonates SJUH) in 21/22.	There are still a number of Clinical category A areas without UPS/IPS systems.	£200K in programme for UPS/IPS installs in years 22/23, 23/24 and 24/25, the priority order for which is under review between Estates and Clinical teams. UPS has been installed to J54 on the central system bur no access allowed for installing the IPS

CRRO3: Harm due to clinically related behaviours that challenge linked to organic, mental health or other reasons	C = 4 L = 4	16	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
									Target Score					Current Score	Initial Score	

Risk Description:
There is a risk of inconsistent responses to patients at risk of clinically related challenging behaviour; leading to agitation/aggression/violence resulting in physical harm to patients, visitors and staff. The result is the potential for a fatality, serious harm or litigation against the Trust.

Executive Lead: Chief Nurse

Date Added to CRR: July 2019
Last Reviewed: December 2022
Next Review: June 2023

Committee reviewed at:
LTHT MHLSG

Controls	Gaps in Control	Further Mitigating Actions
Policy for Conflict Resolution (Reducing violence and aggression in the workplace) and establishment of Security Co-ordinators.	Concern that the policy is not being put into operation across all patient areas- in particular that the environmental and patient specific risk assessment tools are not being completed and used to inform risk reduction plans.	Improved compliance in 2022/23 - 80% of clinical areas have completed Risk Assessment. Security co-ordinators now in place
Restraint and Restrictive Intervention Policy includes detailed practical guidance on prevention strategies and de-escalation strategies Restraint Care Plan bundle rolled out trust wide. Restraint Care plan bundle added to latest version of Restraint Policy as a mandated staff action	Previous restraint audit identified gaps in staff knowledge in relation to the guidance on prevention and de-escalation strategies. Some evidence that the Restraint Care plan bundle is not yet being used for all patients who meet the criteria- potential risk to safety if proportionate	Audit results for 2022/23 still demonstrate areas of risk in relation to knowledge and guidance on prevention and de-escalation strategies. Results shared at Quality Safety Assurance group (November 2022), plans to share and agree improvement plans with Heads of Nursing in December 2022. In reach support from MCA/MHA Team to

	restriction/restraint not being used and monitored; also potential risk of disproportionate restraint/restriction being used without monitoring	continue.
Enhanced Care Procedure in place	Wards report that they struggle to fill 1:1 enhanced care shifts frequently. Gaps identified in the skill mix for enhanced care provision	Croma contractual performance monitored through quarterly contract meeting - croma training programme enhanced to address skills shortage Mental health trained Clinical support worker agency commissioned to provide 1:1 enhanced care in SJUH ED and acute medical admissions wards.
24/7 service provision from Liaison Psychiatry service now meeting PLAN standards and Acute Liaison Psychiatry service 1 hour response in ED implemented	ALPS service currently only partially co-located on hospital site impact on one hour response time	Consultant Psychiatrist now whole time equivalent in ALPS service Capital bid successful for - Improving the Experience of Mental Health Patients Presenting to Leeds Urgent and Emergency Care Services, including secure space at both EDs for high risk MH assessment at PLAN (Psychiatric liaison accreditation network) standard
De-escalation QI collaborative- supporting staff to support patients who may present with clinically related challenging behaviours. 12 high volume areas involved in QI with support from expert faculty members. A range of interventions being tested across collaborative areas; set of KPIs / measures being tracked monthly to evidence progress.	Level 2 training only being offered to De-escalation wards at the moment - level 1 still not ready for delivery Variation of training across the organisation - leading to potential gaps in knowledge/inconsistency of application Mental Health training not consistent across medical and nursing staff or	Increased oversight of monitoring data from De-escalation Collaborative and Violence and aggression Steering Group: • 'Assault' by patients who lack mental capacity - data shows slight downward trend since Nov 21 • Similar downward trend in use of rapid sedation on 3 monitored wards - 2 acute admissions and L10 • Staff reported challenging behaviour also

De-escalate training commissioned for 2 levels of training: E learning (Linus) and face-to-face de-escalation and safe restraint (GoodSense) for wards in the collaborative.	linked to a training needs analysis (TNA)	beginning to drop on collaborative wards Mental Health training needs analysis and education/training plan will be developed through the Violence and Aggression Reduction Steering group. Target completion Q3 2022/23 RMN recruited on a permanent basis in Urgent Care CSU following successful pilot.
CAMHS Crisis team has been operational from the beginning of 2020 the service offers - 7 day week 08.00-00.00	CAMHS not co-located in hospital and less robustly embedded into LTHT governance - leading to some variation in accessing timely psychiatric support for patients aged 0-18. CAMHS Crisis team do not have write access to PPM+ in order to ensure timely visibility of their assessments Nationally and regionally, there has been a surge in demand for specialist Tier 4 mental health inpatient beds for children and young people (CYP). We are currently seeing an increase in	CAMHS in-reach referral pathway redesigned / CAMHS Crisis team resource increased and now includes section 12 approved Doctor with responsibility for MHA assessments on LTHT wards. CAMHS representatives now identified for strategic / operational governance meetings. Medical and Consultant Psychiatry enhanced support agreed for CAMHS patients who remain inpatient for more than 6 days. Write access to PPM+ now escalated to Associate Director of Digital / DIT team for resolution New role - CAMHS Liaison Nurse band 7 and band 5 in post May 2022 - role is to specifically work across LTHT wards in support of admitted CAMHS patients and ward staff Nov 22 - Provider Collaborative Lead, CYP MH, West Yorkshire launching project designed to improve support for CAMHS patients in LTHT -

	demand of up to 1/3 compared to pre Covid times.	project manager in post and project plan developed.
Clinical guideline - Use of Rapid Sedation/Rapid Tranquilisation in place and linked to appropriate Polices/procedures	Current guideline only covers adult patients - need to identify whether additional guideline required for use with paediatric patients requiring rapid tranquilisation	Nov 22 - Adult version under review by appropriate clinical leads in Children Hospital with support from CAMHS Consultant Psychiatrist
LD and Autism - capacity and resource in the team has been temporarily increased to support the upskilling of the workforce and to provide specialist support and guidance	Temporary structure - to be reviewed on an annual basis	

CRRO4: Staff absence Health, Safety and Wellbeing	C = 3 L = 5	15	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
									Target score				Current score		Initial Score	

Risk Description: There is a risk that more people are absent from the workplace due to Covid absence and prolonged periods of pressure which may result in a further depleted and dispirited workforce.	**Executive Lead:** Director of Human Resources **Date added to CRR:** June 2020 **Removed from CRR:** July 2022 **Last Reviewed:** December 2022 (March 2023 updated) **Next Review**: June 2023 **Committee reviewed at:** Workforce Committee Risk Management Committee and Health and Wellbeing Committee

Controls **Note the key controls listed are based on the workstreams within the Optimal Attendance Management project, led by HR on behalf of the whole organisation**		**Gaps in Control**	**Further Mitigating Actions**
Review and Assurance	Regular review of absence management data with Tri team / HRBPs / Operational HR /CSUs with actions agreed.	Review meetings may not be frequent enough to respond to in a timely way to operational pressure. Data provided may not help drive compassionate action and facilitate staff to return to work.	Optimal Attendance Management project established with project plan. There are 3 key workstreams 1. Manager-Led Interventions - progress currently green Leading Leeds way toolkit has been launched. Over 100 staff have attended Supporting Attendance

		Tri teams and operational managers may not be confident in the actions that they can take locally. Tri-teams/Operational HR need to develop standard work to review short term and long-term absence. Organisational focus on operational pressures, managing the pandemic and the operational response to reset and recovery, resulting in a lack of remaining capacity to effectively manage sickness absence.	workshops, with further capacity available where needed. More than 800 staff have accessed the online tool kit. Delivery on track. 2. Review and Assurance - progress currently green, assurance meetings with Tri have commenced and having positive impact on management of sickness. Operational pressures and industrial action continue to impact on staff availability and capacity to manage absence effectively. (Delays recognised and managed). 3. Supportive Interventions - access and provision. Progress currently amber due to ongoing staffing issues on OH. (managed delays to planned timescales) Monthly meeting for Project group established. Daily review of staff covid data

			in place and escalations to Executive team as appropriate.
	Assurance of absence management data occurs at Workforce Committee and Board through the IQPR. Operationally this is reviewed through the people priorities dashboard and at weekly HR huddle. Deep dives have occurred in July/September 2022. Operational oversight occurs through Health and Wellbeing Committee HR Metrics have been developed which include sickness absence these are presented at each Workforce Committee.		Health and Wellbeing Dashboard is a standing Agenda item at Health and Wellbeing Committee and incorporates absence data. The data is reviewed by the Optimal Attendance Steering Group, through business as usual with the HR Managers and Advisors serving CSUs and Corporate Departments. Hot spot areas are identified and mitigating actions are agreed by the CSU and supported by HR As part of the enhancement of the HR metrics and suite of data, the reports CSUs use have been improved using customer feedback along with ongoing work to increase access and use of reports to inform actions and decision making via a self-service route.
Manager Led Interventions	Supporting Absence Guidance agreed with staff side and in place within the organisation. This details the processes around absence management to enable line	Guidance is not always followed due to line manager capacity, capability and span of	Optimal Attendance Management project established with project plan.

	managers to take local action to address sickness absence.	control. There is also a need for managers to manage conflict in a compassionate way this will form part of the absence management work.	There are 3 key workstreams 1. Manager-Led Interventions - progress currently green. Leading Leeds way toolkit has been launched. Over 100 staff have attended the E&F Supporting Attendance workshops. This support package is now being delivered across the trust starting with areas of greatest need as identified by the data. More than 11000hits on the access to the online tool kit. Delivery on track. 2. Review and Assurance - progress currently green, assurance meetings with Tri have commenced and having positive impact on management of sickness. Operational pressures and industrial action continue to impact on staff availability and capacity to manage absence effectively. (Delays recognised and managed). 3. Supportive Interventions - access and

			provision. Progress currently amber due to ongoing staffing issues on OH. (managed delays to planned timescales) In addition clear deliverables including: Embedding of the PPM approach. Summary pathways to detail ways to manage common types of absence.
	Advice and support available for managers to support them to manage sickness absence available from Operational HR and Occupational Health. In addition, over 100 staff have attended Supporting Attendance workshops, with further capacity available where needed. More than 800 staff have accessed the online tool kit.	High levels of demand outstripping available capacity results in managers not always getting the prompt response and advice that they need.	MDT approach to managing challenging cases to enable a shift from blockage to action has commenced and is having a positive impact on managing challenging cases. Increased involvement of HR Ops team in the OH referral process, still in progress. New online referral form now launched which will enable review of OH referrals with CSUs to prioritise those to be seen when demand exceeds capacity. Senior post in HR Ops has now

		Currently high vacancies in both HR Operations and Occupational Health which are impacting upon support to managers.	been filled, with additional support from agency staff in place while review of staffing need undertaken. Review of opportunities to increase empowerment and self-service approach. and review and deployment of resources to areas of greatest need based on sickness absence rates. Significant work in progress on capacity and demand in OH to ensure we have the right roles to meet our legislative and on employment requirements.
	Flexible working and remote working policies have been developed to ensure the needs of the individual, team and service are met, alongside maximising staff availability. Formal project group established to ensure the remote working policy is consistently applied through projects including on going training and support for managers to ensure the principles in the policy are applied. A formal group established to ensure consistency of	Inconsistent management practice in adopting the principles in the flexible working policy.	A formal group established to ensure consistency of application of the flexible working policy, first meeting will occur by end of April 2023. Effective roster management including sharing of best practice and Team Rosters, reviewed every two weeks through financial mitigation

	application of the flexible working policy.		project. Better coordination and application of the flexible working policy via CSU workforce plans.
	We are reviewing and refreshing the LTHT approach to Remote working to move from policy to culture	Policy is not consistently applied and there is a lack of understanding with staff regarding the opportunities for remote working	Working in conjunction with corporate comms - review and refresh communications
	There are a number of routes for staff to raise issues regarding their health and wellbeing, including over demand when at work. These include Mental Health First Aiders and line manager support e.g. by using the health and wellbeing conversations template which has been reviewed to improve effectiveness. Comms programme to increase awareness and usage of the robust financial support offer has generated increased usage of Money Buddies and the Employee Support Fund and directed increased hits to financial support on Intranet. Money Buddies one to one financial advice service commenced May 2022, with good usage. Launch of the Leading the Leeds Way Managers Toolkit	Managers confidence in discussing health and wellbeing needs with their staff. Staff are presenting with increasingly complex social issues that line managers and HR do not have specialist knowledge to support	Continue to roll out MHFA training, currently rated green on IQPR with 638 MHFA trained against a target of 600 by end of March 2023 with over 5,000 supportive conversations undertaken Discussions taking place across Leeds on the provision of a welfare officer role with initial indications that funding is available.

