



CORPORATE RISK REGISTER

September 2023

Summary Corporate Risk Register September 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 <i>Cautious</i>								
CRRW4	Insufficient staff to provide treatment, care and services to patients	May 23	Director of Human Resources, Chief Nurse & Chief Medical Officer	16	May 23	Nov 23		5-11
Workforce Deployment Risk <i>Cautious</i>								
-	-	-	-	-	--	-	-	
Operational Risk								
Business Continuity Risk <i>Cautious</i>								
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	Jul 23	Jan 24		14-17
Health & Safety Risk <i>Minimal</i>								
CRRO3	Harm due to clinically related behaviours that challenge linked to organic, mental health or other reasons	May 15	Chief Nurse	16	Jun 23	Dec 23		18-21
CRRO4	Staff absence Health, Safety and Wellbeing	Oct 20	Director of Human Resources	15	Jun 23	Dec 23		22-28
Change Risk <i>Cautious</i>								
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	Jul 23	Jan 24		29
CRRO7	Risk of failure to deliver the hospital of the future project.	May 20	Director of Finance	20	May 23	Nov 23		30-36
CRRO8	Risk of failure to deliver the pathology project.	May 20	Director of Finance	16	May 23	Nov 23		37-42
CRRO9	Risk of failure to deliver the LGI Site Development Project	Nov 21	Director of Finance	16	May 23	Nov 23		43-46
Information Technology Risk <i>Cautious</i>								
CRRO10	Cyber-attack leading to potential loss of IT systems and/ or data	May 22	Chief Digital & Information Officer	16	Apr/May 23	Oct 23		47
CRRO11	Insufficient DIT resources to meet demand for DIT led projects	Jan 23	Chief Digital & Information Officer	15	Jan/May 23	Sept 23		48
Clinical Risk								
Infection Prevention & Control Risk <i>Minimal</i>								
CRRC1	Healthcare acquired infection	Mar 19	Chief Nurse	16	May 23	Nov 23		49-54
Patient Safety & Outcomes Risk <i>Minimal</i>								

CRRC3	Patient harm – falls and hospital acquired pressure ulcers	Mar 21	Chief Nurse	16	Feb 23	Aug 23		55-57
CRRC4	Failure to achieve Emergency Care Standard	May 14	Chief Operating Officer	20	Jul 23	Jan 24	ED LGI	58-61
CRRC5	18-week RTT target non-compliance	May 14	Chief Operating Officer	20	Mar 23	Sept 23	Ophthalmology / Cardiac Surgery	62-66
CRRC6	62-day cancer target	May 14	Chief Operating Officer	16	Jun 23	Dec 23	MDT & Pancreatic Breast Only	67-71
CRRC7	Failure to achieve 28 day cancelled operations target	May 14	Chief Operating Officer	16	Mar 23	Sept 23	Cardiac	72-74
CRRC8	Patients waiting over 52 & 78 weeks for treatment across a range of services.	Oct 18	Chief Operating Officer	16	Jun 23	Dec 23	Neurosciences	75-80
CRRC9	Patients waiting longer than 6 weeks following referral for diagnostics tests	May 14	Chief Operating Officer	16	Jul 23	Jan 24	Breast cancer	81-82
Capacity Planning Risk							<i>Cautious</i>	
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	83-87
CRRC12	Airedale Hospital Infrastructure: potential risk re transferring patients to LTHT	Feb 22	Chief Operating Officer	16	May 23	Nov 23		88
Financial Risk								
Financial Management & Waste Reduction Risk							<i>Cautious</i>	
CRRF1	Failure to deliver the financial plan 2023/24	May 14	Director of Finance	20	Jan 23	May 23		88-91
CRRF2	Reduction in operational capital allocation	May 23	Director of Finance	16	May 23	Sept 23		92-93

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 <u>inherent</u> risk
Cautious - Preference for safe options that have a low degree of <u>residual</u> 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	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: 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	<p>Inability to reduce vacancy gap due to decrease in supply of staff regionally and nationally. Significant vacancies nationally for specialist roles.</p> <p>Inability to recruit in some specialties due to national shortage of suitable applicants</p> <p>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</p>	<p>Focus on 'growing our own' through in-house courses and apprenticeships. Development of new roles and alternative workforce models.</p> <p>Working with WYAAT on attraction, recruitment and retention.</p> <p>Paper prepared for Discussion at LETC Papers prepared for Executive Committee to discuss pay rates</p> <p>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</p>
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.

<p>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.</p>	<p>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.</p>	<p>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</p> <p>Working with HEE etc for more training across all areas. Apprentice scheme highly successful for engineering, although lag due to training period.</p> <p>Unknown at present as impact still evolving</p>
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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: <ul style="list-style-type: none"> • 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.

		<p>Working with WYAAT on attraction, recruitment and retention.</p> <p>Raising our advertising profile - using INDEED for some roles.</p> <p>Capitalising on social media campaigns linked to Saving Lives in Leeds Documentary.</p> <p>Reviewing entry requirements for some roles.</p>
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CRRO1: Risk of a viral pandemic	C = 5	15	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
	L = 3		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 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: April 2023 Next Review: October 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 pandemic									Arrangements that were in place during the 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.
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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: July 2023 Next Review: January 2024 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, 2023/24 or 2024/24 to upgrade theatres. £1.5m in 2025/26.							
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			This handbook provides the Estates on-call						The handbook is reviewed annually.							

detailed processes and regular review.	team with information of what can be 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 Wing 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 (current version 2021) 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.	<p>The Electrical Safety Group has updated the UPS/ IPS asset list for each site & the current Capital investment prioritisation list (version 7 - based on site knowledge from the Electrical Authorised Person's).</p> <p>An independent technical audit report, for the Medical Location Risk Grading assessment (HTM 06-01 clinical risk grading & BS 7671 Section 710 group locations), will be undertaken across the organisations critical medical (patient safety) & critical equipment (business continuity) locations to get a firm position on compliance & a gap analysis to inform/ develop an annual lifecycle investment plan/ program of works.</p> <p>This will formalise the E&F risk management process to assess the susceptibility to risk from total (or partial) loss of the electrical</p>

		<p>supply with the consequence of a power failure assessed and graded against a wide range of departments with complex requirements and potential risks.</p> <p>This audit will assess the level of funding required & timeframes (impacted by available Capital/ access to areas) to become fully compliant & identify the annual allocation of funds to maintain this position.</p>
<p>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.</p>	<p>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.</p>	<p>Capital investment is required to connect the available IPS/UPS infrastructure Theatre 9 & Recovery in Geoffrey Giles Theatres. Not completed due to access restrictions. Now in 23/24 plan, meetings to agree access being held June 2023.</p>
<p>Some areas (e.g., J54) are fitted with the required UPS provision but not fitted with Isolated Power Supplies (IPS).</p>	<p>Several clinical category Grade A areas are not fitted with IPS as required by HTM 06-01 to safeguard the patient from the risk of electric shock and provide increased local electrical resilience.</p>	<p>IPS should be installed to all clinical category A areas in-line with HTM 06-01 when areas are refurbished. Awareness of the electrical 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.</p>
<p>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</p>	<p>There are still a number of Clinical category A areas without UPS/IPS systems.</p>	<p>£200K in programme for UPS/IPS installs in years 23/24 and 24/25, the priority order for which is under review between Estates and Clinical teams.</p> <p>UPS has been installed to J54 on the central system, phasing options for IPS connections under review, with a view to completing in 2023/24.</p>

