NHS
The Leeds Teaching Hospitals
NHS Trust

CORPORATE RISK REGISTER

March 2024

Summary Corporate Risk Register March 2024

CRR No.	Nature of Risk	Date added to CRR	Executive Lead	Current Risk Score	Last Reviewed By RMC	Next Review By RMC	Link to LIM Value Stream	Page No.
Workforce Risk								
Workforce Supply Risk							*Cautious*	
CRRW4	Insufficient staff to provide treatment, care and services to patients	May 23	Director of Human Resources, Chief Nurse & Chief Medical Officer	16	Dec 23	Jun 24		5-15
Workforce Deployment Risk							*Cautious*	
-	-	-	-	-	--	-	-	-
Operational Risk								
Business Continuity Risk							*Cautious*	
CRRO1	Risk of a viral pandemic	May 18	Chief Operating Officer	15	Oct 23	Apr 24		16-17
CRRO2	Power failure/lack of IPS/UPS resilience due to electrical infrastructure	Aug 15	Director of Estates & Facilities	16	Jan 24	Jul 24		18-21
CRRO13	Brotherton Wing, Blocks 11, 12 and 32 physical condition	Jan 24	Director of Estates & Facilities	20	Jan 24	Jul 24		22
Health & Safety Risk							*Minimal*	
CRRO3	Harm due to clinically related behaviours that challenge linked to organic, mental health or other reasons	May 15	Chief Nurse	16	Dec 23	Jun 24		23-27
CRRO4	Staff absence Health, Safety and Wellbeing	Oct 20	Director of Human Resources	16	Dec 23	Mar 24		28-31
Change Risk							*Cautious*	
CRRO7	Risk of failure to deliver the hospital of the future project.	May 20	Director of Finance	20	Nov 23	May 24		32-38
CRRO8	Risk of failure to deliver the pathology project.	May 20	Director of Finance	16	Nov 23	May 24		39-44
CRRO9	Risk of failure to deliver the LGI Site Development Project	Nov 21	Director of Finance	16	Nov 23	May 24		45-49
Information Technology Risk							Cautious	
CRRO10	Cyber-attack leading to potential loss of IT systems and/ or data	May 22	Chief Digital & Information Officer	16	Oct 23	Apr 24		50
CRRO11	Insufficient DIT resources to meet demand for DIT led projects	Jan 23	Chief Digital & Information Officer	15	Sep 23	Mar 24		51
Clinical Risk								
Infection Prevention & Control Risk							*Minimal*	
CRRC1	Healthcare acquired infection	Mar 19	Chief Nurse	16	Oct 23	Apr 24		52-58
Patient Safety & Outcomes Risk							*Minimal*	

CRRC3	Patient harm – falls and hospital acquired pressure ulcers	Mar 21	Chief Nurse	16	Feb 24	Aug 24		59-61
CRRC4	Failure to achieve Emergency Care Standard	May 14	Chief Operating Officer	20	Jan 24	Jul 24	ED LGI	62-65
CRRC5	18-week RTT target non-compliance	May 14	Chief Operating Officer	20	Sep 23	Mar 24	Ophthalmology / Cardiac Surgery	66-70
CRRC6	62-day cancer target	May 14	Chief Operating Officer	16	Dec 23	Jun 24	MDT & Pancreatic Breast Only	71-75
CRRC7	Failure to achieve 28 day cancelled operations target	May 14	Chief Operating Officer	16	Sep 23	Mar 24	Cardiac	76-78
CRRC8	Patients waiting over 52 & 78 weeks for treatment across a range of services.	Oct 18	Chief Operating Officer	20	Dec 23	Jun 24	Neurosciences	79-83
CRRC9	Patients waiting longer than 6 weeks following referral for diagnostics tests	May 14	Chief Operating Officer	16	Jan 24	Jul 24	Breast cancer	84-85
Capacity Planning Risk							*Cautious*	
CRRC10	High occupancy levels and insufficient capacity and flow across the health and Social care system causing impact on patient safety, outcomes and experience.	Sept 15	Chief Operating Officer	20	Sept 23	Mar 24	MMPS	86-90
CRRC12	Airedale Hospital Infrastructure: potential risk re transferring patients to LTHT	Feb 22	Chief Operating Officer	16	Nov 23	May 24		91
Financial Risk								
Financial Management & Waste Reduction Risk							*Cautious*	
CRRF1	Failure to deliver the financial plan 2023/24	May 14	Director of Finance	20	Nov 23	May 24		92-94
CRRF2	Reduction in operational capital allocation	May 23	Director of Finance	16	Nov 23	May 24		95-96