	is complete.		
	Effective national and local guidance in place for managing sickness absence. National decision that covid absence now managed in line with all other types of sickness.		
Accessing Support	There are pathways for staff to directly access internal staff support services including Occupational Health, Clinical Psychology and Physiotherapy. Health and Wellbeing booklet sent to all staff home addresses in December 2022 to raise awareness of services	. Wait times for NHS services eg counselling, physio can lead to staff being absent whilst awaiting appointments. Line managers are not always aware of how internal services to LTHT can support staff and therefore do not support staff to access them.	. Encourage staff to engage with primary care physicians as early as possible. Reduce OH waiting time to 4 weeks. This has been achieved for referrals to Doctors. Online referral form for OH now live.
Provision of Support	Range of support services available to support staff to return to work and stay well at work including: Occupational Health, Staff Clinical Psychology, Staff Physiotherapy, Individual Risk Assessments and Vaccinations.	The two year Hospital Charity funding for health and wellbeing services will not be renewed. Vaccination numbers for both flu and covid are lower than in previous years but in line with the national uptake.	Review how to reconfigure services to retain as much as possible from within LTHT budget. Executive Paper presented in September 2022 where decision not to continue to fund the extra support funded during covid. Work is ongoing to identify what the gap in terms of support is across the system and ensure remaining

			resources are deployed to meet organisational need. Including a retendering of the EAP service. One to one support will continue to be provided by the Employee Assistance Programme. With post incident support provided by the staff clinical psychologists. Optimal Attendance Management project established with project plan. There are 3 key workstreams and the third, supportive interventions, supports this work: 3. Supportive Interventions - access and provision. Progress currently amber (managed delays to planned timescales) Clear deliverables including: Trial three way referral appointments for line manager, OH and HR ops. Review and refresh work

		This year's winter vaccination programme will need to be managed in house and we do not have capacity to deliver this from existing resources.	related stress guidance to increase line manager confidence and use of this tool. Stakeholder engagement with CSUs to ensure services are meeting their needs. A business case for Winter vaccinations is under development.
Risk of staff absence due to potential Industrial Action	Twice weekly steering group established to plan for potential Industrial Action with staff from Emergency Preparedness, HR, Corporate Nursing, Corporate Medical Team, Corporate Operations and CSUs Triumvirates representaiton. Set of task and finish groups established to ensure effective delivery. Incident Command Center in place in the event of any Industrial action, with positive partnership working with Staff Side embedded. Standard work, including understanding what areas are derogated, established for how to manage the impact. Standard work in place for deployment and staff mitigations and utilising agency workers to support essential services during industrial action.	Following a special NHS Staff Council meeting that took place on 16 March, the government confirmed to the Agenda for Change (AfC) trade unions and employers the details of a revised pay offer for 2022/23 and a proposal for a headline recurrent pay award uplift 2023/24. Strike action for the Agenda for Change Trade Unions has been paused whilst the members vote on the revised pay offer. We do not yet know how	The organisation is considering actions that can be taken to reduce the likelihood and / or level of action in LTHT. These include both engagement and local terms and conditions actions.

	Robust data analysis to ensure understanding of staffing absence in place. Standard work to understand the scale of the potential impact as we recognise that there are staff across all staff groups and services who may take action. Working across West Yorks ICS and Leeds place to ensure plans are in alignment and risk is shared across the ICS and reaches wider ICS footprints e.g. South and North Yorkshire Good employee relations in place with local staff side organisations. The Leeds Way is well established as we manage industrial action. This also mitigates the risk of potential conflict in teams due to industrial action. FAQs, Ask the Expert, comms plan and guidance regularly updated to ensure understanding across the organisation as the situation develops.	members of the various Trade Unions will vote and whether future strike action will be called. Strike action for the BMA Junior Doctors is scheduled for 11-15th April. We do not currently know how the outcome of all the votes and how they will impact LTHT.	

CRRO6: Risk of further delays in delivering the refurbishment of the Generating Station Complex (GSC) at LGI	C = 4 L = 4	16	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25

Risk Description:
The management of this risk is commercially sensitive information which has been removed from the public version of the Corporate Risk Register.

Executive Lead: Director of Estates & Facilities

Date added to CRR: October 2018
Last reviewed: January 2023
Next review: July 2023

Committee reviewed at:
Finance and Performance Committee (by exception)

Controls	Gaps in Control	Further Mitigating Actions

CRRO7: Risk of failure to deliver the hospital of the future project.	C = 5 L =4	20	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
											Target Score			Initial Score	Current Score	

Risk Description:

There is a risk that the Hospitals of the Future Project fails to deliver its objectives as a result of:

- programme delays due to a lack of progress and approvals by NHP, NHSE and HMT of the Trust's Outline Business Case (OBC), and delays by the New Hospital Programme (NHP) surrounding the confirmation of procurement approaches, budgets, design guidance, and technical standards to be met;
- increases in costs resulting from programme delays, general inflation and increases in the costs of materials and construction costs;
- a failure by the NHP, NHSE and HMT to approve sufficient capital funding to deliver all of the Trust's requirements (including the planned hospital scope, digital by design, equipment, net zero carbon, car park, education and training);
- NHP imposed changes to specification, design and quality driven by changes to standards resulting in design reviews and/or reduced budgets;
- problems associated with inter-connectivity to the existing digital infrastructure;
- ineffective programme and project assurance;
- inadequate engagement with key stakeholders; and
- an inability to accommodate education and training requirements within available space and funding.

If the project is not delivered, the Trust will:

- not deliver the benefits specified within the OBC for the new healthcare facilities;
- have insufficient capacity to meet service demand and education and training requirements;
- have to address high and growing levels of backlog maintenance which present a risk to the Trust's ability to maintain service delivery and wider capital budgets;
- not be able to deliver efficiency improvements in a number of areas, including estates utilisation;
- not be able to deliver its stated objectives and benefits, including recommendations from the statutory public consultation and commissioner requirements relating to the centralisation of maternity and neonatal services on one site, resulting in increases in transfers between sites, short notice reductions in service provision, and difficulties in covering staff rotas and changes in protocols to mitigate risks;
- be restricted in its ability to transform clinical services; and

Executive Lead: Director of Finance

Date Added to CRR: May 2020
Last Reviewed: November 2022
Next Review: May 2023

Committee reviewed at:
Building Development Committee, 13 April 2023
BtLW Programme Board, 5 April 2023
HofF Project Board, 27 March 2023

suffer reputational damage.

Controls	Gaps in Control	Further Mitigating Actions
Programme Delays The Trust has responded to recommendations from the NHP's assessment of the HofF Project through the development of a comprehensively revised OBC submitted to NHP on 3 August 2022. Continued regular liaison between the SRO/Programme Director and NHP to understand progress relating to the NHP programme delivery, phasing, design standards and procurement strategy. NHP updates are a standing agenda item on the Building Development Committee and BtLW Programme Board agendas, with matters escalated to the Trust Board as necessary for Chair and Chief Executive action. An NHP representative attends BtLW Programme Board. The Communications Team is co-ordinating an on-going programme of communications, events and visits to promote the importance and benefits of the HofF scheme to Government and with the support of senior stakeholders including local MPs, the Northern Powerhouse, the Trust Chair and Chief Executive. Programme Director involved in networking with other Trusts in the NHP on a regular basis to understand shared/common and individual issues/scheme implications.	Lack of influence over the detail and pace of NHP work and the OBC approvals process. Not all of NHP's requirements and technical design standards are known or formally confirmed. There is a distinct lack of clarity surrounding funding and budgets which continues to present a risk to the delivery of the Programme. Lack of clarity surrounding procurement and delivery strategies to be adopted as well as funding allocations.	SRO and Programme Director to continue to liaise with key members of the NHP Team and specifically the need for clarity on phasing, design standards, funding and procurement strategy. The Communications Team to continue to liaise with the Trust Board and BDC around further communications, events and visits targeted at delivering a successful outcome. The BtLW Programme Team to continue to develop mitigations and associated communication plans in the event that the Trust's 'Preferred Way Forward' is not approved.
Funding and Cost Increases	Lack of knowledge around the level of	SRO and Programme Director to continue to undertake on-

The Trust has responded to recommendations from the NHP's assessment of the HofF Project through the development of a comprehensively revised OBC submitted to NHP on 3 August 2022. Continued regular liaison between the SRO/Programme Director and NHP to understand progress relating to the NHP programme delivery, phasing, design standards and procurement strategy. NHP updates are a standing agenda item on the Building Development Committee and BtLW Programme Board agendas, with matters escalated to the Trust Board as necessary for Chair and Chief Executive action. An NHP representative attends BtLW Programme Board. The BtLW Finance Workstream continues to support delivery through maintaining links to the Trust's wider financial management processes and consider the implications across the Trust as well as supporting the management of financial implications and risks, ensuring that integrated financial plans are in place and that performance against the Long-Term Financial Plan and Government guidance is monitored. The BtLW Programme Team has established processes to support the identification of value-engineering and cost mitigation strategies for assessment and implementation as necessary as the project is progressed. Robust change management/control processes established and implemented to monitor for design	funding likely to be allocated by the NHP to the Trust. Leeds Hospitals Charity £30m fundraising target impacted by inflationary changes.	going liaison with key members of the NHP Team on progress around the approvals process for the revised OBC and the need to fund all of its requirements. External advisers to provide regular updates on known and forecast key policy/design standard changes. Finance Workstream to review and update LTFM twice-yearly to capture any financial changes (and identify risks) in costs/income/inflation. BtLW Equipment Team to refine equipment requirements as the project progresses in consultation with Trust clinical and non-clinical leads and update forecast costs. Capital Planning Group to monitor progress surrounding the approved £18m Transfer equipment replacement. The BtLW Workforce Workstream and Deputy Chief Executive/Director of Estates are co-ordinating discussions with key CSUs to support the on-going development of workforce requirements ensuring they continue to be developed appropriately and are aligned with ways of working and workspaces to be implemented within the new healthcare facilities as well as meeting affordability and workforce planning requirements for the Full Business Case. BtLW Programme Team to prepare outline plans to mitigate the scenario of the Trust receiving reduced funding. Discussions required with the Leeds Hospitals Charity following the re-establishment of the Capital Appeal Board surrounding the specific nature of fundraising contributions and also to consider inflationary increases to

and cost variance against the submitted OBC. Regular monthly updates are provided to the HofF Project Board, BtLW Programme Board and Building Development Committee on funding and affordability issues including quarterly inflation updates. Inflationary updates are reported to the NHP as part of the monthly Programme Director's report. The BtLW Programme Team has established a risk/contingency allowance based upon a quantified risk assessment which has informed the Outline Business Case. This is supported by a robust change control process managed by the BtLW Programme Team with approvals and further assurance by the HofF Project Board, BtLW Programme Board and Building Development Committee. Key market updates on economic factors are reported to the HofF Project Board, BtLW Programme Board and Building Development Committee on a quarterly basis. Financial due diligence reports are completed on key contractors prior to their recommendation of appointment. There are robust controls in place to manage supplier contracts. Business cases are reviewed by NHSE, DHSC, and HMT at each stage to ensure compliance with guidance and to provide further on-going assurance. The Charities Workstream supports work to deliver the charitable funding target of £30m towards equipment with bi-monthly reporting presented by the		the £30m.

Programme Director to the Capital Appeal Board about progress to deliver the Project.		
Specification, design and quality The NHP requirements and the Trust's Design Brief/design requirements are seeking to deliver a robust, flexible and agile design solution within the constraints of affordability and build upon lessons learned including the recent COVID-19 experience. Significant clinical engagement completed by the BtLW Programme Team in the development of design briefing documentation and the design solution. Design proposals approved by CSUs. Robust change management/control processes established and implemented to monitor for design and cost variance against the OBC. A comprehensive governance structure implemented to oversee and manage the co-ordination and delivery of the design development process. Regular dialogue between SRO and Programme Director and key members of the NHP Team around the need for clarity and guidance on standards regarding single rooms, room sizes, structural grids, net zero and digital requirements.	Not all of NHP's requirements and technical design standards are known or formally confirmed.	SRO and Programme Director to continue liaison with key members of the NHP Team on need for clarity and guidance on standards.
Assurance The Trust has implemented a robust programme assurance framework for the delivery of the BtLW Programme and the Hospitals of the Future Project with internal management controls and delivery	Full implementation of local assurance controls, measures and processes through the BtLW PMO. Undertake a review of supplier	BtLW Programme Team to continue to review and respond to PwC assurance reviews and recommendations (on-going). BtLW Programme Team to monitor services and works delivered by specialist/professional advisers in terms of the

assurance supported through independent assurance provided by the Building Development Committee (and other Committees, Boards and Groups in the governance structure) and a programme of assurance activities undertaken by PwC as the Trust's auditors. The BtLW Programme Team has regular discussions with NHS regulators, technical, financial and legal advisors and strategic partners around technical design development, procurement and commercial strategies and business case development (on-going). Reviews are undertaken by NHSE, DHSC, and HMT at each key business case stage to ensure compliance with guidance and to provide further on-going assurance.	assurance processes and procedures/quality plans in connection with the delivery of contracts.	quality of deliverables through established project delivery arrangements.
Stakeholder Engagement The BtLW Programme Team has established a programme-level Communications and Stakeholder Engagement Plan, supported by a specific plan to support the delivery of the Hospitals of the Future Project aligned to project and workstream delivery plans. The BtLW Programme Team has developed a Stakeholder Management Database which captures key stakeholder information and the status of engagement in supporting effective reporting. Monthly reporting of communications activities are presented at the Hospitals of the Future Project Board, the BtLW Programme Board and the Building		

Development Committee. A quarterly report on Stakeholder Engagement is presented to the Hospitals of the Future Project Board, BtLW Programme Board and Building Development Committee. A six-monthly BtLW Staff Surveys is completed alongside a Staff Temperature Check in-between each key six monthly survey. The BtLW Programme maintains information updates on the Trust's website and internal intranet including the presentation of the latest information on developments.		