2021. IPS was installed in J1 (Neonates SJUH) in 21/22.		
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CRRO3: Harm due to clinically related behaviours that challenge linked to organic, mental health or other reasons	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 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: June 2023 Next Review: December 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			restraint audit identified gaps in staff knowledge in relation to the guidance on prevention and de-escalation strategies. Proposed new Elsievier restraint care does not currently meet our needs as it is not compliant with MCA requirements regarding restraint used for patients who lack mental capacity – MCA team						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). Improvement plans identified by each CSU March 2023 In reach support from MCA/MHA Team to continue.							

	<p>have recommended it does not replace LTHT Restraint Care plan bundle and Trust process is being followed in relation to implementation of new care plans</p> <p>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 restriction/restraint not being used and monitored; also potential risk of disproportionate restraint/restriction being used without monitoring</p>	
Enhanced Care Procedure in place	<p>Wards report that they struggle to fill 1:1 enhanced care shifts frequently.</p> <p>Gaps identified in the skill mix for enhanced care provision</p>	<p>Croma contractual performance monitored through quarterly contract meeting - croma training programme enhanced to address skills shortage</p> <p>Mental health trained Clinical support worker agency commissioned to provide 1:1 enhanced care in SJUH ED and acute medical admissions wards.</p> <p>MH bank working with MCA/MHA team to strengthen training around de-escalation</p>
24/7 service provision from Liaison Psychiatry service now meeting PLAN standards and Acute Liaison Psychiatry service 1 hour response in ED implemented	<p>ALPS service currently only partially co-located on hospital site impact on one hour response time</p>	<p>Consultant Psychiatrist now whole time equivalent in ALPS service</p> <p>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</p>

		MH assessment at PLAN (Psychiatric liaison accreditation network) standard
<p>De-escalation QI collaborative- supporting staff to support patients who may present with clinically related challenging behaviours.</p> <p>12 high volume areas involved in QI with support from expert faculty members.</p> <p>A range of interventions being tested across collaborative areas; set of KPIs / measures being tracked monthly to evidence progress.</p> <p>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.</p>	<p>Level 2 – monthly course -sessions available until December 2023 at the moment with plans to roll out into 2024</p> <p>Level 1 e-learning now developed but will not go live until June 2023</p> <p>Variation of training across the organisation - leading to potential gaps in knowledge/inconsistency of application</p> <p>Mental Health training not consistent across medical and nursing staff or linked to a training needs analysis (TNA)</p>	<p>Increased oversight of monitoring data from De-escalation Collaborative and Violence and aggression Steering Group.</p> <p>Mental Health training needs analysis and education/training plan – Band 8b post funded (12 months) to lead this work - currently recruiting to the post</p> <p>Funding secured for Children Hospital MH Champion role to work closely with WY MH co-ordinator role who will be located with LTHT as Pilot – both funded through NHSE</p> <p>RMN recruited on a permanent basis in Urgent Care CSU following successful pilot.</p>
<p>CAMHS Crisis team has been operational from the beginning of 2020 the service offers - 7 day week 08.00-00.00</p>	<p>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.</p> <p>CAMHS Crisis team do not have write access to PPM+ in order to ensure timely visibility of their assessments</p>	<p>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.</p> <p>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.</p> <p>Write access to PPM+ now escalated to Associate Director of Digital / DIT team for</p>

	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 demand of up to 1/3 compared to pre Covid times.	<p>resolution</p> <p>CAMHS Liaison Nurse band 7 and band 5 both left posts during 2023 – both posts now re recruited</p> <p>Provider Collaborative Lead, CYP MH, West Yorkshire project designed to improve support for CAMHS patients in LTHT - project manager in post and project plan developed; work begun with Children hospital.</p>
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	Adult version reviewed and approved April 2023 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	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 = 5								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 strike 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: June 2023 Next Review: December 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.															
	Optimal Attendance Management project established with project plan and monthly meeting.															
	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.															

	<p>Operational oversight occurs through Health and Wellbeing Committee.</p> <p>Health and Wellbeing Dashboard is a standing Agenda item at Health and Wellbeing Committee and incorporates absence data.</p> <p>Daily review of staff covid data in place and escalations to Executive team as appropriate.</p> <p>HR Metrics have been developed which include sickness absence, these are presented at each Workforce Committee.</p>		<p>Review the content of the daily covid sickness report to ensure relevant post pandemic. To be completed by 30 June '23.</p>
Manager Led Interventions	<p>Effective national and local guidance in place for managing sickness absence.</p> <p>National decision that covid absence now managed in line with all other types of sickness.</p> <p>Supporting Absence Guidance agreed with staff side and in place within the organisation. This details the processes around absence management to enable line managers to take local action to address sickness absence.</p> <p>Advice and support available for managers to support them to manage sickness absence available from Operational HR and Occupational Health.</p>		

	<p>Assurance meetings now in place with all CSUs to review both long- and short-term absence.</p> <p>Leading Leeds way toolkit has been launched to support managers.</p> <p>Embedding of the PPM approach.</p> <p>Supporting Attendance workshops now in place for managers to attend.</p> <p>MDT approach to managing challenging cases to enable a shift from blockage to action is now in place.</p> <p>Increased involvement of HR Ops team in the OH referral process.</p> <p>New online Occupational Health referral form now launched.</p> <p>Training sessions to support line managers and HR write better and appropriate referrals completed.</p>	<p>Further work required to understand capacity and demand in OH to be completed by June '23</p>	<p>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.</p>
	<p>Mental Health First Aiders now in place across the Trust</p> <p>Health and wellbeing conversations template available which has been reviewed to improve effectiveness.</p> <p>Employee Support Fund available for financial support.</p>	<p>Staff are presenting with increasingly complex social issues that line managers and HR do not have specialist knowledge to support.</p>	<p>Discussions taking place across Leeds on the provision of a welfare officer role with initial indications that funding is available. Confirmation</p>