Corporate Risk Register - Key

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

Risk Appetite Scale

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

Risk Score

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

CRRW4: Insufficient staff to provide treatment, care and services to patients	C = 4	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 organisation has insufficient staff numbers or utilises existing staff inefficiently resulting in:

1. A potential failure to provide safe care and treatment to patients
2. Staff suffering psychological and physical harm (burn-out)
3. Loss of stakeholder confidence and/or material breach of CQC conditions of registration.

This could be caused by

1. Inability to recruit to staff vacancies across all professional group and support workers, caused by a local and national shortage of qualified and experienced staff
2. Failure to retain existing staff, for example due to early retirement or staff taking on roles elsewhere
3. Not utilising staff appropriately due to poor rostering / job planning or staff undertaking duties not appropriate for their role

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

Date Added to CRR: May 2014
Last reviewed: December 2023
Next Review: June 2024

Committee reviewed at: Workforce Committee

Controls	Gaps in Control	Further Mitigating Actions
NURSING, MIDWIFERY AND AHP's - Lead Interim Chief Nurse		
Ongoing Deep dives into Nursing & Midwifery Recruitment and retention New entry routes created for those 'new to care' through apprentice CSW and trainee CSW routes. Excellence in Practice programme in place for both registered and unregistered workforce Learning Practitioner programme Focus on 'growing our own' through in-house courses and apprenticeships.	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) Significant attrition in children's student nurse's cohorts prior to qualification – work ongoing to deep dive into rationale	System wide large scale recruitment events working with system providers. 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 International Nurse recruitment 819 WTE international nurses now in post (November 2023).	Further pastoral support and supervision to be provided to international recruits after 1 years' service	HR/Nursing/Medics working together to develop approach to pastoral support

Co-hort International recruitment now paused. **Midwifery** Centralised recruitment held across West Yorkshire & Harrogate Local Maternity & Neonatal System with 74 undergraduates putting LTHT as first choice for employment. Recruitment offered to fill 50 WTE places. 27/11/2023 - the recruited newly qualified midwives have now all commenced in post and currently completing induction / orientation programmes Recruitment event held Feb 2023 at Thackray Museum to highlight careers / opportunities available in maternity and neonatal services - - 200 plus attendees Recruitment to Midwifery Apprenticeship scheme at University of Huddersfield with 3 MSWS to commence midwifery apprenticeship September 2023, with CSU plan to recruit annually Across West Yorkshire and Harrogate LMNS monthly meetings held with local universities to explore new ways of working / opportunities. NHSE System workstreams across NE & Y re attrition of student nurses and midwives, to address concerns of students and address issues raised.Exit interviews held for all Workforce lead appointed within Women's CSU who works closely with preceptorship lead midwife, PMA lead midwife and clinical educators for hospital and community which has led to the development of a workforce strategy for the CSU. Pastoral support via HWB lead and PMA Team HR workforce measures of sickness & absence, attrition, retention all reviewed and discussed monthly along with data from exit interviews	**Midwifery**	Temporary wards (seasonal and surge capacity) included in external safer staffing return once opened for full roster period of six weeks. **Midwifery** WY& H LMNS relaunching the system wide workforce group for maternity and neonatal services
Safer staffing guidance and escalation pathway to ensure	Variance in practice across CSU's in	