CRRO8: Risk of failure to deliver the pathology project.	C = 4	16	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
	L = 4		1	2	3	4	5	6	8	9	10	12	15	16	20	25
											Target Score			Current/Initial Score		

Risk Description:

There is a risk that the Pathology Project fails to deliver its objectives as a result of:

- a failure by the Principal Contractors for the New Pathology Laboratory at SJUH and the new AHL Lab at the LGI to deliver within the agreed contract sum, to the specified quality and within the agreed contract programme;
- delays in developing and implementing effective workforce and associated change management plans;
- delays to the delivery of associated CSU Projects that are incorporated within the overall critical path;
- delays to the re-procurement and implementation of the Pathology Managed Services Contract (MSC) and the implementation of the new Laboratory Information Management System (LIMS) to the operationalisation of the new Pathology facilities at the SJUH and LGI site.

If the project is not delivered, the Trust will:

- not deliver the benefits specified within the Full Business Case (FBC) for the New Pathology Lab at the SJUH site and the AHL at the LGI site;
- be unable to transfer all identified Pathology services into the New Laboratory and the AHL following their commissioning;
- be unable to transform and improve the quality of its services for patients;
- not improve the Service's efficiency in line with the Naylor Report by developing affordable estates and infrastructure and reducing backlog maintenance;
- not improve recruitment and retention and attract a high-quality workforce with the right skills; and

not contribute effectively to the implementation of the WYAAT Network Pathology Strategy.

Executive Lead: Director of Finance

Date Added to CRR: May 2020
Last Reviewed: November 2022
Next Review: May 2023

Committee reviewed at:
Building Development Committee, 13 April 2023
BtLW Programme Board, 11 April 2023
Pathology Project Board, 28 March 2023

Controls	Gaps in Control	Further Mitigating Actions
Guaranteed Maximum Price/Affordability The BtLW Finance Workstream continues to support delivery through maintaining links to the Trust's wider financial management processes and considering the implications across the Trust as well as supporting the	Mitigation plans to meet further significant rises in inflation over and above risks are identified in the FBCs for the new SJUH Lab and AHL and any subsequent impacts upon the delivery	Finance Workstream to review and update Long-Term Financial Model (LTFM) twice-yearly to capture any financial changes (and identify risks) in costs/income/inflation. Finance Workstream Lead to report on the LTFM to

management of financial implications and risks, ensuring that integrated financial plans are in place and that performance against the Long-Term Financial Plan is monitored. Financial risks and issues are reviewed and managed within workstreams at a project delivery level with regular monthly updates provided to the Pathology Project Board, BtLW Programme Board and Building Development Committee. Full Business Case for the new Pathology Lab was reviewed and approved by NHSE and DHSC in February 2022 with approval provided to address the £8 million funding shortfall via NHP funding. Full Business Case for the new Acute Hospital Lab was reviewed and approved by the Building Development Committee in July 2022. Robust change management/control processes established and implemented to monitor for design and cost variance against the FBC for the new Lab and the AHL. Regular monthly cost monitoring of scheme capital costs. The BtLW Programme Team has established processes to support the identification of value-engineering and cost mitigation strategies for assessment and implementation as necessary as the project is progressed. The BtLW Programme Team has established risk/contingency allowances within the FBC which was	of construction works. Capital contingencies to support the management of any impact resulting from delivery issues associated with non-BtLW projects (e.g. MSC).	the BtLW Programme Board and Building Development Committee so that any actions required, including integration with other services in LTHT, are monitored and escalated as appropriate.

based upon a set of stated affordability assumptions as approved by the Trust Board. This is supported by a robust change control process managed by the BtLW Programme Team with approvals and further assurance provided by the Pathology Project Board, BtLW Programme Board and Building Development Committee. Regular monthly updates are provided to the Pathology Project Board, BtLW Programme Board and Building Development Committee on funding and affordability issues including quarterly inflation updates. Mitigation plans identified to address impact of significant increases to inflation and project costs to deliver the new SJUH and AHL Labs.		
Managed Services Contract (MSC) Delays* Programme plan for MSC re-procurement established and mapped to New Pathology/AHL projects. Progress monitoring of the MSC Project is reported to the Pathology Project Board, BtLW Programme Board and BDC in addition to separate governance arrangements for the MSC Project linked with WYAAT. A Pathology Change Management and Dependency Working Group (PCMDWG) has been established to support the mapping and co-ordination of critical path dependencies relating to the MSC, LIMS and CSU projects and reporting to Pathology Project Board, BtLW Programme Board and BDC.	Knowledge of the new equipment supplier and equipment specifications to further inform the New Pathology Lab and AHL operationalisation planning and to support the completion of the works.	

WYAAT LIMS Deployment Project* A regional deployment plan for LIMS has been developed with LTHT-specific implementation plan in place for completion by September 2023. LIMS Project Board for Leeds facilities in place from January 2022 and meeting monthly to complement the regional WYAAT Pathology Implementation Board. Progress monitoring of the LIMS Project is reported to the Pathology Project Board, BtLW Programme Board and Building Development Committee in addition to separate governance arrangements to support the delivery of the LIMS Project linked with WYAAT. A Pathology Change Management and Dependency Working Group (PCMDWG) has been established to support the mapping and co-ordination of critical path dependencies relating to the MSC, LIMS and CSU projects and reporting to Pathology Project Board, BtLW Programme Board and BDC.		
Pathology CSU Projects The Pathology CSU is responsible for the delivery of several projects/change initiatives necessary to support the operationalisation of the new Labs and linked to the transformation of Pathology services at LTHT. These need to be aligned with the BtLW-led projects. The BtLW Programme Team are providing co-ordination and oversight support to the CSU in delivery of these projects and the management of dependencies which may impact operationalisation of		

the new facilities. A Pathology Change Management and Dependency Working Group (PCMDWG) has been established to support the mapping and co-ordination of critical path dependencies relating to the MSC, LIMS and CSU projects and reporting to Pathology Project Board, BtLW Programme Board and BDC.		
Cost Price Inflation Processes in place to continue to monitor inflationary changes and the impact on the new SJUH and AHL Works Contracts. Key market updates on economic factors are reported to the Project Board, BtLW Programme Board and Building Development Committee on a quarterly basis. Financial due diligence reports are completed on key contractors prior to their recommendation of appointment.		
Assurance The Trust has implemented a robust programme assurance framework for the delivery of the BtLW Programme and the Pathology Project with internal management controls and management assurance supported through independent assurance provided by the Building Development Committee (and other Committees, Boards and Groups in the governance structure) and a programme of assurance activities undertaken by PwC as the Trust's auditors. The Programme Team has regular discussions with NHS	Full implementation of local assurance controls, measures and processes through the BtLW PMO. Undertake a review of supplier assurance processes and procedures/quality plans in connection with the delivery of contracts.	BtLW Programme Team to review and respond to PwC assurance reviews and recommendations (on-going). BtLW Programme Team to monitor services and works delivered by specialist/professional advisers in terms of the quality of deliverables through established project delivery arrangements.

regulators, legal, technical and financial advisors and partners on procurement strategies and the development of business cases for the Project and subsets of the Project (on-going). Reviews are undertaken by NHSE, DHSC, and HMT at each key business case stage to ensure compliance with guidance and to provide further on-going assurance.		

* Note: this manages the interface issues between the Pathology New Lab Project, the MSC Project and the LIMS Project only. LIMS and MSC Project risks documented separately in accordance with governance.

CRRO9: Risk of failure to deliver the LGI Site Development Project	C = 4 L = 4	16	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
											Target Score			Initial & Current score		

Risk Description:

There is a risk that the LGI Development Site Project fails to deliver its objectives as a result of:

- a failure by the Trust to secure sufficient funding for the HofF Project in a timely manner;
- a failure by the LCC to address the future of the A58M Inner Ring Road tunnel;
- uncertainty in terms of when the Old Medical School will be vacated by Pathology services.

If the project is not delivered, the Trust will:

- continue to incur on-going operational and maintenance costs for buildings, some of which may be surplus to requirements;
- be unable to contribute as expected to the Leeds Innovation Arc;
- be unable to support the city's economic regeneration as expected;
- suffer reputational damage.

Executive Lead:
Director of Finance

Date Added to CRR: May 2020
(Removed from CRR Nov 2020
Re-added back to CRR: November 2021
Last Reviewed: November 2022
Next Review: May 2023

Committee reviewed at:
Innovation District Committee, 17 March 2023
BtLW Programme Board, 11 April 2023

Controls	Gaps in Control	Further Mitigating Actions
Assurance A robust programme and project delivery governance and controls framework is in place to support the delivery of the LGI Development Site Project objectives involving key stakeholders within the Trust and also with other partners. A strategic governance body, the Innovation District Committee, was set-up in November 2021 to provide more focus on, and support for, the Project. The Trust has obtained professional advice on specific		LDS Project Team to review and respond to PwC assurance reviews and recommendations (on-going).

issues, e.g. review of OMS disposal route by legal advisors.		
Guidance and Market Position The Trust complies with the NHS Estates Code and the Trust's Standing Orders, coupled with advice from advisors and position in the market to provide a clear steer on most appropriate disposal route and best value. The LDS Project Team has reviewed the property market/developer position on the OMS specifically and the remainder of the LDS site more generally as part of the Disposal Strategy development and agreement with IDC and Trust Board.		The LDS Project Team will prepare and implement a plan to review the property market position at key points in the disposal process for the remainder of the LDS (e.g. excluding the OMS) and identify actions to address the position of the development market/ commercial property market.
Business Case Business cases are being developed aligned to the HMT 5 Case Model. The Strategic Outline Case (SOC) was completed outlining key benefits, objectives, risks, financial positions, and economic options. The SOC was submitted to, and reviewed by, NHSE. An internal Trust business case for the Old Medical School has been developed and was approved by IDC at its meeting in March 2023.	.	An internal Trust business case for the Old Medical School will be reviewed by Trust Board in May 2023.
Stakeholder Engagement A specific LGI Development Site Project Communications and Stakeholder Engagement plan has been developed which complements the BtLW Programme-level Communications and Engagement		

Plan. Engagement with Trust staff as well as a range of strategic and supplier-based stakeholders will be undertaken to support the Project (on-going). IDC receives a comms and engagement update at each meeting. The approach to the disposal of the OMS being shared informally on a regular basis with the NHSE national disposals lead. An annual Communications and Engagement Plan has been developed and was approved in March 2023.		
Programme Delays BtLW Programme Director is undertaking regular liaison with NHP leads to understand their progress on the business case process. NHP forms a standing agenda item for the Building Development Committee and matters are escalated to the Trust Board as necessary for Chair and Chief Executive action. Progress and timetable issues for HofF and Pathology are discussed at various programme and project boards. The LDS Project Director attends BtLW Programme Board and the LDS Project Manager attends HofF and Pathology project boards.		
Site Usage The IDC and Trust Board have agreed a decisive and clear strategy for the use of the OMS with the aim of selecting a developer with the expectation of creating		The LDS Project Team will develop a set of options in terms of how the remainder of the site will be marketed to create opportunities for regeneration and bring best value.

an innovation centre which will deliver the expected economic growth. The LDS Project Team has become a proactive member of other innovation initiatives within the Leeds City area to ensure alignment of objectives.		The Trust will influence the uses for the remaining LDS to be complementary to the delivery of HofF. The LDS Project Team will undertake soft market testing with a range of developers to identify ideas for future usage for the remaining LDS.