	<p>Money Buddies one to one financial advice service commenced May 2022, with good usage.</p> <p>Launch of the Leading the Leeds Way Managers Toolkit is complete.</p>		anticipated in May
Accessing Support	<p>There are pathways for staff to directly access internal staff support services including Occupational Health, Clinical Psychology and Physiotherapy.</p> <p>Health and Wellbeing booklet sent to all staff home addresses in December 2022 to raise awareness of services.</p> <p>Online referral form for OH now live.</p> <p>Maintain OH wait times for management referrals at 4 weeks.</p> <p>Encourage staff to engage with primary care physicians as early as possible.</p>	<p>Wait times for NHS services eg counselling, physio can lead to staff being absent whilst awaiting appointments.</p> <p>Line managers are not always aware of how internal services to LTHT can support staff and therefore do not support staff to access them.</p>	
Provision of Support	<p>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.</p>	<p>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.</p> <p>The internal staff clinical psychology team have identified that the majority of</p>	<p>Retendering of the EAP service to be completed by August '23</p> <p>One to one support will continue to be provided by the Employee Assistance Programme. With post incident support provided by the staff clinical psychologists.</p>

	Flu staff vaccinations are available for all staff on site via the Peer Vaccinators	<p>support services are reactive, providing interventions to address established issues. A gap in provision of therapeutic preventative work has therefore been identified, with limited organisational resources to address this,</p> <p>Vaccination numbers for both flu and covid are lower than in previous years but in line with the national uptake.</p> <p>The central model utilised for give Covid staff vaccinations last year is no longer available and will need to be managed in house and we do not have capacity to deliver this from existing resources.</p> <p>A review of other key staff vaccinations is required to include Mpx, Pertussis, BRG.</p>	<p>Continue to undertake work to address cultural issues to prevent poor mental health, including increased awareness and peer support.</p> <p>A business case for all staff vaccinations has been approved and recruitment is underway.</p>
Risk of staff absence due to potential Industrial Action	Twice weekly steering group is established t and stepped up when required to plan for potential Industrial Action with staff from Emergency Preparedness, HR, Corporate Nursing, Corporate Medical Team, Corporate Operations and CSUs	.	

	<p>triumvirates representation. Set of task and finish groups established to ensure effective delivery.</p> <p>An Incident Command Centre is put in place in the event of any Industrial action, with positive partnership working with Staff Side embedded. Standard work, including a clear understanding of whether derogations are available and what areas are derogated is established for how to manage the impact.</p> <p>Standard work in place for deployment and staff mitigations and utilising agency workers to support essential services during industrial action.</p> <p>Robust data analysis to ensure understanding of staffing absence in place.</p> <p>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 act.</p> <p>Working across West Yorks ICS (Integrated Care System) 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</p> <p>Good employee relations in place with local staff side organisations.</p> <p>The Leeds Way is well established as we manage</p>		
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	<p>industrial action. This also mitigates the risk of potential conflict in teams due to industrial action.</p> <p>FAQs, Ask the Expert, comms plan and guidance regularly updated to ensure understanding across the organisation as the situation develops.</p>		
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CRRO6: Risk of further delays in delivering the refurbishment of the Generating Station Complex (GSC) at LGI	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	
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: July 2023					
												Next review: January 2024					
												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	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 =4										Target Score			Initial Score	Current Score				
Risk Description:																Executive Lead: Director of Finance			
There is a risk that the Hospitals of the Future Project fails to deliver its objectives as a result of:																Date Added to CRR: May 2020			
<ul style="list-style-type: none">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; andan inability to accommodate education and training requirements within available space and funding.																Last Reviewed: November 2022			
If the project is not delivered, the Trust will:																Next Review: May 2023			
<ul style="list-style-type: none">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																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
<p>Programme Delays</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Programme Director involved in networking with other Trusts in the NHP on a regular basis to understand shared/common and individual issues/scheme implications.</p>	<p>Lack of influence over the detail and pace of NHP work and the OBC approvals process.</p> <p>Not all of NHP's requirements and technical design standards are known or formally confirmed.</p> <p>There is a distinct lack of clarity surrounding funding and budgets which continues to present a risk to the delivery of the Programme.</p> <p>Lack of clarity surrounding procurement and delivery strategies to be adopted as well as funding allocations.</p>	<p>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.</p> <p>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.</p> <p>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.</p>
Funding and Cost Increases	Lack of knowledge around the level of	SRO and Programme Director to continue to undertake on-

<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Robust change management/control processes established and implemented to monitor for design</p>	<p>funding likely to be allocated by the NHP to the Trust.</p> <p>Leeds Hospitals Charity £30m fundraising target impacted by inflationary changes.</p>	<p>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.</p> <p>External advisers to provide regular updates on known and forecast key policy/design standard changes.</p> <p>Finance Workstream to review and update LTFM twice-yearly to capture any financial changes (and identify risks) in costs/income/inflation.</p> <p>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.</p> <p>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.</p> <p>BtLW Programme Team to prepare outline plans to mitigate the scenario of the Trust receiving reduced funding.</p> <p>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</p>
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<p>and cost variance against the submitted OBC.</p> <p>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.</p> <p>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.</p> <p>Key market updates on economic factors are reported to the Hoff Project Board, BtLW Programme Board and Building Development Committee on a quarterly basis.</p> <p>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.</p> <p>Business cases are reviewed by NHSE, DHSC, and HMT at each stage to ensure compliance with guidance and to provide further on-going assurance.</p> <p>The Charities Workstream supports work to deliver the charitable funding target of £30m towards equipment with bi-monthly reporting presented by the</p>		<p>the £30m.</p>
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<p>Programme Director to the Capital Appeal Board about progress to deliver the Project.</p>		
<p>Specification, design and quality</p> <p>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.</p> <p>Significant clinical engagement completed by the BtLW Programme Team in the development of design briefing documentation and the design solution.</p> <p>Design proposals approved by CSUs.</p> <p>Robust change management/control processes established and implemented to monitor for design and cost variance against the OBC.</p> <p>A comprehensive governance structure implemented to oversee and manage the co-ordination and delivery of the design development process.</p> <p>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.</p>	<p>Not all of NHP's requirements and technical design standards are known or formally confirmed.</p>	<p>SRO and Programme Director to continue liaison with key members of the NHP Team on need for clarity and guidance on standards.</p>
<p>Assurance</p> <p>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</p>	<p>Full implementation of local assurance controls, measures and processes through the BtLW PMO.</p> <p>Undertake a review of supplier</p>	<p>BtLW Programme Team to continue to review and respond to PwC assurance reviews and recommendations (on-going).</p> <p>BtLW Programme Team to monitor services and works delivered by specialist/professional advisers in terms of the</p>

<p>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.</p> <p>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.</p>	<p>assurance processes and procedures/quality plans in connection with the delivery of contracts.</p>	<p>quality of deliverables through established project delivery arrangements.</p>
<p>Stakeholder Engagement</p> <p>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.</p> <p>The BtLW Programme Team has developed a Stakeholder Management Database which captures key stakeholder information and the status of engagement in supporting effective reporting.</p> <p>Monthly reporting of communications activities are presented at the Hospitals of the Future Project Board, the BtLW Programme Board and the Building</p>		