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. All safer staffing documentation reviewed and monitored through the Nursing, Midwifery, AHP Workforce Group (NMAWG) Safer staffing resources, escalations and safer staffing policy available on the Trust intranet.	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 operational pressure, including ESA escalation.	
Programme of Nursing and Quality Framework reviews with CSUs Corporate support for areas of concern. Escalation process in place.	Variance in results of quality and safety reviews. Risk of Nursing staff retiring early due to risk of high pension tax liability	Corporate task and finish group established to identify potential impact
Adult Therapies AHPs DHRBP in post in AT CSU for AHPs to lead on WF plan Implementation of CSU IAM meeting with all data including WF metrics monthly ToR drafted for CSU level WF committee for all Professions in CSU to be members of and agree all actions and operational activity.	Variance in understanding of WF issues and available data No central governance around sign off and equity in WF issues in CSU Only applicable to AT CSU not inclusive of all AHP groups in the trust	
Adult Therapies CSU AHP Specific Development of a capacity and demand tool for AT CSU to understand available resources Apprentice analyst within CSU supporting data process Meeting with national C&D team from NHSE September 2023 for support and challenge.	Variance of data relating to activity across each professional group and how captured. Data manually collated no electronic capability Acuity not part of C&D tool Lack of technical capability Lack of national guidance re	Ongoing work with PPM regarding capability to pull activity in contacts and duration AHP professions linking with professional bodies for steer on complexity tools

	development of suitable tool	
Adult Therapies CSU: Deep dives into AHP groups in AT CSU to support where identified retention or turnover is a concern	Number of services requiring support	Rapid improvement time limited projects underway to provide strategy for a profession and light touch approach Working with regional AHP faculty to implement partner strategies where appropriate.
Therapy Radiographers (Oncology) On-going recruitment. Apprenticeship commenced March 2023 (3-year programme) - 2 places available. 1 person left the course in August so currently we have only 1 apprentice. Inter We continue to succesfully recruit Band 5 and Band 6 radiographers. Continued Focus on internal growth and development i.e., band 5 to 6 radiographers.	Difficult to recruit enough band 5s due to a national shortage and the demand for radiotherapy continues to rise. Annual increase in demand for radiotherapy is 5%. There are not enough students being trained nationally. Difficult to retain experienced staff as they are attractive to other organisations (band 7s/promotions) Unable to support international recruits at the moment due to lack of capacity for educational support.	An Expansion of the apprenticeship programme in 2024 to take on more apprentices to become a qualified radiographer. HEE have funded 4 apprentices for 2024 intake. Trust has supported 4 posts for 2024. Looking at recruitment and retention initiatives such as developing our band 2 and band 3 workforce to become radiographers possible via apprentice route. This could be a 5-year process. International recruitment may be a longer-term option – National funding of £7000 per recruit has been offered. Leeds have declined this funding at the moment. Currently we have approximately 10 vacant therapy radiographer posts. Interviewing In December for 2024 Apprentice Intake
Radiographers (Radiology) AHPs – Radiographers Regular recruitment cycle in place Investment in apprentice radiographer roles, apprentice assistant roles and apprentice radiographer practitioner	Retention risks due to independent sector offering more attractive salaries (Ultrasound and MRI) with no on-call commitment. Unknown impact of the CDCs.	Work to modify training pathways in X-ray to improve time to competency once radgraphers are qualified is in place. HEE funded clinical educators on 12 month FTC x 3 Introduction of a band 4 role to undertake more 'simple' scanning procedures is being piloted in MRI.