CRRO10: Cyber-attack leading to potential loss of IT systems and/ or data	C = 4 L = 5	20	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25

Risk Description:
The management of this risk is commercially sensitive information which has been removed from the public version of the Corporate Risk Register.

Executive Lead: Chief Digital & Information Officer

Date added to CRR: May 2022
Last Reviewed: October 2022
Next Review: May 2023

Committee reviewed at:
Risk Management Committee
6 October 2022

Controls	Gaps in Control	Further Mitigating Actions

CRRO11: Insufficient DIT resources to meet demand for DIT led projects.	C = 3 L = 5	15	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25

Risk Description:
The management of this risk is commercially sensitive information which has been removed from the public version of the Corporate Risk Register.

Executive Lead: Chief Digital & Information Officer

Date added to CRR: Jan 2023
Last reviewed: January 2022
Next Review: May 2023

Committee reviewed at:
Risk Management Committee

Controls	Gaps in Control	Further Mitigating Actions

CRRO12: Closure of data centre in December 2023	C = 3	15	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
	L = 5		1	2	3	4	5	6	8	9	10	12	15	16	20	25

Risk Description:
The management of this risk is commercially sensitive information which has been removed from the public version of the Corporate Risk Register.

Executive Lead: Chief Digital & Information Officer

Date added to CRR: May 2023
Last reviewed: May 2023

Committee reviewed at:
Risk Management Committee 04 May 2023

Controls	Gaps in Control	Further Mitigating Actions

CRRC1: Risk of exposure to HCAI	C = 4	16	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
	L = 4					Target Score								Current Score	Initial Score	

Risk Description:
There is a risk of patients developing hospital-acquired *Clostridioides difficile* infection, Methicillin Sensitive *staphylococcus aureus* (MSSA)bloodstream infection(BSI), respiratory infections and bloodstream infections caused by multi-resistant organisms due to a reliable and effective management system not being in place to protect patients from infection due to estate constraints, compliance with infection prevention procedures, including hand hygiene, decontamination, environmental cleaning and training. There is a risk of hospital-acquired respiratory infections, including Covid-19 as a consequence of staff not following the guidance consistently.

This may result in serious harm or death to a patient, prolonged length of stay, unsatisfactory patient experience, significant financial loss, loss of stakeholder confidence, and/or a material breach of CQC conditions of registration.

Executive Lead: Chief Nurse

Date added to CRR: March 19
Last reviewed: Nov 2022
Next Review: May 2023

Committee reviewed at:
HCAI Group December 2021
Infection Prevention and Control Sub-Committee January , April 2022, July 2022, October 24th 2022, January 2023, April 2023

Controls	Gaps in Control	Further Mitigating Actions
Risk Assessment: Patient level assessment of risk on administration/arrival/transfer (filled in patient care record) IPC/Microbiology risk assessment completed electronically in PPM. IPC alert mechanism incorporated into electronic patient record (PPM+). Updated surveillance software installed HCAI reports generated weekly and circulated to clinical service units to monitor performance COVID 19 reports provided through PPM+ To continue with current technology (PCR), and reduce to the specified guideline frequency	LTHT does not have a process for trust wide surgical site infection surveillance.	Phase 3 Surgical Module delivery has been paused- Baxter have completed their part of the process however the theatre system third party supplier is unable to provide a date for completing the interface required. There is verbal agreement in principle to appoint a deputy IPC lead in surgery/anaesthesia, the application for funding is in progress. Time frame for funding being established. TRS have volunteered to test proof of concept

UKHSA has updated its UK IPC guidance with new COVID-19 pathogen-specific advice for health and care professionals, only symptomatic staff will have access to covid-19 test kits. Communications throughout the Trust shared how to access Covid-19 test kits if symptomatic. External audit of the HCAI performance data processes completed all recommendations adopted.		for the SSI module
Training, Policies and Guidelines: Essential and Mandatory infection prevention and control training to all staff, with an overarching Infection Prevention and Control Policy and a suite of Guidelines and SOPs. Trial of new CPE guidance has established new screening requirements within the adult population, along with isolation and laboratory resource. Business case was supported in September 2022. National Carbapenemase Producing Enterobacteriaceae (CPE) guidance not fully implemented in adults. Current national CPE guidance followed if more than one linked CPE case identified in Children's hospital Quality Improvement methodology adopted with a Trust wide HCAI collaborative and LIM. Incident command structure in place for COVID-19 related gaps in compliance to ensure a rapid approach to learning and trust wide dissemination. Core principles to reduce the risk of respiratory infection transmission, including Covid-19 (Updated February 2023)	National Carbapenemase Producing Enterobacteriaceae (CPE) guidance not fully implemented in Children's hospital	Plan in place for implementation in Children's hospital. eform revision required Completion planned for end of May 2023

The National Infection Prevention and Control Manual (NIPCM) for England applies to all NHS settings or settings where NHS services are delivered. The Trust is working through the implications for CSU's. Current national CPE guidance followed if more than one linked CPE case identified	National IPC Manual implemented plan re-aligned with HCAI Annual Commitment.	Plan in place to align LTHT and national guidance by Spring 2023
Environmental Controls: Environmental decontamination programme and standards, segregation and safe disposal of waste process, programme of water safety, ventilation safety and IPC design incorporated into refurbishments and new builds. Opportunities taken to undertake HPV when a ward has been returned to cold elective activity as part of the recovery plan. Rolling programme of deep cleans established Hierarchy of controls completed by clinical teams which details controls, risks, and mitigations for Covid-19. All adult haematology en suite side rooms redesigned	Rolling programme of HPV ward decontamination paused as current decant facility is providing winter bed capacity	Continue to HPV infections of CDI & CPE, taking the opportunity to HPV all patient shared equipment where possible. HPV ongoing in Oncology CSU admissions ward
to reduce risk from water borne infection All patients in adult haematology receive written information about reducing risk of infection related to water hygiene and safety Antimicrobial stewardship in adult haematology including weekly patient screening A multidisciplinary task and finish group has been formed to	Learning from the haematology *Pseudomonas aeruginosa* outbreak has highlighted the need to have active surveillance in all augmented care, and regular multi-disciplinary *Pseudomonas aeruginosa* risk assessments and evaluation of probable water-borne infection in all augmented care units at LTHT.	Review of each immunosuppressed and critical care unit is underway to establish and collate information that will inform local regular assurance checks, environmental improvement and a set of Trust wide safe water hygiene standards. Ten reviews completed to date

deliver an assurance programme for the trust based on the learning in haematology. IPC involvement in design, refurbishment and new builds. Side room capacity increased in ED, ARCU and Critical Care, with additional 12 side rooms across LGI, SJUH and CAH Feasibility study completed on the ability for 3 extra side rooms in Gledhow wing, namely J15,16 and J17 A further increase of 3 side rooms have been provided on J33 in December 2022 Respiratory patient pathway areas under review to understand where further mechanical ventilation or increased side room capacity is required. Review completed. A monthly Trust-wide ventilation safety group has been established from September 2021 to provide monitoring, oversight and assurance around our current ventilation and enhance the use of new technologies. CSUs undertaking a review of the hierarchy of control risk assessments to identify any gaps and mitigations, all estates gaps will be reviewed through the ventilation safety group	Limited side room capacity in the unplanned pathway. Large parts of the estate have natural ventilation only. An options appraisal for understanding where further mechanical ventilation is required.	Progress with the redevelopment of ward J42/J43, this would increase the number of side rooms within the Trust. The funds for this development is within the Trust's capital plan. Corporate planning leading on a collaborative side room review in the SIM. Findings and proposal expected May 2023 Following the Respiratory Pathways and Safe Patient Placement review four working groups have been established, 1. Tactical operational response group, 2. Beckett Wing patient placements and Environment, 3. Multi Occupancy rooms for infections 4. Business Case development. Monitoring and oversight will occur through the OIPC group.
Antimicrobial Stewardship: Policies and Standards, City Wide Group, Ward Rounds and day 3 IV antimicrobial review		
Detection: Monthly surveillance monitoring and assurance through monthly Perfect Ward meetings and additional hand hygiene audits and ward assurance visits. IPC Leadership team continued to review the HCAI		

performance at Trust CSU and ward level. Consultant Microbiologists provided ward and CSU level review and feedback. HCAI assurance monitoring through the Perfect Ward expanded to include all national HCAI objectives by January 2022. IQPR expanded to include all national HCAI objectives by January 2022.		
Recovery and lessons Learned: Outbreak Management. Incident investigations. City wide Outbreak response group. CSUs manage individual root cause analysis reviews and Outbreak Meetings with support from Consultant Microbiologists, IPCT, Antimicrobial Pharmacists and DIPC/DDIPC. Stop the line investigation process instigated for single COVID-19 nosocomial investigations Revised and strengthened the IPC governance committee structure to enable the Trust to ensure monitoring and oversight occurs and assurance is reported and recorded through the appropriate IPC structure and integrated within the Trust Quality and Safety governance structure.	Feedback of lessons from RCAs to clinicians is variable across LTHT, in some areas learning may not be shared effectively	Development of CSU microbiologist role to include reporting of themes and trends from RCAs to CSU clinicians, reporting to IPCT to allow trust-wide learning- consultation completed implementation as part of annual commitment
Assurance: HCAI assurance is monitored through the Infection Prevention and Control Governance Structure. Latest BAF and Health and Social Care Act 2008: Code of	Review of IPC AP & BAF identified a	Medical AMS lead role JD and recruitment in process expected to commence May 2023

Practice document for health and adult social care on the prevention and control of infections and related guidance published December 2022, changes incorporated into the IPC AP & BAF. Covid-19 assurance is monitored through the Trust OIPC group and IPC governance structure. Board oversight is provided through the Infection Prevention and Control Annual Programme and combined Board Assurance Framework, published by NHSE in May 2020. **Cross-ref: CRR04-** Integration of the IPC Annual programme and new Board Assurance Framework within the reset work streams completed, and CSU's are invited to provide an assessment of their position against the programme at the operational infection prevention and Control Group (OIPC) and HCAI group**. C**ontrol now intergrated into CRR01**,** and workstreams have now moved into transforming services workstream. CSU's presenting assurance to OIPC against the annual programme and BAF. Medical Workforce redesign completed. New Medical IPC Lead role appointed 1 September 2022. Review of current medical leadership to support the Medical IPC Lead completed recommendations adopted in principle. IPCN development plan in place. Clinical Lead infectious disease consultant providing COVID-19 operational support.	requirement for a Trust AMS lead. IPCN, vacancy recognised national shortage of IPCNS	New JD to include AHP and secondment opportunities in place

CRRC3: Patient harm – falls and hospital acquired pressure ulcers	C = 4	16	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
	L = 4		1	2	3	4	5	6	8	9	10	12	15	16	20	25
									Target Score					Initial/Current Score		

Risk Description: There is a risk of hospital-acquired harm to patients related to pressure ulcers and falls due to increased demand for beds including exceptional surge capacity, gaps in compliance, and increased demand for enhanced care.

Cross-reference CRRS16: risk of re-commencing normal activity levels due to reduced capacity (COVID-19)

Executive Lead: Chief Nurse

Date added to CRR: March 2021
Last Reviewed: February 2023
Next Review: August 2023

Committee reviewed at:
Quality and Safety Assurance Group

Controls	Gaps in Control	Further Mitigating Actions
Risk assessment framework and clinical guidelines/care plans for staff in practice	Variable compliance with completion of documentation. Mixed models of paper and digital risk assessment documentation.	Elsevier Steering Group established to oversee the progress to an external digital care planning system, working collaboratively with Digital, Clinical Documentation Operational Group (CDOG) and clinical experts. Planned launch March 2023 Joint Strategic clinical nursing documentation group provides strategic oversight for transfer of paper records to digital format, in partnership with Mid York's Hospital Trust. Working group established to progress the digitalisation of nursing documents which reports into the Joint Strategic Clinical nursing documentation group
Ward metrics/audit process – ward assurance visits	Capacity of Professional Practice Safety Standards team to respond to increased assurance visits due to increased workload.	Falls in-reach reviews undertaken in clinical areas where there is an increase in falls reported (with moderate harm) by CSU staff New Collaborative Ward Healthcheck monthly review

		meeting, attended by corporate leads to share intelligence and to triangulate patient safety data to better support wards, whilst reducing overall visits from different teams. To launch February 2023
Governance framework – Perfect Ward review meeting, specialty and CSU Quality Assurance (governance) meetings.		Nursing Quality review meetings commenced May 2021 with all clinical CSU's to review patient safety outcomes and data. Meetings are scheduled twice per year as part of a wider Nursing Quality framework.
Root Cause Analysis (RCA) investigation process – review panel.	Consistency/variability in standard of completion of RCAs.	Investigation and lessons learnt process for Falls and PU being reviewed in line with PSIRF (Patient Safety Incident Response Framework). Currently being piloted.
Quality Improvement Faculty falls/pressure ulcers	Ability for staff to attend meetings due to operational challenges	Virtual meetings provided to increase attendance
Safety huddles/enhanced care	Demand for enhanced care has increased and CSW workforce shortfalls.	On-going CSW recruitment. Bi-annual establishment review process to identify additional enhanced care need requirements.
Specialist support – Tissue Viability Team	Capacity to provide support to all clinical areas. Increase in patients admitted with existing pressure ulcers	Quarterly assurance report to QSAG detailing pressure ulcer RCA outcomes and update against the Trusts internal pressure ulcer reduction trajectory Monthly city wide meeting to discuss relevant cross working and data sharing. Standardised criteria for 'admitted with' pressure damage. Education to ward staff regarding assessment of skin on admission.