<p>Development Committee.</p> <p>A quarterly report on Stakeholder Engagement is presented to the Hospitals of the Future Project Board, BtLW Programme Board and Building Development Committee.</p> <p>A six-monthly BtLW Staff Surveys is completed alongside a Staff Temperature Check in-between each key six monthly survey.</p> <p>The BtLW Programme maintains information updates on the Trust's website and internal intranet including the presentation of the latest information on developments.</p>		
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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: <ul style="list-style-type: none">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: <ul style="list-style-type: none">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: May 2023 Next Review: November 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							

<p>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.</p> <p>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.</p> <p>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.</p> <p>Full Business Case for the new Acute Hospital Lab was reviewed and approved by the Building Development Committee in July 2022.</p> <p>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.</p> <p>Regular monthly cost monitoring of scheme capital costs.</p> <p>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.</p> <p>The BtLW Programme Team has established risk/contingency allowances within the FBC which was</p>	<p>of construction works.</p> <p>Capital contingencies to support the management of any impact resulting from delivery issues associated with non-BtLW projects (e.g. MSC).</p>	<p>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.</p>
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<p>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.</p> <p>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.</p> <p>Mitigation plans identified to address impact of significant increases to inflation and project costs to deliver the new SJUH and AHL Labs.</p>		
<p>Managed Services Contract (MSC) Delays*</p> <p>Programme plan for MSC re-procurement established and mapped to New Pathology/AHL projects.</p> <p>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.</p> <p>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.</p>	<p>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.</p>	

<p>WYAAT LIMS Deployment Project*</p> <p>A regional deployment plan for LIMS has been developed with LTHT-specific implementation plan in place for completion by September 2023.</p> <p>LIMS Project Board for Leeds facilities in place from January 2022 and meeting monthly to complement the regional WYAAT Pathology Implementation Board.</p> <p>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.</p> <p>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.</p>		
<p>Pathology CSU Projects</p> <p>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</p>		

<p>the new facilities.</p> <p>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.</p>		
<p>Cost Price Inflation</p> <p>Processes in place to continue to monitor inflationary changes and the impact on the new SJUH and AHL Works Contracts.</p> <p>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.</p>		
<p>Assurance</p> <p>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.</p> <p>The Programme Team has regular discussions with NHS</p>	<p>Full implementation of local assurance controls, measures and processes through the BtLW PMO.</p> <p>Undertake a review of supplier assurance processes and procedures/quality plans in connection with the delivery of contracts.</p>	<p>BtLW Programme Team to review and respond to PwC assurance reviews and recommendations (on-going).</p> <p>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.</p>

<p>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).</p> <p>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.</p>		
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* 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	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 that the LGI Development Site Project fails to deliver its objectives as a result of: <ul style="list-style-type: none">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: <ul style="list-style-type: none">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: May 2023 Next Review: November 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		

<p>Plan.</p> <p>Engagement with Trust staff as well as a range of strategic and supplier-based stakeholders will be undertaken to support the Project (on-going).</p> <p>IDC receives a comms and engagement update at each meeting.</p> <p>The approach to the disposal of the OMS being shared informally on a regular basis with the NHSE national disposals lead.</p> <p>An annual Communications and Engagement Plan has been developed and was approved in March 2023.</p>		
<p>Programme Delays</p> <p>BtLW Programme Director is undertaking regular liaison with NHP leads to understand their progress on the business case process.</p> <p>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.</p> <p>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.</p>		
<p>Site Usage</p> <p>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</p>		<p>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.</p>

<p>an innovation centre which will deliver the expected economic growth.</p> <p>The LDS Project Team has become a proactive member of other innovation initiatives within the Leeds City area to ensure alignment of objectives.</p>		<p>The Trust will influence the uses for the remaining LDS to be complementary to the delivery of Hoff.</p> <p>The LDS Project Team will undertake soft market testing with a range of developers to identify ideas for future usage for the remaining LDS.</p>
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CRRO10: Cyber-attack leading to potential loss of IT systems and/ or data	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	
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: April 2023 (May 2023)				
													Next Review: October 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	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: Jan 2023			
													Last reviewed: January/May 2023			
													Next Review: September 2023			
													Committee reviewed at: Risk Management Committee			
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 <i>Clostridioides difficile</i> infection, Methicillin Sensitive <i>staphylococcus aureus</i> (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: May 2023 Next Review: Nov 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							

<p>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.</p> <p>External audit of the HCAI performance data processes completed all recommendations adopted.</p>		<p>for the SSI module</p>
<p>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.</p> <p>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.</p> <p>Current national CPE guidance followed if more than one linked CPE case identified in Children's hospital</p> <p>Quality Improvement methodology adopted with a Trust wide HCAI collaborative and LIM.</p> <p>Incident command structure in place for COVID-19 related gaps in compliance to ensure a rapid approach to learning and trust wide dissemination.</p> <p>Core principles to reduce the risk of respiratory infection transmission, including Covid-19 (Updated February 2023)</p>	<p>National Carbapenemase Producing Enterobacteriaceae (CPE) guidance not fully implemented in Children's hospital</p>	<p>Plan in place for implementation in Children's hospital. eform revision required Completion planned for end of May 2023</p>

<p>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.</p> <p>Current national CPE guidance followed if more than one linked CPE case identified</p>	<p>National IPC Manual implemented plan re-aligned with HCAI Annual Commitment.</p>	<p>Plan in place to align LTHT and national guidance by Spring 2023</p>
<p>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.</p> <p>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</p> <p>Hierarchy of controls completed by clinical teams which details controls, risks, and mitigations for Covid-19.</p> <p>All adult haematology en suite side rooms redesigned</p> <p>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</p> <p>A multidisciplinary task and finish group has been formed to</p>	<p>Rolling programme of HPV ward decontamination paused as current decant facility is providing winter bed capacity</p> <p>Learning from the haematology <i>Pseudomonas aeruginosa</i> outbreak has highlighted the need to have active surveillance in all augmented care, and regular multi-disciplinary <i>Pseudomonas aeruginosa</i> risk assessments and evaluation of probable water-borne infection in all augmented care units at LTHT.</p>	<p>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</p> <p>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</p>

<p>deliver an assurance programme for the trust based on the learning in haematology.</p> <p>IPC involvement in design, refurbishment and new builds.</p> <p>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</p> <p>Respiratory patient pathway areas under review to understand where further mechanical ventilation or increased side room capacity is required. Review completed.</p> <p>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.</p> <p>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</p>	<p>Limited side room capacity in the unplanned pathway.</p> <p>Large parts of the estate have natural ventilation only. An options appraisal for understanding where further mechanical ventilation is required.</p>	<p>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</p> <p>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.</p>
<p>Antimicrobial Stewardship: Policies and Standards, City Wide Group, Ward Rounds and day 3 IV antimicrobial review</p>		
<p>Detection: Monthly surveillance monitoring and assurance through monthly Perfect Ward meetings and additional hand hygiene audits and ward assurance visits.</p> <p>IPC Leadership team continued to review the HCAI</p>		