roles. A fast-track undergraduate masters course in radiography commenced in November 2022. Undergraduate ultrasound course to commence in Sept 2024 to avoid the need to train as a radiographer first		Working on a plan to offer training in a second modality for interested staff on either a secondment or part time basis. Working to staff the CDC from within, CDC seen as an attractive place to work.
AHPs (Theatres) Recurring recruitment advertisements. Successful internal anaesthetic skills course.	National shortage of ODPs/nurses with anaesthetic skills therefore poor response to recruitment campaigns. Limited number of places available due to back-fill requirements.	Moving to 20 apprentice ODPs per year by increasing to 10 students per year from Huddersfield University and 10 from Sheffield Hallam University. This course is now offered as an academic and non-academic course. In 2023/24 we are hoping to increase the non-academic course to twice per year.
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' service	Use of international recruitment agencies. HR/Nursing/Medics working together to develop approach to pastoral support
There are a number of Ongoing Deep dives into Medical Recruitment and retention .	Inability to reduce vacancy gap due to decrease in supply of staff regionally and nationally. Significant vacancies nationally for specialist roles. Inability to recruit in some specialties due to national shortage of suitable applicants Increase in numbers of junior doctors choosing to work less than full time	Focus on 'growing our own' through in-house courses and apprenticeships. Development of new roles and alternative workforce models. Working with WYAAT on attraction, recruitment and retention. Paper prepared for Discussion at LETC describing the impact of Junior doctors working less than full time

	Potential inability to fill gaps with locums due to rates of remuneration being lower than other organisations	Papers prepared for Executive Committee to discuss pay rates Medical Staff wellbeing strategy which will look at ways to ensure medical staff feel valued and recognised for their work
	Low morale and burnout in medical staff as indicated by results of staff survey	
		Corporate Task and Finish group established to identify the impact of the change
	Issues around HOLT Agency and the need for 3 years references prior to employment	Development of a consultant retention strategy to include pension planning, flexible working and other key actions
	Risk of consultants reducing PA's or retiring early due to risk of high pension tax liability	Executive paper to be developed by the end of August outlining any areas of risk.
	Junior doctors prospective leave cover is under review following the publication of a HSJ article	Paper presented to Executives regarding prospective leave cover and relevant rotas now amended.
		In terms of retention, considerable on-going work around trainee engagement (greater visibility of the Chief Registrar, Junior Doctor Body, Clinical Leadership Fellowships, routine unannounced ward visits to engage with trainees, and more), Rest facilities improved at the SJUH site, and being reviewed at LGI.
Consistent job planning and annual leave management to ensure most effective utilisation of existing medical workforce	Some variation in job planning with regards to balance of direct clinical care (DCC) and supporting professional activities (SPA)	Move to electronic job planning, 50% consultants on this and allows greater transparency and consistency. Job planning steering group
	Lack of knowledge of demand meaning services cannot plan workforce needs effectively	Training being delivered in team job planning and mapping of capacity and demand, with expectation that this will become the norm for

		departments
	Annual leave for consultants is not always transparent, with potential for taking above entitlement	Work being done to look at areas where leave management needs improvement. Move to e-rostering.
	Deepdive curently underway to look at Rolled up Annual leave following legal challenges in some other Trusts.	Paper on rolled up annual leave to be taken to Executives in December 2023.
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 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.	Concerns over staffing levels in audiology esp. paediatric audiology. Raised with clinical effectiveness and outcomes group. Still pressures from AQP competition, 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	Local audit and external audit completed, and no errors issues identified but national review of paediatric audiology following Lothian review. Using February for setting staffing levels is not the best time as levels are well below the annual level at this time. Better to use the level in September otherwise this introduces another pressure into the workforce. To be discussed within RMG Working with HEE etc for more training across all areas. Apprentice scheme highly successful for engineering, although lag due to training period.

	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	Unknown at present as impact still evolving
	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.	
	Hyper specialist services with half of the 52 specialisms with only 5 or less staff creating sustainability risk.	
GENERAL WORKFORCE ISSUES – Director of HR and OD		
Each CSU has a workforce plan All CSU Workforce plans have a focus on Retention with Clear action plans		
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 Weekly HRBP huddle with Centres of Excellence and Director of HR to discuss workforce issues		
The organisation has a Structured Approach to Winter Planning where annual leave is mapped together with projected absence against available staffing		
The organisation has a structured approach to managing the risk of staff retiring early due to risk of high pension tax	There is a need to understand the implications for all staff groups and liaise	Corporate task and finish group has been established to identify the potential impact.