CRRC4: Emergency Care Standard non-compliance	C = 4	20	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
	L = 5								Target Score					Initial Score	Current Score	

Risk Description:
Failure to achieve the Constitutional Standard of 95% compliance threshold against the 4-hour Emergency Care Standard and/or the 76% Emergency Care Standard required by March 2024 as referenced in the national annual planning guidance for 2023/24. This failure is caused by increase in department attendances, insufficient rostered workforce to meet the timely needs of patients and long delays in patient placement into the hospital bed base. This can lead to a congested department impacting on patient outcomes, patient experience, increased infection risk, staff morale, non-compliance with required national standards, patients in the department for longer than 12 hours and financial penalties. COVID19 has become endemic with predicted 3 monthly surges. Challenges with inpatient flow continue due to changes in patient placement pathways both within and out with the hospital responding to infections. Hospital occupancy levels have risen reflecting change in patient demand.

Executive Lead: Chief Operating Officer

Date Added to CRR May 2014
Last Reviewed: January 2023 (March 2023)
Next Review: July 2023

Committee reviewed at:
Finance & Performance Committee

Controls	Gaps in Control	Further Mitigating Actions:
CSM status reports, bronze escalation meetings chaired by Associate Director of Operations or Director of Nursing and silver meeting aligned to the operational response guidance in place. -There is a bronze and silver command escalation process both within LTHT and across the city system.	Sustained high numbers of patients within the bedbase with no reason to reside impacting on hospital capacity and ability to place new patients who require an acute bed placement. This impacts on ED congestion	Early identification of patients without a reason to reside in hospital and referral to the Transfer of Care hub for review of the patient's on-going care needs. (Purpose of the transfer of care hub is to reduce time waste in the referral to decision to service time and increase the home first policy) Escalation process updated to ensure senior leadership input earlier into the patient pathway to resolve issues. When demand for inpatient beds outstrips capacity and certain pre agreed triggers are met the Exceptional Surge Area (ESA) escalation framework is evoked to balance clinical risk for the ED's.
Daily monitoring and reporting of 4-hour performance	Timeliness of bed allocation by CSUs to ED	Focus through the ECS weekly Key Line of Enquiry report on key enablers to timely care and

	Absence of real time electronic bed state and real time bed and patient placement overview.	alternatives to admission where appropriate.New trajectory to deliver 76% ECS by March 2023 as per planning guidance has been established and submitted with workstreams and measures to enable delivery developed. ED Patient 2 hourly safety rounds completed and recorded with assurance checks completed and long waiting patients more than 12 hours from bed request) reviewed and reported to weekly quality meeting. Patients over 24 hours in ED reported on the weekly Executive score card After hours Response Team at SJUH implemented to support timeliness of bed release and creation of capacity at SJUH 6pm until midnight seven days a week. Re-focus Unplanned Care programme with increased oversight and governance regarding non elective flow and discharge.
Alternatives to ED attendance and patient streaming in place to most appropriate route via the Same Day Response city offer and streaming to GP, Minor injuries, Minor illness service and Same Day Emergency Care Units (SDEC).	Medical, older adult SDEC model current estate and footprint constraints Acute Medicine Consultant workforce constraints Access to SDEC model via 111First	Continued monitoring of ED attendance profile and 95% compliance and breach analysis for patients streamed away from ED. Use of a national tool understanding the city Directory of Service offer against the needs of people with conditions that could be managed outside the hospital setting is being used to understand any gaps in city service provision- due for completion in April 2023- phase 1 and 2 of the review already complete. Continue to maximum opportunity for SDEC pathways and alternatives to admission as clinically appropriate.

Creation of space to support increased numbers of patients in the Emergency Departments to support internal flows.	The estate footprint constraints. Requirement to consistently fully staff the extended footprint so it can be consistently used including the Extended Observation Unit at LGI.	Both St James's and LGI ED footprint has increased. Nurse and medical staffing reviewed to ensure patient safety and timeliness of care across a larger footprint. LGI ED has a modular build to support internal ED flow. Agreed surge plans for extremis developed as part of a Decision Management Tool to space within or adjacent to the ED's Minor Injury and Minor illness services remain centralised at LGI out with the ED footprint. Minor injury straight to test is routine practiceto support rapid test and treat/decision
System Gold action plan being implemented and monitored through SROG / System Coordination Group.	Community capacity to support timely transfer of patients from acute bed base. Complexity of discharge pathways. Measurable impact of system actions.	Implement work plan and monitor against the key objectives through weekly SROG and System Coordination Group. LTHT Transforming Services-Unplanned Care programme has an established number of agreed work streams with increased focus on LTHT opportunities to improve early decision making, alternatives to attendance and /or admission and reducing delays for inpatients and improving outcomes. These will be reviewed against the Trust Goals and the City Same Day Response Board established and chaired by LTHT Medical Director for unplanned care. City System Flow Programme Board established with LTHT engagement.
System level mutual aid actions (system wide agreed tactical options to be considered during periods of escalating pressures)	Ability of system partners to respond in a timely fashion and with known effect.	Monitoring of Mutual Aid actions through System Resilience Operational Group and System Coordination Group.
Seasonal planning with CSU's and system partners for	Unpredictable activity levels	Operational response guidance developed and

2022/23		monitored through daily operational processes developed and refined i for 22/23 System owned schemes monitored for implementation and impact weekly at SROG.
COVID19 and flu modelling in place for further waves and response in order to proactively manage and support flow and admissions across LTHT.	Novel modelling with a 7day forward view only. Unknown impact of potential variants	Modelling versus actuals is reviewed to enable responsive configuration of services, state of readiness and discussed at SROG.

CRRC5: 18-week RTT target non-compliance	C = 4	20	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
	L = 5		1	2	3	4	5	6	8	9	10	12	15	16	20	25
									Target Score					Initial Score	Current Score	

Risk Description:
There is a risk that the Trust will not recover 18-week RTT performance as a result of reduced levels of activity during periods of COVID19 admissions having lengthened waiting times for most of the Trust's services. COVID-19 restrictions resulted in a reduction in non-urgent face to face outpatient clinic activity and the majority of elective surgical activity to allow staff to be released to support additional critical care and inpatient capacity. This was required to support increased COVID19 admissions. As a result of suspending this activity, the number of patients waiting over 18 weeks, as well as the total Trust waiting list increased significantly.

This results in a poor experience for patients and there is a risk that some patients will deteriorate while waiting for treatment. Recovery may result in the risk of increased scrutiny and additional capacity being required at increased cost.

Executive Lead: Chief Operating Officer

Date Added to CRR: May 2014
Last Reviewed: March 2023
Next Review: Sept 2023

Committee reviewed at: Finance & Performance Committee

Controls	Gaps in Control	Further Mitigating Actions:
Implementation of telephone and video conferencing facilities have enabled non-face-to-face appointments to be delivered.	Not suitable for patients where investigation or examination is required	Face to face activity is restored where clinically required. Alternatives to follow-up (PIFU) and remote monitoring of patients are being developed, but uptake is not as rapid as hoped.
Triage of referrals enables identification of some patients at risk of harm if appointments are delayed.	Quality of referrals from GPs can vary.	Delivering easier access to consultant opinion for GPs ahead of referral through enhanced advice and guidance systems Focus on improving Advice and Guidance. This is also included as part of our activity planning submission.
Delivery contracts have been revised to link to H2 planning guidance to focus on key outcomes. 104 week and 78 week delivery trajectories agreed with each CSU, and plans underway to develop 65 week delivery trajectories	Demand variation from winter modelling / Covid modelling will impact elective delivery	LTHT Winter Plan approved to manage capacity through anticipated spikes in non-elective demand and to protect elective capacity.

		Elective Recovery Funding used to support CSUs to increase capacity through insourcing / substantive workforce or use of the Independent Sector
Single points of access in some specialties will allow onward referral of routine activity to AQP's spreading burden across providers	AQPs will be subject to same restrictions on activity as LTHT.	
Effective advice and guidance can support primary care decision making and reduce unnecessary referrals	Absence of system to support capture of advice into EPR prevents roll-out to all specialties.	System requirements being scoped as part of business case development.
Development of guidance and offer of support in development of patient initiated follow up (PIFU) pathways helps reduce unnecessary appointments in outpatients releasing capacity for other patients.	Some pathways require remote monitoring or use of apps - no current portal link to EPR	Work underway with DIT colleagues to explore potential for implementation of patient portal. A pilot of a minimal viable product to commence our journey towards a patient portal will commence in March 2023. Delivery targets for 2023/24 being developed for CSUs to uptake PIFU within specialities. PPM+ development work is being scoped to understand system opportunities to delivery efficient PIFU across LTHT and support CSUs uptake.
Recovery plans allocate available theatre, critical care, ward and staff capacity to areas of greatest clinical risk.	Prioritises clinically more urgent patients and so does not improve RTT position.	All P4 patients above 80 weeks as P3 patients to support booking of long waiting patients Additional theatre capacity sourced through the use of Insourcing Teams and through the development of additional theatres I.e. Mobile Theatre at WDH and the use of two additional theatres at SJUH which were originally developed to support maintenance of existing theatres

Use of Royal College guidance to prioritise elective activity to improve planning for capacity allocation to patients with greatest clinical need.	Prioritises clinically more urgent patients and so does not improve RTT position.	
Established arrangements are in place to allow additional outpatient and inpatient activity to be scheduled outside normal working hours - will be required during recovery phase	Pension taxes had reduced number of additional sessions provided by consultant staff	Additional medical payments agreed to support additional activity specifically for treatment of long waiting patients
Independent sector capacity likely to be available to support during recovery phase.	Capacity available for higher volume outpatient activity is limited. Contract change means IS only accepting IPT of low complexity high tariff patients in a limited number of specialties.	Further specialties have had above tariff contracts agreed to support treatment of long waiting patients
Use of external theatre resource to staff LTHT theatre capacity to 100% of pre-covid	Financially expensive model Insource teams are limited to the less complex work but this still supports the reduction in the total waiting list	Further extensions of insourcing support requested to March 2023
ICS Elective coordination group established to support regional recovery of admitted waiting list through a collaborative approach to increase elective capacity in low complexity / high volume specialties	Providers at different stages of recovery RE internal capacity and management of P2 patients. Payment mechanism is a barrier to shared working approaches	WYAAT Elective Coordination group offering capacity for specialties at risk of not delivering zero 104 / 78 week waits.
Develop ~~sites~~ Elective hubs (CHOC & WGH) to increase elective activity that can be delivered.	Currently requires dedicated capital and revenue to support the development of these sites and will not be delivered before Summer 202~~2~~3 for WDH and 2025 for CHOC	Vanguard Mobile theatre commenced operating in January 2023 at WDH WDH business case approved by NHSE. CHOC business case in development for Trust Board in April 2023 Allocations linked to WL position as well as

		ability to treat P2 patients Continued increase in ACC workforce planned through September and October 2023.
Reallocation of elective theatre allocations to support specialties with capacity and demand mismatch Weekly collaborative critical care clinical prioritisation review by LGI and SJUH CSUs to support listing of clinically urgent patients and to match listed activity to anticipated capacity	Re-allocation reduces capacity for other specialties Critical Care capacity can change overnight due to staffing absence or high numbers of unplanned admissions and result in on day cancellations	
Planned Care Programme is focussed on theatre productivity through a number of workstreams to keep increasing performance against key KPIs such as theatre utilisation / Day case rate / Elective LoS / Average Case per session - British association of day case (BADs) - Enhanced Care Beds - Theatre Productivity & Efficiency - Preoptimisation - Elective Hubs	Impact of unplanned pressures on elective bed base Willingness of clinicians to do extra work due to pension / tax issues Capacity to focus on improvement work alongside operational pressures	Recognising the pressures on teams, and the pressures on the organisation, the improvement work through theatres has focussed on those areas less impacted by loss of elective beds. Reallocation of J24 as a protected surgical ward for Oncology and Womens CSUs

CRRC6: 62-Day Cancer Target	C = 4	16	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
	L = 4		1	2	3	4	5	6	8	9	10	12	15	16	20	25
									Target Score					Current Score	Initial Score	

Risk Description:
There is a risk that the Trust will not treat 85% of patients within 62 days in line with the 62 day referral to treatment constitutional standard

This is due to the volume of 62 day patient backlog, increases in 2ww referrals from May to October 2022, particularly for the Breast, Skin, Head and Neck, Prostate and Colorectal pathways alongside increased demand through pathology. This created an imbalance between capacity and demand, for key pathways or at key pathway points. This was further exacerbated by IT system issues affecting the ability to triage skin patients in particular, and higher than expected demand for acute and urgent care.