<p>performance at Trust CSU and ward level.</p> <p>Consultant Microbiologists provided ward and CSU level review and feedback.</p> <p>HCAI assurance monitoring through the Perfect Ward</p> <p>expanded to include all national HCAI objectives by January 2022.</p> <p>IQPR expanded to include all national HCAI objectives by January 2022.</p>		
<p>Recovery and lessons Learned: Outbreak Management. Incident investigations. City wide Outbreak response group.</p> <p>CSUs manage individual root cause analysis reviews and Outbreak Meetings with support from Consultant Microbiologists, IPCT, Antimicrobial Pharmacists and DIPC/DDIPC.</p> <p>Stop the line investigation process instigated for single COVID-19 nosocomial investigations</p> <p>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.</p>	<p>Feedback of lessons from RCAs to clinicians is variable across LHT, in some areas learning may not be shared effectively</p>	<p>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</p>
<p>Assurance: HCAI assurance is monitored through the Infection Prevention and Control Governance Structure.</p> <p>Latest BAF and Health and Social Care Act 2008: Code of</p>	<p>Review of IPC AP & BAF identified a</p>	<p>Medical AMS lead role JD and recruitment in process expected to commence May 2023</p>

<p>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.</p> <p>Covid-19 assurance is monitored through the Trust OIPC group and IPC governance structure.</p> <p>Board oversight is provided through the Infection Prevention and Control Annual Programme and combined Board Assurance Framework, published by NHSE in May 2020.</p> <p>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. Control 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.</p> <p>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.</p> <p>Clinical Lead infectious disease consultant providing COVID-19 operational support.</p>	<p>requirement for a Trust AMS lead.</p> <p>IPCN, vacancy recognised national shortage of IPCNS</p>	<p>New JD to include AHP and secondment opportunities in place</p>
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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.													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. Trial commenced in Paediatrics June 2023. Adults roll out planned to follow paediatric trial. 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						Falls in-reach reviews undertaken in clinical areas where there is an increase in falls reported (with moderate harm) by CSU staff							

	workload.	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. Launched in May 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. To combine Medical and Nursing quarterly reviews in Q3 2023
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. Working group established to review the enhanced care procedure aim to complete by January 2024
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 PSIRF education to areas prior to adopting new process which empowers staff to assess and validate the categorisation of pressure ulcers within the clinical area, aiming to reduce TV workload to allow

		<p>them to concentrate on specialist and educational role</p> <p>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.</p>
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CRR4: 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. Respiratory infections including COVID19 is unpredictable with any certainty. Challenges with inpatient flow continue due to changes in patient placement pathways both within and out with the hospital. Hospital occupancy levels have risen reflecting change in patient demand.													Executive Lead: Chief Operating Officer				
													Date Added to CRR May 2014				
													Last Reviewed: July 2023 (March 2023)				
													Next Review: January 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.	<p>alternatives to admission where appropriate. Current review of medical and nursing staff for the ED's aligned to reducing cost and increasing productivity will be measured each month for impact.</p> <p>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.</p> <p>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.</p> <p>Patients over 24 hours in ED reported on the weekly Executive score card</p> <p>Expected in July 2023 a test of change for patient placement following a Leeds Improvement Method review of waste in a patients journey .</p> <p>Re-focus Unplanned Care programme with increased oversight and governance regarding non elective flow and discharge.</p>
Mental health patients with long waits for a mental health bed are flagged on the Daily Operation report within LTHT. There is an escalation process to LYPFT (mental health Trust)	There is insufficient mental health inpatient bed capacity to meet demand.	Multi Agency Discharge Event occurred in June 2023 at LYPFT with cross system partners to understand how to reduce length of stay in mental health beds. Action plan being developed.
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	<p>Continued monitoring of ED attendance profile and 95% compliance and breach analysis for patients streamed away from ED.</p> <p>Use of a national tool understanding the city Directory of Service offer against the needs of people with conditions that could be managed</p>

		<p>outside the hospital setting is being used to understand gaps in city service provision- phase 1 and 2 of the review already complete.</p> <p>Continue to maximum opportunity for SDEC pathways and alternatives to admission as clinically appropriate.</p>
<p>Creation of space to support increased numbers of patients in the Emergency Departments to support internal flows.</p>	<p>The estate footprint constraints.</p> <p>Requirement to consistently fully staff the extended footprint so it can be consistently used including the Extended Observation Unit at LGI.</p>	<p>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.</p> <p>Agreed surge plans for extremis developed as part of a Decision Management Tool to space within or adjacent to the ED's</p> <p>Minor injury straight to test is routine practice to support rapid test and treat/decision</p>
<p>System Gold action plan being implemented and monitored through SROG / System Coordination Group.</p>	<p>Community capacity to support timely transfer of patients from acute bed base.</p> <p>Complexity of discharge pathways.</p> <p>Measurable impact of system actions.</p>	<p>Implement work plan and monitor against the key objectives through weekly SROG and System Coordination Group.</p> <p>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 7 annual commitments. City Same Day Response Board established and chaired by LTHT Medical Director for unplanned care. City System Flow Programme Board established with LTHT engagement.</p>

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 2023/24	Unpredictable activity levels	Annual review of the Operational response guidance developed and monitored through daily operational processes will be completed by August 2023 System owned schemes monitored for implementation and impact weekly at SROG.
Respiratory Infection, COVID19, RSV and flu modelling in place for further surges and response in order to proactively manage and support flow and admissions across LTHT.	Novel modelling with a 7day forward view only.	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 deliver 18-week RTT performance as a result of waiting list growth and reduced levels of activity during and after the COVID pandemic combined with referral growth in some areas. This is made more challenging by the reduction in activity that has occurred as a result of periods of industrial action. Ongoing periods of higher Respiratory infection prevalence including COVID will result in increased admissions and staff absences impacting on elective capacity and activity. This results in a poor experience for patients and there is a risk that some patients will deteriorate while waiting for treatment. There is a reputational risk for the organisation and 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: September 2023 Committee reviewed at: Finance & Performance Committee			
Controls						Gaps in Control				Further Mitigating Actions:						
The 2023/24 priorities and operational planning guidance set the challenge that NHS organisations reduce the longest waits for patients to 65 weeks by March 2024 and 52 weeks by March 2025. This recognises that delivery of 18 weeks will not be achieved						18-week RTT remains a constitutional standard										
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 Virtual activity does not clock stop as many patients RTT pathways as face to face activity.				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. 78 & 65 week delivery trajectories agreed with each CSU-	Demand variation from winter modelling / Covid modelling will impact elective delivery Continued impact of Industrial Action reduces available capacity	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 specialties. 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.	<p>Pension taxes had reduced number of additional sessions provided by consultant staff</p> <p>BMA rate card has reduced the number of sessions provided by consultant staff</p> <p>Additional requirement for consultants to cover Jr Dr Industrial Action periods has reduced the number of additional sessions provided</p>	Additional medical payments agreed to support additional activity specifically for treatment of long waiting patients
Use of Independent sector capacity.	Independent Sector capacity has returned to business as usual with priority given to low complexity high tariff activity that doesn't necessarily support RTT performance in at risk specialities	CSUs prioritising access to the Independent Sector to support most at risk specialities

	ICB Funding to utilise the Independent Sector has been reduced in 2023/24	
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 78 & 65 week waits.
Develop sites Elective hubs (CHOC & WGH) to increase elective activity that can be delivered. 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	Currently requires dedicated capital and revenue to support the development of these sites and will not be delivered before Spring 2023 for WDH and 2025 for CHOC 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	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.