liability	with CSUs to develop plans.	Guidance under development draft expected for early December 2023.
There is a 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 Task and Finish group developed to develop both the Exit interview process and also to develop a stay interview. Pilot Exit form introduced with Review in December 2023.
Optimal Attendance Management project established with project plan. Further detailis contained within CRR04. Regular review of absence management data with Tri team / HRBPs / Operational HR /CSUs with actions agreed.		
Roster management tools in place to support staff groups. New Roster metrics developed and these are reviewed through HONS meetings and also through RMG	Roster management not embedded consistently across the organisation	Work remains going as part of the recent Internal Audit to support CSUs with effective Roster management. A review is also ongoing to consider the ROI of this work.
Continued focused recruitment to professional staff groups and support roles with development of new roles to support workforce: • Apprentice programme • Advanced Practitioners • Physician Assistants • Volunteer programme	New role with limited evidence base on patient outcomes. PAs not yet regulated	Adherence to best practice and safer staffing guidance. Nursing Associate deployment reference group commenced to support governance and assurance of new role. It has been agreed that the GMC will regulate. Deputy DME overseeing PA undergraduate placement program at LTHT. Future You programme implemented to create workforce plan, recruitment and retention strategy for the Nursing Associate role. Progress reviewed through NMAWG and RMG.
Use of temporary workforce (bank and agency), including specialist agencies to provide observation, supervision and	Ability to respond to increase in demand as part of operational pressures and	Monitoring of staffing requirements through daily staffing meeting.

safe care to patients	winter planning.	
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.
A gap analysis has been undertaken against the National long term workforce plan.	Clear action plans to be developed by both RMG and LETC	WFC Forward plan to be amended to ensure that updates are presented.
Retention is one of this year's annual commitments and a Project plan is in place and progress reported though Staff Engagement Group Staff survey results monitored and actions cascaded through Staff Engagement Group. Vacancy control panels now operating in all CSUs with oversight of CSU vacancy trackers through Trust Expenditure Review Group (TERG)	Clear communication received from NHSE of the need to reduce Non Clinical Agency staff	TERG now reviewing all existing nonclinical agency staff and processes under development to capture existing agency and any new agency staff members.
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.	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 this is currently in the pilot phase Focus on 'growing our own' through in-house courses and apprenticeships. Development of new roles and alternative workforce models. Use learning from Exit Interviews to improve retention. Working with WYAAT on attraction, recruitment and retention. Raising our advertising profile - using INDEED for some roles. Capitalising on social media campaigns linked to Saving Lives in Leeds Documentary.

		Reviewing entry requirements for some roles.
ADMINISTRATION PROFESSIONAL, NON-REGISTERED AFC STAFF - DIRECTOR OF HR AND OD		

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

Risk Description:	
There is a risk that the Trust may have to invoke its Emergency Response Arrangements due to a viral pandemic (e.g. influenza or COVID-19) causing the absence of significant numbers of Trust staff and large increase in demand which could overwhelm the Trust's ability to deliver routine care and result in potential fatalities and significant financial loss. There is a risk of Trust services being overwhelmed (either in part or as a whole) caused by a viral pandemic resulting in significant staff absence and large numbers of casualties/fatalities leading to significant performance and financial impacts.	**Executive Lead:** Chief Operating Officer
	Date added to CRR: May 2018 **Last reviewed:** October 2023 **Next Review:** April 2024
	Committee reviewed at: Emergency Preparedness

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 consultation has concluded and a live version has been circulated.	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)		Reviewed as part of pandemic plan consultation.

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 in relation to any future pandemic.