These pressures can result in poor timeliness of care, unsatisfactory patient experience, and unacceptable delays for patients, deterioration in stage of cancer at the point of treatment with worsened clinical outcomes and/or deterioration in LTHT's governance rating.

Executive Lead: Chief Operating Officer

Date added to CRR: May 2014
Last Reviewed: December 2022
Next Review: June 2023

Committee reviewed at:
Finance and Performance Committee

Controls	Gaps in Control	Further Actions Planned:
The Trust Board has a named Executive Director responsible for delivering the national cancer waiting time standards.	None	None
The Board receives 62 day cancer wait performance reports for each individual cancer tumour pathway, as well as overall and will scrutinise actions to improve performance.	None	None
The Trust has a cancer operational policy in place which has been approved by the Trust Board.	None	Annual review in line with required updates
The national guidance on reporting methodology being consistently applied.	None	None
The Trust maintains and publishes timed pathways, agreed with the local commissioners and any other	Referrals from other providers do not always occur in a timely manner to	

Providers involved in the pathway, taking support from the WY&H Cancer Alliance for key areas	support delivery of 62 performance. LTHT capacity does not match the demand to deliver treatment within 62 days.	New governance structure in place for oversight of cancer services with a New Trust board chaired by COO and Medical Director, underpinned by a new monthly assurance board, chaired by Deputy Medical Director and ADOP for Cancer. Multidisciplinary site specific cancer pathway meetings are in place with robust action plans Weekly PTL meetings reviewing long waiting patients clear documented actions. Overview of tracking by CSU and cancer site of the total number of patients waiting throughout their pathway to ensure clear weekly understanding of the position and actions are being taken.
The Trust maintains a valid cancer specific PTL and carries out a weekly review for all cancer tumour pathways to track patients and review data for accuracy and performance.	Awareness of 62 day Breach risks are not always clearly visible to CSU management teams	PTL meetings reviewing long waiting patients clear documented actions that are reviewed weekly. Pathology KPIs and PTL dashboards have now been developed and monitoring/ recovery actions agreed. Harm review process reviewed and refined to provide assurance of long waiters for attention.
LTHT 2ww referral volumes back to normal levels and flowing into the system as per normal process.	2ww referrals have continued to increase to higher levels that previously seen causing increased activity and delivery	Colorectal introducing a new triage process to support straight to test pathway. Endoscopy mitigations successfully delivered

	challenges particularly in Breast (2 spikes), Skin, Colorectal and Head and Neck	additional capacity Skin have introduced a new internal IT solution implemented which is improving triage and reducing the 2ww backlog.Breast mitigations have been successful with the use of Medinet, and IS/ AQP use. Mutual aid in place from March 2022 Urology prostate, timeout undertaken with a new triage pathway being trialled.
Capacity and demand analysis and reporting for key pathway elements to support timely delivery is carried out systematically and routinely.	Capacity & demand modelling has been completed for all elements of every pathway, however this is not easily repeatable or routinely reported to support early intervention/ planning Radiotherapy capacity is currently not sufficient due to planning staff gaps and impact of delivering new expansion plan	Actions and trajectories agreed with CSU's (by specialty) in relation to 2ww, 28-day FDS and 62 day backlog reduction. Pathology agreed recovery actions /KPIs in place with Radiology being developed (to be agreed end of May 2022). Position is reviewed weekly through corporate operations team and depending on the risk depends on either monthly or weekly with the CSUs for pathway support. Increase in Lynax machine capacity now in place.
MDT coordinator central resource to track and escalate patients at risk of breach or harm is in place supported by weekly high risk meetings with CSUs and Cancer team	MDT staffing gaps are significant and recruitment has proved difficult despite rolling advertisement of the role across multi-media platforms alongside NHS jobs	Cancer management team supporting routine validation to ensure CSUs/ coordinators are focussing on highest risk patients for attention. Full review of recruitment and retention programme within the MDT Team to a format of 'growing our own'.

		Timeout with the MDT team to review the 'rocks in their shoes', aspirations, and training. Ensure that they have the opportunity to follow patient pathways. Training of mental health first aiders Health and Wellbeing work being undertaken by new manager of the MDT team to identify issues
Weekly review of the longest (over 104 day) waiting patients is in place with escalation to Associate Medical Director for Cancer/ Treating Clinician or Lead Clinician/Clinical Director where required.	Volume can be challenging	To focus on those pathways where patients are at higher risk of cancer progression due to wait (e.g. bladder) and those patients where care is not progressing
Root cause breach analysis is carried out for each pathway not meeting current standard.	Root cause analysis is not always carried out for the 10 previous breaches across all non performing pathways	Due to continued volume of current breaches, a weekly cancer team review of all patients on the 2ww, 31day and 62day cancer pathway has been introduced with challenge by the Associate Medical Director of Cancer where required. This alternates between the 10 longest waiting patients and the 10 patients that have just missed the standard and a revised process will be introduced where the CCT feed this information back to CSUs for review and action via their Governance meetings
Weekly surgical/ HDU prioritisation processes continue to be in place, with additional operating accessed in the Independent sector where possible/ appropriate. Clinical triage process established and continues weekly for HDU/HOBS cases should any further surges result in the requirement to reduce/ suspend cancer surgical	Bed, theatre, HDU staffing and patient priorities not optimally aligned due to continuing acute bed pressures. Volume of acute and COVID patients has continued to impact upon the ability for cancer surgical activity to return to normal levels/ recover to that planned	Teams to continue to access Independent Sector capacity and to use surgical prioritisation to support allocation of theatre capacity. Cancer surgical recovery requirement re backlog and routine run rate being refreshed and fed through Planned Care Programme board to review any possible additional actions.

activity Capacity for cancer surgery and key pathway steps is prioritised for access/ listing and in line with most recent NHSE/I guidance. Pre-op COVID testing/preparation guidelines in place.	despite P2 and CC prioritisation (booking into capacity available but still not sufficient in all areas)	

CRRC7: Failure to achieve 28 days cancelled operations target	C = 4	16	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
	L = 4		1	2	3	4	5	6	8	9	10	12	15	16	20	25
									Target Score					Initial Score Current Score		

Risk Description:
There is a risk that the Trust does not achieve the 28 day cancelled operations target due to acute activity pressures, critical care capacity, availability of theatre time, patient flow and the impact on elective bed availability, resulting in delays to patient treatment and possible harm and financial penalties.

Executive Lead: Chief Operating Officer

Date added to CRR: May 2014
Last Reviewed: March 2023
Next Review: Sept 2023

Committee reviewed at: Finance and Performance Committee

Controls	Gaps in Control	Further Mitigating Actions Planned:
To support elective recovery a programme of work led by the Medical Director of Operations and supported by the ADOPs for Planned and Cancer care was established in October 2020 to focus on increasing Critical Care, inpatient and day case capacity, and improving efficiency and patient experience within the elective pathway (Pre-op, Peri-op, and Post op), which will develop and strengthen the controls for CRRP 4. The projects include British Association of Daycase Project Enhanced Care Areas Theatre Productivity & Efficiency Pre-optimisation Development of elective hubs	Focussed on transformation programmes and long term developments Impact of unplanned pressures on elective bed base	Reallocation of J24 as a protected surgical ward for Oncology and Womens CSUs

The programme reports monthly to the Tactical Sponsorship group chaired by the COO		
Prompt starts for all elective theatre lists to automatically send for patients requiring inpatient or day case capacity All ACC SJUH patients are automatically sent to theatre and Priority 1-4 patients at LGI are automatically sent to theatre	Co-ordination of theatre/ ward and critical care capacity does not always align leading to greater risk of cancellations Not all Critical Care patients can be automatically sent for	Daily circulation of planned TCIs and previous cancellation status the day prior to surgery
All CSUs have weekly access meetings to identify available theatre capacity for additional sessions, manage risks and review cancellations and discharge and theatres KPI's using the LTHT scheduling tool. The scheduling project Collaborative CSU process to 'book' patients into an admission area by appointment and lock down of list order to improve patient flow and reduce risk of late starts and subsequent on day patient cancellations Daily email prompt to CSUs highlighting their 28 day breach risks Weekly collaborative critical care clinical prioritisation review by LGI and SJUH CSUs to support listing of clinically urgent patients and to match listed activity to anticipated capacity LTHT scheduling tool has been updated with the 'Monte Carlo' simulation to improve scheduling accuracy and theatre efficiency	Critical Care capacity can change overnight due to staffing absence or high numbers of unplanned admissions and result in on day cancellations	Continued Increase in ACC workforce planned through September and October 2023.
Multidisciplinary BADs Daycase project identifying CSUs and individual procedures through PLICS and Model Hospital that could be treated as day case to reduce need for IP beds and risk	Theatre staff and surgeons are not always available to undertake additional activity in response to	BTLW at LGI will design bespoke admission and discharge areas for day case pathways. SJUH estate strategy reviewing options to

of cancellation Use of Independent sector to increase available capacity and treatment options for patients Monthly focus on 6-4-2 process and Specialty level performance.	peaks in demand Independent sector contract restricts type of patient able to be transferred for treatment.	consolidate day case estate and pathways at SJUH Planned Care Dashboard developed to highlight BADs / Daycase opportunity by procedure Business case approved for additional 2 theatres at WDH Increase theatre and day case capacity available over the weekend to spread demand and offer more opportunities to rebook patients GIRFT project embedded in Theatre efficiency project to ensure appropriate patient pathway is followed.

CRRC8: Patients waiting over 52 & 78 weeks for treatment across a range of services.	C = 4 L = 5	20	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
									Target Score						Initial & Current Score	

Risk Description:
There is a risk that patients may have excessive waits for treatment as a result of on-going constraints on activity and the backlog of patients waiting for treatment resulting from the Trusts response to Covid-19 and non-elective pressures. In some specialties waiting times May exceed 78 weeks for both outpatient and admitted waiting lists, with a small number of specialties having patients waiting more than 104 weeks for treatment.
This may result in a poor experience and harm to patients, significant external scrutiny and impact on the Trust's reputation through media coverage. There has previously been the risk that financial penalties would be imposed or payments required to release additional capacity internally or from other providers.

Executive Lead: Chief Operating Officer

Date Added to CRR May 2015
Last Reviewed: Dec 2022 (March 2023)
Next Review: June 2023

Committee reviewed at:
Finance and Performance

Controls	Gaps in Control	Further Actions Planned:
Surgical teams across the Trust have reviewed their revised theatre allocations and subsequently prioritised clinically urgent patients (including cancer patients), and longest waiting patients. This continues to be reassessed in line with updated clinical prioritisation The PAS system has now been updated to include the recording of P status within the patient's waiting list entry.	Increased COVID19 admissions may result in the suspension or reduction of elective activity. Increased non elective admissions may result in the suspension or reduction of elective activity	In line with national guidance issued on 10 May 2021, by NHSE/I 'Clinical prioritisation of waiting lists for endoscopy and diagnostic procedures', the Trust have nearly completed clinical prioritisation of diagnostic waiting lists using national D codes, which is expected to be complete by end August/ early September 2021. A process has now been established for adding the P category to the patient's record at the time of Decision to Admit and the Diagnostics D code at time of test request. Patient safety, quality or governance risks are escalated through CSU Governance Meetings in line with Quality Governance Framework. CSUs will highlight specific risks through their CSU risk registers. Longest waits prioritised for validation. Specialties

		with known risks already prioritise. Planned Care focus on protecting elective activity through winter by maximising the use of elective hubs at SJUH / LGI / CHOC / WGH
Clinical validation of all follow-up patients waiting beyond anticipated review date requested to determine if patient suitable for discharge, conversion to PIFU, requiring of urgent review or able to wait	Volume of reviews has delayed validation in some areas. Validation does not deliver any additional capacity in areas where backlog continues to grow Volume of patients means that capacity to undertake reviews is limited and may require cancellation of clinics	
Recovery planning recognises the need to deliver capacity for long waiting patients. Theatre, admission and inpatient capacity has been focussed on specialities requiring additional capacity Service Delivery Contract's developed at CSU level which include focussed KPI on reducing longest admitted and non-admitted waits LIM standard work used to support corporate monitoring of performance against CSU and Specialty agreed 104 & 78 week trajectories.	Some specialties have larger waiting lists and / or more constrained capacity to deliver 104 and 78 week trajectories	Chief Operating Officer and Director of Operations meet with CSUs that are unable to meet agreed trajectory with the relevant ADOP. Additional support identified and recovery actions agreed.
Above pre pandemic theatre and inpatient bed capacity may be provided by re-allocation of theatre sessions and bed capacity to those with longest waits Adult Spines elective lists at CHOC	Existing surgeons must be allocated to cover additional sessions, which can stretch teams if more sites need cover. Reallocation of capacity may result in	