<p>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</p> <ul style="list-style-type: none"> - British association of day case (BADs) - Enhanced Care Beds - Theatre Productivity & Efficiency - Preoptimisation - Elective Hubs 	<p>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</p>	<p>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.</p>
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CRR6: 62-Day Cancer Target	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 that the Trust will not treat 85% of patients within 62 days in line with the 62 day referral to treatment constitutional standard Since October '22 the backlog has reduced achieving the year end position for Trust. The 62 day standard also shown steady improvement and is on being closely monitored alongside the backlog to ensure we are improving our time to treatment for our patients. We continue to work to improve pathways such as Skin to ensure streamlining of the 2 week wait pathway. Although this also continues to improve with the continued embedding of tele dermatology where triage has reduced to 7 days. The score for achieving the 62 day referral to treatment standard however is still rated as a 16 due to the impact that Industrial Action has had on capacity and peak demands in referrals post Industrial Action days, however continued capacity and demand modelling and work on optimal pathways supports the sustainable approach to improving the provision of treatment within 62 days. Work is also underway through the Alliance and with our colleagues across WYAAT & Harrogate to improve the here timeliness of referrals through IPT reducing the number of patients being transferred over 38 days for diagnostics or treatment.															Executive Lead: Chief Operating Officer Date added to CRR: May 2014 Last Reviewed: June 2023 Next Review: December 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			None						None									

performance.		
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 Providers involved in the pathway, taking support from the WY&H Cancer Alliance for key areas	<p>Referrals from other providers do not always occur in a timely manner to support delivery of 62 performance.</p> <p>LTHT capacity does not match the demand to deliver treatment within 62 days.</p>	<p>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.</p> <p>Multidisciplinary site specific cancer pathway meetings are in place with robust action plans</p> <p>Weekly PTL meetings reviewing long waiting patients clear documented actions.</p> <p>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.</p>
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	<p>PTL meetings reviewing long waiting patients clear documented actions that are reviewed weekly.</p> <p>Pathology KPIs and PTL dashboards have now been developed and monitoring/ recovery actions agreed.</p> <p>Harm review process reviewed and refined to</p>

		<p>provide assurance of long waiters for attention.</p> <p>Concise timely performance reports are required for the CSU leads, currently being agreed with the GM's</p>
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 than previously seen, causing increased activity and delivery challenges particularly in Breast (2 spikes), Skin, Colorectal and Head and Neck	<p>Colorectal introducing a new triage process to support straight to test pathway.</p> <p>Endoscopy mitigations successfully delivered additional capacity</p> <p>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</p> <p>Urology prostate, timeout undertaken with a new triage pathway being trialled.</p>
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	<p>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).</p> <p>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.</p>

	Radiotherapy capacity is currently not sufficient due to planning staff gaps and impact of delivering new expansion plan	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	<p>Cancer management team supporting routine validation to ensure CSUs/ coordinators are focussing on highest risk patients for attention.</p> <p>Full review of recruitment and retention programme within the MDT Team to a format of 'growing our own'.</p> <p>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.</p> <p>Training of mental health first aiders Health and Wellbeing work being undertaken by new manager of the MDT team to identify issues</p> <p>MDT team lead structure reviewed and amended to reflect the importance of maintaining data quality and develop KPI's to demonstrate this</p>
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
<p>Weekly surgical/ HDU prioritisation processes continue to be in place, with additional operating accessed in the Independent sector where possible/ appropriate.</p> <p>Clinical triage process established and continues weekly for HDU/HOBS cases should any further surges result in the requirement to reduce/ suspend cancer surgical activity</p> <p>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.</p>	<p>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 despite P2 and CC prioritisation (booking into capacity available but still not sufficient in all areas)</p>	<p>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.</p>
<p>Weekly and Monthly meetings continue to be in place with the Cancer Alliance to update on the total number of patients that have been transferred to LTHT for diagnostics or treatment past day 38.</p>	<p>Impacts due to industrial action and post covid recovery continues to impact on pathways across other Trusts. Patients that required diagnostics or treatment at LTHT are transferring over day 38 leave less time for treatment within 62 days. Internal reports have been developed and are discussed at the LTHT Cancer Huddle weekly, with an update provided to the Alliance weekly</p>	<p>Escalation report for late IPT pts with direct conversation with referring Trusts via Cancer Management team</p> <p>Review at the CSU PTL meetings weekly to support pulling patients through the system</p> <p>Linking of Optimal Pathways transformational work with referring trusts work programmes to improve timely transfers.</p>

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 Industrial Action, 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						Service Delivery Framework and Integrated Accountability Meetings used to support the daily management of CSU KPIs and delivery of the 28 day constitutional target for CSUs							

<p>The programme reports monthly to the Tactical Sponsorship group chaired by the COO</p>		
<p>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</p>	<p>Co-ordination of theatre/ ward and critical care capacity does not always align leading to greater risk of cancellations</p> <p>Not all Critical Care patients can be automatically sent for</p>	<p>Daily circulation of planned TCIs and previous cancellation status the day prior to surgery</p>
<p>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.</p> <p>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.</p> <p>Daily email prompt to CSUs highlighting their 28 day breach risks</p> <p>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</p> <p>LTHT scheduling tool has been updated with the 'Monte Carlo' simulation to improve scheduling accuracy and theatre efficiency</p> <p>The number of 28 day cancellations has continued to reduce</p>	<p>Critical Care capacity can change overnight due to staffing absence or high numbers of unplanned admissions and result in on day cancellations</p>	<p>Continued Increase in ACC workforce planned through September and October 2023.</p>

and performance has been sustained.		
<p>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 of cancellation</p> <p>Use of Independent sector to increase available capacity and treatment options for patients</p> <p>Monthly focus on 6-4-2 process and Specialty level performance within Theatre Board.</p>	<p>Theatre staff and surgeons are not always available to undertake additional activity in response to peaks in demand</p> <p>Independent sector contract restricts type of patient able to be transferred for treatment.</p>	<p>BT LW at LGI will design bespoke admission and discharge areas for day case pathways.</p> <p>SJUH estate strategy reviewing options to consolidate day case estate and pathways at SJUH</p> <p>Planned Care Dashboard developed to highlight BADs / Daycase opportunity by procedure</p> <p>Business case approved for additional 2 theatres at WDH</p> <p>Increase theatre and day case capacity available over the weekend to spread demand and offer more opportunities to rebook patients.</p> <p>GIRFT project embedded in Theatre efficiency project to ensure appropriate patient pathway is followed.</p>