Elective schedule reallocated in WGH & DBDU to support specialties with longest waiting lists (Urology & Colorectal) All P4 patients above 80 weeks as P3 patients to support booking of long waiting patients	growing waits in other services.	
Additional outpatient sessions are relatively easy to schedule and outpatient waiting lists can reduce quickly if clinicians are available	Reliant on staff willing to do overview time/additional hours.	Roll out of alternative working models (e.g. virtual reviews) can deliver additional capacity. Service Delivery Contract's includes KPI on reducing longest outpatient waits – this will be monitored on monthly basis
Established arrangements in place to allow additional outpatient and inpatient activity to be scheduled outside normal working hours.	Relies on staffing throughout overtime and additional hours.	Saturday outpatient clinics are routinely being held to support specialities. Bookwise (new clinic scheduling tool) is being implemented across adult clinics areas which should support identifying clinic room efficiency and allow additional weekday clinics to be held. Children's CSU delivered pilot of Bookwise from 28 February 2022 creating additional clinic capacity of an additional 200 clinics per month equating to an additional circa. 1000 appointments per month. Expecting Bookwise to be implemented by March 2023
Use of Insourcing Company to increase available theatre sessions began July 21 and has been consistently utilised in Adult and Paediatric theatres. LTHT is now beginning to reduce its use of insourcing theatre teams as substantive workforce is increasingly able to run the theatre sessions with LTHT staff.	Case complexity suitable for insourcing team reduces ability to treat more complex patients	Insourcing team used to support low complexity / high volume pathways, freeing up substantive teams to support more complex pathways
Independent sector capacity used to deliver activity where possible but does not now support long waiting patients as these patient cohorts who were suitable for the IS have now been treated		LTHT continues to negotiate additional activity directly with the Independent sector providers as local contracts either above tariff, or providing consumables, kit and devices directly to support more complex work.

Develop Elective hubs (CHOC & WGH) to increase elective activity that can be delivered. Outline Business Cases in development for both schemes. Targeted Investment Funding allocated to both schemes	Currently requires dedicated capital and revenue to support the development of these sites and will not be delivered before Summer 2023 for WGH, and summer 2025 for CHOC. Mobile Vanguard theatre delivered to WGH in October 2022 and will be operational in December 2022	Higher observation beds at CHOC will be delivered ahead of the main CHOC scheme by December 2022 and will be operational in January 2023
Outpatient appointments reviewed, converted to telephone/video consultations where clinically appropriate	Reduction in outpatient capacity due to requirements to maintain social distancing (currently delivering approximately 99% normal baseline outpatient activity) Increased COVID19 admissions may result in the suspension or reduction of outpatient activity and staff may need to be reallocated to support inpatient or critical care areas. Volume of reviews has delayed validation in some areas.	Maintaining a percentage of appointments delivered by video/telephone (2022/23 YtD position is 35%) and encouraging wider use of remote consultations that are clinically appropriate and the use progresses the patient pathway or delivers clock stop. To reduce risk and manage potential harm to patients, clinicians have clinically reviewed patients on all outpatient waiting lists to assess clinical priority. Service Delivery Contracts have been agreed at CSU level which will include focussed KPI on reducing longest outpatient waits - this will be monitored on monthly basis.
Validation (clinical, administrative and technical) of long waiting patients on the non-admitted and admitted waiting lists	Staff capacity to deliver clinical and administrative validation of waiting lists	Focussed efforts from CSUs, supported by Corporate Ops and Performance, to validate long waiters through technical, administrative, and clinical validation. Undertaking a proof of concept (November 2022) to deliver administrative validation of non-admitted waiting list through the use of Robotic Process Automation and expecting to scale this up at pace across all the admitted and non-admitted waiting lists.
Clinical Advisory Group (CAG) established 24 March 2020 to review concerns raised by clinical teams, including	Critical Care capacity can change overnight due to staffing absence or high	Risk assessed social distancing and IPC measures in low risk pathways in outpatients and day case /

clinical concerns re planned and elective treatments. Weekly collaborative critical care clinical prioritisation review by LGI and SJUH CSUs to support listing of clinically urgent patients and to match listed activity to anticipated capacity. Operational Infection Prevention Control (OIPC) to review guidance and recommendations relating to infection prevention	numbers of unplanned admissions and result in on day cancellations Still restricted to National Guidance for the NHS	elective admission areas to increase the productivity of this capacity
Reset recovery groups established to 'build back better'. Led by cross CSU senior clinical and management teams, and supported by the Corporate Operations team to focus on reset of services to 19/20 activity levels and then 104% of 19/20 activity as per planning guidance. 5 groups cover the following areas - SJUH elective recovery - LGI elective recovery - Outpatients - Diagnostics - Patient Placement The work of the reset groups in diagnostics and outpatients are being taken forward through the Operational Transformation Strategy and the Transformation Services Group.	Non elective pressures and high bed occupancy preventing full return to pre-covid elective efficiency. Ongoing Covid peaks through the year and subsequent impact on Covid inpatients and staff availability	SJUH site will free up additional elective day case ward (J23) for gynae and breast surgery by consolidating medical patients from within Lincoln wing onto one ward. Business case being developed for re-organisation of elective and non-elective wards at LGI to support elective flow Outpatients continued focus for CSUs is to recover against the activity levels of 19/20, deliver more new appointments and reduce the number of follow ups, and minimising lost capacity through DNA/WNB. Digital innovation is supporting the build back better including implementation of a new outpatients appointments portal, Patient Hub, which will be delivered across all specialities (where appropriate to do) by end of 2022. A new DNA/WNB analyser predictor tool is being scoped to identify patients likely to DNA/WNB to then allow focussed efforts on these groups of patients to encourage attendance. The tool is expected to deliver a pilot against live data in January 2023.
A process for undertaking harm reviews for any patient	The process approved is time	A more streamlined digital process is being

listed for treatment has been approved by QSAG. These reviews assess the likelihood of a patient suffering harm as a result of extended waits and prioritising treatment for any at increased risk. Reviews are to be repeated every 3 months for patients who have waited over 52 weeks.	consuming, and requires forms to be completed manually and uploaded to PPM+.	developed by R Baker in collaboration with DIT.

CRRC9: Patients waiting longer than 6 weeks following referral for diagnostics tests	C = 4	16	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
	L = 4		1	2	3	4	5	6	8	9	10	12	15	16	20	25
									Target Score					Initial Score & Current Score		

Risk Description:
There is a risk that the Trust has more than 1% of patients waiting more than 6 weeks at month end following referral for the defined basket of 15 tests against this standard.
During wave 1 of COVID-19, there was a significant growth is diagnostic backlog as all routine work, other than urgent, was suspended. This backlog has been significantly reduced since the recovery restart in June 2020, however capacity remains lower than required in some modalities to clear backlogs especially those which require General Anaesthetic.
Performance will therefore remain challenging due to reduced levels of activity and increased demand as cancer, IP and OP elective activity recovery is undertaken with the on-going risk of COVID-19 admissions requiring higher levels of IP diagnostic provision than previously seen.
Delays in acheiveing the diagnostics tests waiting times may have an impact on patient safety.

Executive Lead: Chief Operating Officer

Date Added to CRR: May 2014
Last Reviewed: January 2023
Next Review: July 2023

Committee reviewed at:
Finance & Performance

Controls	Gaps in Control	Further Actions Planned:
Weekly review of current diagnostic operational pressures alongside to review current position and inform decision making processes on levels of activity that continue to be delivered.	Unexpected levels of demand (resulting in shortfalls in capacity) which mean patients wait in excess of 6 weeks.	Continuation of weekly review of operational status - shortfalls to be flagged as soon as possible to facilitate additional capacity.
To support operational pressures across the organisation, diagnostic inpatient activity will continue to be prioritised.	Unexpected levels of demand. Outpatient activity may be reduced or cancelled if required which may impact on diagnostic backlog position.	Weekly review of operational status will be continued, with outsourcing/additional outpatient capacity sourced where possible.
Weekly Tactical meetings now moved to Monthly Diagnostic Tactical workstream, chaired by Radiology CD supported by ADOP with input from all relevant CSUs. Processes in place to support	Data available to all diagnostics teams is not the same, with limitations in data from some clinical systems (e.g. CRIS and Cardiobase) to support management and recovery planning.	Awaiting embedding of Endoscopy and PAS system upgrades and then will review options for better reporting oversight 2022/23

recovery and any additional COVID requirements.	Support from IT is constrained to support better data production.	
Weekly Diagnostic month end breach prediction process continues to be in place.	Unexpected levels of demand may result in activity being reduced or cancelled to support increases in admissions and reallocate resource.	Weekly monitoring of position and supporting actions re- instated. Review of IP requesting with key specialties now stood up as a recovery work programme to try and address increasing IP demand for MRI and CT.
Equipment replacement programmes agreed for MRI, CT and Cath Laboratories during 2020/21 to 2024/25.	Impact of plans being progressed on Diagnostic recovery if mitigating action plans do not align.	MRI replacement and expansion (by 1 more unit) plans completed in 2020/21. 1st 2 new Cath labs in now in place. Mobile MRI remained in place to end of August 2021 to further support recovery. Due to staffing issues and summer increases in demand, this was brought back in mid-October with additional van sourced from end of November 2021 (both staffed). Mobile MRI van brought back again in December 2022 to support with increased demand. CT mobile in place from May 2022 to support recovery and remains to also support increased demand Use of independent sector/ AQPs continues for CT, MRI and Ultrasound where available.

CRRC10: High occupancy levels and insufficient capacity and flow across the health and Social care system causing impact on patient safety, outcomes and experience	C = 4 L = 4	16	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
											Target Score			Current Score		Initial Score

Risk Description:
There is a risk to maintaining sufficient capacity to meet the needs of patients attending and being admitted for planned/elective care and unplanned (acute) care caused by demand being greater than the available hospital capacity. Efficiency of patient flow and placement due to high occupancy is impacting on patient safety, outcomes and experience. There is also a risk to the delivery of constitutional standards, impacting on the Trust's delivery and efficiency ratings and reputation.

Cross-referenced to Corporate risks **CRRC4, CRRC5, CRRC6, CRRC7, CRRC8, CRRC9, CRRC11**.

Executive Lead: Chief Operating Officer

Date Added to CRR: September 2015
Last Reviewed: February 2023
Next Review: September 2023

Committee reviewed at:
Finance & Performance Committee

Controls	Gaps in Control	Further Mitigating Actions:
Operational: Established Operations Centre with 24/7 clinical site manager's oversight to maximise capacity use and support patient flow and best patient placement. Weekend on call team are briefed every Friday with the plan to meet expected demand Operational Response guidance and process with identified escalation levels including daily battle rhythm , standard work for silver status and a separate Decision Management Tool for adults, children's services and infection prevention and control.	Operationally implemented Live bed state to support real time understanding of capacity Track of the DMT actions taken, frequency and potential impact as a learning organisation	Live bed state in development with a planned implementation of March 2023 Further review of reducing risk of respiratory infection transmission in Beckett wing in progress to reduce harms to patients , support discharges and reduce beds lost due to infection to be completed by February 2023 Weekly tracking of DMT actions taken.

Agreed Full Capacity Protocols (FPC) for surge 1, 2 and 3 with implementation capture and assurance process measures. This includes utilisation of the Exceptional Surge Area (ESA) plan.	Weekly report of use and associated audit of use compliance for FCP	Weekly report to weekly Quality meeting to understand the frequency of use and safety checks. Monthly report provided to the Quality & Safety Assurance Group (QSAG)
Bed modelling analysis to identify expected activity surges based on public health intelligence for COVID, Flu, RSV and Noravirus with a planned local and system response	Insufficient space and staff to meet expected surges if baseline inpatients including the numbers of patients that no longer need to reside in hospital are maintained	
	Bed modelling for BH doesn't include planning to maintain discharge rates	Current review of BH impact on discharges and agree a test of change plan for Easter BH with a review and evaluation to capture learning for future implementation
	Some areas identified for FCP3 include day rooms on our no reason to reside wards which will not allow for use of day rooms by other patients. This may increase risk of deconditioning and have an impact on the patient experience on those ward areas.	Patient experience question used as part of audit of patients in ESA Apology letter given to patients
	Overall patient experience impacted by use of ESA beds	
Process for all discharges that do and do not proceed to on-going community support with an understanding of what could have been better (Pathways 1,2 and 3) shared	Completing of learning through the ward efficiency metrics requires DIT development	Weekly sharing of a report on discharges that did not proceed- with a route cause identified for any discharge failure
Management of long length of stay patients	Increase in the number of patients without a Reason to Reside within the hospital setting awaiting on-going care provision.	Work being undertaken to establish drivers for the increased length of stay in the patients with a

Protected elective capacity at SJUH,CAH and Wharfedale Hospitals to support elective (planned patient) capacity All patients on an active elective waiting list receive regular correspondence from the Trust advising them that they are still on a waiting list, and what to do / who to contact if their condition has changed etc	Significant waits for Social Worker intervention National increase in the numbers of patients in hospital with a longer length of stay and 5 or more co morbidities Continue with high numbers of Super stranded / No Reason to Reside patients within hospital bed base.	reason to reside and understand hot spot areas and actions to reduce impact. To be completed by March 2023 Plan for further cohorting across SJUH surgery, Oncology and women's services to maximise patient flow 4 additional wards currently open in LTHT to meet the need of patients no longer requiring hospital in patient care (134 beds). Structure established to ensure a weekly review of the longest waiting patients on Pathway 3, to ensure timely escalation of patients and to identify suitable alternative pathways that will result in earlier discharge. All patients on an admitted pathway are given a clinical prioritisation status at the point of decision to admit to reflect the expected treatment timeframe and to support TCI of patients by clinical priority rather than chronological booking. Where those patients are waiting longer than the expected treatment, these patients are reviewed by the clinical and administrative teams to ensure the clinical prioritisation status is accurate, and to escalate patients to be seen more urgently if required.
Tactical: Alternatives to admission-		

Established Same Day Emergency Care unit 7 days per week	Physical space constraint until October 2023 when newly refurbished estate will be ready for medicine and older adult care	Review of the headache pathway to convert to ambulatory pathway and reduce non elective admission where clinically appropriate by March 2023
Primary Care Access Line receives calls for primary care colleagues, GPs and ambulance services to navigate as clinically appropriate away from ED and admissions to a series of rapid access clinics, specialist advice of a consultant, SDEC or assessment area - Nationally recognised for its success	Skilled workforce and cross system capacity to enable change	Rapid test of change to develop PCAL + across system in association with Yorkshire Ambulance Service to redirect Category 3 and 4 ambulance patients and cat 2 patients aligned to the 9 conditions NHSE advise should be cared for in alternatives to hospital admission. Test of change expected in February 2023
Developed Virtual Ward for respiratory and frailer adults to support early discharge and alternative care for lower acuity admissions	Maximum Virtual Ward capacity is below Nationally described opportunity Workforce gaps in wards of the city remain a challenge	Appointed a Clinical Lead Consultant from LTHT for the city Virtual Ward and telemetry development in January 2023
Strategic:		
Establishment of Leeds urgent community response group with delivery of 2 hour community response 8am till 8pm to avoid ED and admission conveyance	National requirement for 24/7 offer not currently delivered Workforce and share system clinical risk approach	Planned use of the A-TED national improvement tool to review the city Directory of Service (DOS) Jan 2023 to map opportunity and current capacity for community rapid response services
Intermediate Care redesign scoped and the city opportunity analysed and collectively understood. Programme of work agreed to transform and maximise this opportunity by 2024.	Workforce challenges Risk sharing across the city and information governance risks.	

CRRC12: Airedale Hospital Infrastructure: potential risk re transferring patients to LTHT	C = 4 L = 4	16	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
									Target Score					Current Score & Initial Score		

Risk Description:
There is a risk of mass dispersal of patients caused by RAAC structural incident at Airedale NHS Trust resulting in approximately 70 patients being transferred to LTHT significantly impacting on the delivery of services.

There is a risk of structural deterioration at Airedale General Hospital due to its building construction and age. This could potentially lead to the need to transfer patients to partner Trusts at short notice, including LTHT, resulting in risks related to the Trust's capacity, staffing, and managing patient handover, patient records and medicines. [Note for May's Risk Management Committee. The controls and mitigations set out below were reviewed in April 2023 and have not changed since October 2022 when they were last formally reviewed.].

Executive Lead: Clare Smith

Date added to CRR: Feb 2022
Last Reviewed: Nov 2022
Next Review: May 2023

Committee reviewed at:
Risk Management Committee

Controls	Gaps in Control	Further Mitigating Actions
The current Incident Response Plan will assist in dealing with the receipt of large numbers of patients (or casualties in the event of a building collapse that resulted in casualties). However, the current level of occupancy and demand in LTHT means that this would not significantly mitigate the risk.	This plan is designed to manage casualties rather than transfer of patients.	An addendum to the IRP has been produced to assist in managing an evacuation from Airedale.
A regional dispersal plan has been developed.	The full regional evacuation remains under development (despite being expected in Spring 2022) and until this has been completed there are no plans for transferring patients, patient records or staff from Airedale to assist in patient care.	The plan development is being coordinated by NHS England at regional level and LTHT is reliant on this work being concluded. The West Yorkshire plan is currently with the ICB for sign off and as soon as this has been circulated the risk can be updated appropriately.

CRRF1: Failure to deliver the financial plan for 2023/24	C = 5 L = 4	20	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
							Target Score								Current Score	Initial Score

Risk Description:

There is a risk that the Trust does not achieve its planned control total in 2023/24. This would have the following impacts:

- Reducing the internal funding for the Trust's ambitious Five Year Capital programme, including Building the Leeds Way leading to:
  - Limiting the capital programme/not replacing equipment
  - Relying on external sources of funding
  - Cash shortfall and risk to supplier payment
  - Potential non-compliance with new medical devices regulation (Regulation EU 2017/45)
- Reputational damage, as the Trust fails to deliver on a key statutory duty
- Potential to cause the Integrated Care System to miss its overall control total

Executive Lead: Director of Finance

Date added to CRR: November 2020
Last reviewed: May 2023

Committee reviewed at:
Risk Management Committee on 04-05-23

Controls	Gaps in Control	Further Mitigating Actions
Yearly Board approved five year plan. The Board agree the Five Year plan, including Income and Expenditure position and Five Year Capital Plan. The Board are sighted on risks to delivery of the plan through a risk range and executive agreed mitigation plans	• Failure to achieve Elective Recovery Framework thresholds • Potential introduction of Payment by result system for elective activity. • Requirement for additional resources if Covid-19 costs continue at historic levels • No reason to reside issue is not resolved • Restrictions on capital allocation due to funding formula.	• Capital Planning Group puts increasing focus through the year on strength of programme managers forecasts and ability to complete. Confidence levels and risks are specifically addressed • Proposed alternative payment mechanism submitted by Director of Finance to NHS England. • Executive review of Backlog work and COVID expenditure. Development of an in-house mitigation plan. • Detailed review of underlying cost base and associated savings plans. • Regular updates to the Executive Team and Finance and Performance Committee

		including Exec lead on financial risk and associated mitigations • Regular communication with ICS to assess and mitigate risks
Annual Financial Plan signed off by the Board. The Income and Expenditure Plan and the Capital Plan are signed off by the Board. In addition to this the Finance and Performance Committee are sighted on the progress of the Waste Reduction identification and CSU forecasts for the following year	None	• Regular updates to the Executive Team and Finance and Performance Committee including Exec lead financial mitigations • Regular communication with NHSE/I to identify and adapt to changes
Quarterly Fundamental Review of the Trusts Financial Position to Finance and Performance Committee setting out the risk range of the in-year financial position and executive owned mitigations		• Development on in-house mitigation plan • Detailed review of underlying cost base and associated savings plans. • Regular updates to the Executive Team and Finance and Performance Committee including Exec lead financial mitigations
Weekly reporting of the Waste Reduction position CSU to the Director and Deputy Director of Finance which in turn feed into Finance Performance Framework CSU meetings	Waste reduction is not delivered in full	• Development of in-house mitigation plan • Regular meetings with the PMO to assess risks to the programme
CSU ownership of realistic control targets and run rate based forecasts linked to the Integrated Accountability Framework.		• Development of in-house mitigation plan • Regular updates to the Executive Team and Finance and Performance Committee including Exec lead financial mitigations
Operation of the financial performance framework with: • Monthly Clinical Director signed off forecasts and a RAG rating against CSU agreed Control Totals • Escalation meetings with Director of Finance for RED rated CSUs and with the Deputy Director of Finance for AMBER CSUs	None	• Regular updates to the Executive Team and Finance and Performance Committee including Exec lead financial mitigations

• Financial sustainability board, including the Chief Executive and other Executive Directors, for those CSUs on Amber and Red for multiple months		
Fixed Income allocations through the negotiation of Aligned incentive contracts with ICS and NHSE	Potential introduction of PbR for elective activity	• Regular meetings with commissioners and attendance at all ICS finance forums • Regular communication with NHSE/I to identify and adapt to changes • Proposed alternative payment mechanism submitted by Director of Finance to NHS England.
Implementation of Finance the Leeds Way Improvement Plan	None	None
Emergency cash funding available to meet payment obligations or unforeseen capital emergencies through NHSE/I bidding process	This is a bidding process and not all requests will be supported	Estates and Facilities Risk Review Group required to prioritise schemes for any funding that is made available
Progress against the five year capital plan is overseen by the Capital Planning Group including specific prioritisation for the MSE, BME and DIT programmes.	None	CPG puts increasing focus through the year on strength of programme managers forecasts and ability to complete. Confidence levels and risks are specifically addressed
Capital programme - priority bidding process for clinical services/specialty teams overseen by Head of Medical Physics & Engineering and Deputy Chief Medical Officer/Medical Director (Operations).	None.	Any unforeseen equipment failure would lead to immediate re-assessment of current year spending priorities with a view to substitution

CRRF2: Reduction in operational capital allocation	C = 4	16	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
	L = 4		1	2	3	4	5	6	8	9	10	12	15	16	20	25
						Target score								Current score	Initial score	

Risk Description:
Operational capital allocations to address strategic capital risks across the ICB are insufficient to meet expected programme plans for 2023/24 and future years. This will have the following impacts:

- Reducing the internal funding for the Trust's ambitious Five Year Capital programme, including Building the Leeds Way leading to:
  - Limiting the capital programme / not replacing equipment
  - Greater reliance on external sources of funding
  - Potential non-compliance with regulatory requirements
- Increased clinical risk due to inability to replace capital assets within agreed replacement schedules
- Reputational damage, as the Trust fails to invest in equipment, estate and digital infrastructure to support service development

Executive Lead: Director of Finance

Date added to CRR: May 2023
Last reviewed: May 2023

Committee reviewed at:
Risk Management Committee on 04-05-2023

Controls	Gaps in Control	Further Mitigating Actions
Monthly ICB Capital Working Group and ICB Director of Finance meetings to review risks and opportunities at an ICB level as well as discussing priorities and impact on individual Trusts of decision making	• Other ICB Trusts show a preference towards top slicing the ICB allocation reducing operational capital budgets for all Trusts	• Key LTHT risks to be worked up to show scale of impact if a top slice approach is taken • Regular updates provided to Director of Finance and Director of Strategy immediately following the meeting • Regular updates provided to Capital Planning Group and any necessary escalations to Finance and Performance Committee.
Progress against the five year and annual capital plan is overseen by the Capital Planning Group including specific prioritisation for the MSE, BME and DIT programmes.	• None	• CPG puts increasing focus through the year on strength of programme managers forecasts and ability to complete. Confidence levels and risks are specifically addressed.
Development of in house mitigation plan allows for the Trust to respond to changes in funding allocations or utilise slippage in other Trusts.	• Restrictions on capital allocation due to funding formula. • Restrictions on capital allocation due	• Capital Planning Group puts increasing focus through the year on strength of programme managers forecasts and ability to complete

	to lack of New Hospitals Programme funding certainty places additional pressure on operational capital.	and flex programmes where necessary. Confidence levels and risks are specifically addressed. • Regular updates to Finance and Performance Committee including Exec lead on financial risk and associated mitigations • Regular communication with ICB to assess and mitigate risks • Regular communications with New Hospitals Programme to assess and mitigate risks
External funding opportunities monitored closely with bid and applications submitted wherever possible	• Constrained by available opportunities • Bids and applications not always successful	• Capital Planning Group regularly discuss opportunities to maximise external funding opportunities.
Capital Planning Group to assess LTHT priorities which should be considered by the ICB if a topslice is implemented e.g. expansion of radiotherapy service provision to meet regional demand.	• Would still reduce LTHT allocation	• Influence NHSE to identify route for medium to major schemes to be considered for central funding.