CRR8: Patients waiting over 52, 65 & 78 weeks for treatment across a range of services.	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 & 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. 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. Planning guidance has required NHS Trusts to reduce RTT waits to below 104 weeks (by July 2022), then 78 weeks (by April 2023) and 65 weeks (by April 2024).													Executive Lead: Chief Operating Officer			
													Date Added to CRR May 2015			
													Last Reviewed: June 2023			
													Next Review: December 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 Increased referrals to the Trust may result in increases to the total waiting list						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 has completed clinical prioritisation of diagnostic waiting lists using national D codes. 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							

<p>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</p>	<p>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</p>	<p>with known risks already prioritise. Planned Care focus on, and increasing the productivity of all elective capacity</p> <p>Robotic Automation Process (RPA) has commenced in November 2022 to deliver a successful RTT administrative waiting list validation solution by using technology to create an interface with patients to identify patients suitable for discharge. Furthermore, a focussed project is underway (Q1 & 2 2023/24) to deliver a dedicated focus on administrative validation covering the RTT and non-RTT overdue FU backlog with an initial focus on AMS and H&N CSUs due to the volume of patients. Clinical validation will accompany the administrative validation. CSUs are working through PIFU protocols to support the validation outcomes and embedding wider PIFU options in specialities.</p>
<p>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</p> <p>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</p>	<p>Some specialties have larger waiting lists and / or more constrained capacity to deliver 104 and 78 & 65 week trajectories</p>	<p>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.</p>

& 65 week trajectories.		
<p>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</p> <p>Adult Spines elective lists at CHOC</p> <p>Elective schedule reallocated in WGH & DBDU to support specialties with longest waiting lists (Urology & Colorectal)</p> <p>Overnight stays reinstated at WDH for 1-2 nights per week.</p> <p>Enhanced Care beds opened at CHOC to increase case complexity of patients able to be treated at the elective Hub.</p> <p>Vanguard mobile operating theatre operational from Jan 22 to increase capacity.</p> <p>All P4 patients above 80 weeks as P3 patients to support booking of long waiting patients</p>	<p>Existing surgeons must be allocated to cover additional sessions, which can stretch teams if more sites need cover.</p> <p>Reallocation of capacity may result in growing waits in other services.</p>	
<p>Additional outpatient sessions are relatively easy to schedule and outpatient waiting lists can reduce quickly if clinicians are available</p>	<p>Reliant on staff willing to do overview time/additional hours.</p>	<p>Roll out of alternative working models (e.g. virtual reviews) can deliver additional capacity.</p> <p>Service Delivery Contract's includes KPI on reducing longest outpatient waits – this will be monitored on monthly basis</p>
<p>Established arrangements in place to allow additional outpatient and inpatient activity to be scheduled outside normal working hours.</p>	<p>Relies on staffing throughout overtime and additional hours.</p>	<p>Saturday outpatient clinics are routinely being held to support specialities.</p> <p>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.</p> <p>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.</p> <p>Expecting Bookwise to be implemented by March 2023</p> <p>Enhanced rate available to staff to support activity</p>

		that delivers additional capacity for the treatment of long waiting patients
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	Financial constraints for 22/23 mean potential reduction in use of the Independent Sector	LTHT working collaboratively with the ICS to prioritise and maximise use of the Independent Sector within place and financial budget.
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 Spring 24 for WGH, and summer 2025 for CHOC.	Enhanced Care beds operational at CHOC as of March 23. Vanguard Mobile Theatre operational as of January 23
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.
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.	Critical Care capacity can change overnight due to staffing absence or high numbers of unplanned admissions and result in on day cancellations	Increased workforce within critical care has increased available bed capacity and reduced the risk of cancellation of elective activity
<p>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</p> <ul style="list-style-type: none"> - SJUH elective recovery - LGI elective recovery - Outpatients - Diagnostics - Patient Placement <p>The work of the reset groups in SJUH Elective Recovery, LGI Elective Recovery, diagnostics and outpatients are being taken forward through the Operational Transformation Strategy and the Transformation Services Group.</p>	<p>Non elective pressures and high bed occupancy preventing full return to pre-covid elective efficiency.</p> <p>Ongoing Covid peaks through the year and subsequent impact on Covid inpatients and staff availability</p>	<p>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.</p> <p>Business case being developed for re-organisation of elective and non-elective wards at LGI to support elective flow</p> <p>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.</p> <p>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.</p> <p>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</p>

		January 2023.
A process for undertaking harm reviews for any patient 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.	The process approved is time consuming, and requires forms to be completed manually and uploaded to PPM+.	A more streamlined digital process is being 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 in 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 and paediatric services. 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 achieving 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: July 2023 Next Review: January 2024 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/actions to mitigate. Specific targeted work with theatres and paediatrics in Q1/2 2023/24 to support capacity requirements to deliver diagnostics long waiters (i.e. patients waiting >13 weeks) and sustain delivery.							
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 Activity and Performance workstream, chaired by Radiology CD supported by ADOP with input from all relevant CSUs. Processes in place to support recovery and sustainability.	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. Support from IT continues to be is-constrained to support better data production.	Awaiting embedding of Endoscopy and PAS system upgrades and then will review options for better reporting oversight 2022/23
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.	<p>MRI replacement and expansion (by 1 more unit) plans completed in 2020/21. 1st 2 new Cath labs in now in place.</p> <p>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.</p> <p>CT mobile in place from May 2022 to support recovery and remains to also support increased demand.</p> <p>Use of independent sector/ AQPs continues for CT, MRI and Ultrasound where available.</p>

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	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	
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.			Fully operationally implemented Live bed state to support real time understanding of capacity Tracking of the DMT actions taken, frequency and potential impact as a learning organisation						Live bed state developed with a staged roll out plan of implementation expected roll out complete in November 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–Estates plan agreed to develop additional siderooms in Beckett wing to be completed by November 2023 Weekly tracking of DMT actions taken.							

<p>Agreed Full Capacity Protocols (FPC) for surge 1, 2 and 3 Exceptional Surge Areas (ESA'S)–with implementation capture and assurance process measures. <u>This includes utilisation of the Exceptional Surge Area (ESA) plan.</u></p> <p>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</p> <p>process for all discharges that do and do not proceed to ongoing community support with an understanding of what could have been better (Pathways 1,2 and 3) shared</p>	<p>Weekly report of use and associated audit of use compliance for FCP</p> <p>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</p> <p>Bed modelling for this winter is not based on prevalence as accurately as previous years due to reduction in COVID testing.</p> <p>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.</p> <p>Overall patient experience impacted by use of ESA beds</p> <p>Completing of learning through the ward efficiency metrics requires DIT development</p>	<p>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)</p> <p>External audit of-winter planning and governance. 3 recommendations implemented.</p> <p>Patient experience question used as part of audit of patients in ESA Apology letter given to patients</p> <p>Weekly sharing of a report on discharges that did not proceed- with a route cause identified for any discharge failure</p> <p>External audit of LOS analysis commissioned and completed in August 2023. Key findings identified and action plan in development. Work in progress of right sizing the bed base for</p>
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<p>Management of long length of stay patients</p> <p>Protected elective capacity at SJUH,CAH and Wharfedale Hospitals to support elective (planned patient) capacity</p> <p>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</p>	<p>The number of patients without a Reason to Reside within the hospital setting awaiting on-going care provision has not seen a statistical reduction . Significant waits for Social Worker intervention</p> <p>National increase in the numbers of patients in hospital with a longer length of stay and 5 or more co morbidities</p> <p>Continue with high numbers of Super stranded / No Reason to Reside patients within hospital bed base.</p>	<p>specialities that constantly place patients outside their bedbase to reduce patient moves and align to right place first time</p> <p>4-Additional wards currently open in LTHT to meet the need of patients no longer requiring hospital in patient care. With seasonal plans to meet additional demand</p> <p>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.</p> <p>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.</p>
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contact if their condition has changed etc		
<p>Tactical:</p> <p>Alternatives to admission-</p> <p>Established Same Day Emergency Care unit 7 days per week</p> <p>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</p> <p>Developed Virtual Ward for respiratory and frailer adults to support early discharge and alternative care for lower acuity admissions</p>	<p>Physical space constraint until October 2023 when newly refurbished estate will be ready for medicine and older adult care</p> <p>Skilled workforce and cross system capacity to enable change-Capacity in 2 hour response across the city to enable redirection from the ambulance lower acuity calls</p> <p>Maximum Virtual Ward capacity is below Nationally described opportunity Workforce gaps in wards of the city remain a challenge</p>	<p>Review of the headache further clinical pathways to convert to ambulatory pathway and reduce non elective admission where clinically appropriate by November 2023</p> <p>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 rolling PDSA cycles across city to increase the number of redirections.</p> <p>Appointed a Clinical Lead Consultant from LTHT for the city Virtual Ward and telemetry development which is due to commence in September 2023</p>
<p>Strategic:</p> <p>Establishment of Leeds urgent community response group with delivery of 2 hour community response 8am till 8pm to avoid ED and admission conveyance</p>	<p>National requirement for 24/7 offer not currently delivered Workforce and share system clinical risk approach</p>	<p>One of the three areas of focus for the ICB following a 2023 NHSE self assessment. Programme to be developed.</p> <p>5 main projects: established</p>

<p>Intermediate Care redesign called Home First programme and the city opportunity analysed and collectively understood. To reduce LOS and number of patients with no reason to reside in hospital and 5 Programmes of work agreed to transform and maximise this opportunity by 2024.</p>	<p>Workforce challenges Risk sharing across the city and information governance risks.</p>	<p>1, active recovery- home based care on discharge 2, enhanced care at home-helping people to stay at home so people don't need to come to hospital 3, converting from beds to home 4, transfer of care- LLOS meetings and system 5, System visibility-shared understanding of capacity and impact of changes Regular comms updates describing progress to date</p>
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CRRC12: Airedale Hospital Infrastructure: potential risk re transferring patients to LTHT	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	
														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: Chief Operating Officer Date added to CRR: Feb 2022 Last Reviewed: May 2023 Next Review: Nov 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	20	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
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: <ul style="list-style-type: none">Reducing the internal funding for the Trust’s ambitious Five Year Capital programme, including Building the Leeds Way leading to:<ul style="list-style-type: none">Limiting the capital programme/not replacing equipmentRelying on external sources of fundingCash shortfall and risk to supplier paymentPotential non-compliance with new medical devices regulation (Regulation EU 2017/45)Reputational damage, as the Trust fails to deliver on a key statutory dutyPotential 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			
													Next Review: Nov 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			<ul style="list-style-type: none">Failure to achieve Elective Recovery Framework thresholdsPotential introduction of Payment by result system for elective activity.Requirement for additional resources if Covid-19 costs continue at historic levelsNo reason to reside issue is not resolvedRestrictions on capital allocation due to funding formula.						<ul style="list-style-type: none">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 addressedProposed 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							

		<p>including Exec lead on financial risk and associated mitigations</p> <ul style="list-style-type: none"> • 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	<ul style="list-style-type: 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		<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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.		<ul style="list-style-type: none"> • Development of in-house mitigation plan • Regular updates to the Executive Team and Finance and Performance Committee including Exec lead financial mitigations
<p>Operation of the financial performance framework with:</p> <ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Regular updates to the Executive Team and Finance and Performance Committee including Exec lead financial mitigations

<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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: <ul style="list-style-type: none">Reducing the internal funding for the Trust’s ambitious Five-Year Capital programme, including Building the Leeds Way leading to:<ul style="list-style-type: none">Limiting the capital programme / not replacing equipmentGreater reliance on external sources of fundingPotential non-compliance with regulatory requirementsIncreased clinical risk due to inability to replace capital assets within agreed replacement schedules, address critical maintenance backlogs, and invest in infrastructure across the capital programmes.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			
													Next Review: September 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. Key LTHT risks worked up to show scale of impact if a top slice approach is taken and briefing provided to ICB Director of Finance				<ul style="list-style-type: none">Other ICB Trusts show a preference towards top slicing the ICB allocation reducing operational capital budgets for all Trusts						<ul style="list-style-type: none">Regular updates provided to Director of Finance and Director of Strategy immediately following the meetingRegular updates provided to Capital Planning Group and any necessary escalations to Finance and Performance Committee.						
The Trust takes a risk-based approach to the prioritisation of internal capital funding via the annual refresh of the five-year capital plan. Progress against the five-year plan is overseen by the Capital Planning Group including				<ul style="list-style-type: none">None						<ul style="list-style-type: 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.						

specific prioritisation for the MSE, BME and DIT programmes.		
Development of in-house mitigation plan allows for the Trust to respond to changes in funding allocations or utilise slippage in other Trusts.	<ul style="list-style-type: none"> • Restrictions on capital allocation due to funding formula. • Restrictions on capital allocation due to lack of New Hospitals Programme funding certainty places additional pressure on operational capital. 	<ul style="list-style-type: none"> • Capital Planning Group puts increasing focus through the year on strength of programme managers forecasts and ability to complete 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	<ul style="list-style-type: none"> • Constrained by available opportunities • Bids and applications not always successful 	<ul style="list-style-type: none"> • Capital Planning Group regularly discuss opportunities to maximise external funding opportunities.
Capital Planning Group will 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.	<ul style="list-style-type: none"> • Would still reduce LTHT allocation 	<ul style="list-style-type: none"> • Influence NHSE to identify route for medium to major schemes to be considered for central funding.