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			
			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 power failure at a Trust site (ward or clinical area) Due to failure to comply with HTM 06 01 caused by outdated electrical infrastructure and the absence of complete IPS/UPS resilience in Clinical Category Grade A : Life support/complex surgery (Risk to patient due to loss of supply) or Grade 1 : Medical support services (Risk to business continuity due to loss of supply) locations May result in a poor patient experience; a failure to protect patients or staff from serious harm or fatality; loss of stakeholder confidence; and/or a material breach of CQC conditions of registration or HSE prosecution	**Executive Lead:** Director of Estates & Facilities
	Date added to CRR: August 2015 **Last Reviewed:** January 2024 **Next Review:** July 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 specifically identified in 5-year capital plan; if specific theatre risk items are identified they would need to be prioritised from our backlog investment profile.
Complete assessment of telephony switchboard resilience in terms of UPS protection and autonomy (up to 4 hours)	Not all Information Technology systems are supported by UPS with the required autonomy to maintain a service upon loss of supplies.	

Estates Handbook updated for emergency plans with detailed processes and regular review.	This handbook provides the Estates on-call team with information of what can be done when power interruptions occur but does not assist with the shortcomings of the installed systems.	The handbook is reviewed annually.
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.	The Electrical Safety Group has updated/ approved the UPS/ IPS live compliance tracker for each site which will inform the Capital investment prioritisation list, following engagement with an independent Electrical Engineering Consultant (technical audit assessment/ report, for the Medical Location Risk Grading accordance with HTM 06-01 clinical risk grading & BS 7671 Section 710 group locations). This 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. This will formalise the E&F risk management

		process to assess the susceptibility to risk from total (or partial) loss of the electrical supply with the consequence of a power failure assessed and graded against a wide range of departments with complex requirements and potential risks. 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.
A UPS/IPS infrastructure was installed to support Geoffrey Giles Theatres 1 to 8 and Recovery in 2017. Theatres 1-8 connected to the system in 2020/21. Theatre 9 connected to the system in 2023/24. Recovery is scheduled to be connected in Q4 2023/24 or Q1 2024/25 depending on access.	Although the UPS/IPS infrastructure has been installed (£600,000) to support Geoffrey Giles Theatres 1 to ~~8~~9 and Recovery the final connection and rewiring of Recovery is still required.	Capital investment is required to connect the available IPS/UPS infrastructure Recovery in Geoffrey Giles Theatres. In the 23/24 plan, meetings to agree access being held.
Some areas (e.g., J54) are fitted with the required UPS provision but not fitted with Isolated Power Supplies (IPS).	Several clinical category Grade A areas are not fitted with IPS as required by HTM 06-01 to safeguard the patient from the risk of electric shock and provide increased local electrical resilience.	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.
UPS/IPS systems have been installed in a number of clinical category A locations including those detailed above in Geoffrey Giles (theatres 1-~~8~~9); Cath Labs 1, 4, 5 & 6; LGI - 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	There are still a number of Clinical category A areas without UPS/IPS systems.	£200K in programme for UPS/IPS installs in years 24/25 and 25/26, the priority order has been reviewed by the Electrical Safety Group. A further £10m is allocated to electrical backlog priorities from 25/26 to 28/29, from which the mitigation of this risk is a top priority.

2021. IPS was installed in J1 (Neonates SJUH) in 21/22.		UPS has been installed to J54 on the central system, phasing option/s for IPS connections under review, with a view to completing in 2023/24 (subject to access).

CRRO13: Brotherton Wing, Blocks 11, 12 and 32 physical condition	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/ Current Score	

Risk Description:	Executive Lead: Director of Estates & Facilities
• There is a risk of Brotherton Wing becoming unsafe for occupying patients, staff and visitors. • Due to a failed roof covering, deteriorating building fabric and aged engineering services (impacting statutory compliance requirements). • Resulting in a risk to patient safety and quality of care, poor working environment for LTHT staff and a negative impact on LTHT reputation from patients, staff and visitors.	**Date added to CRR:** Jan 2024 **Last reviewed:** Jan 2024 **Next Review:** July 2024
	Committee reviewed at: Finance & Performance Committee

Controls	Gaps in Control	Further Mitigating Actions
Estates Staff working to control flow of water by collecting in receptacles.	Water is being managed once within the building structure, due to total failure of Block 11 roof covering, cannot capture/ control all flowing water.	Receptacles sited at known spots for flowing water, daily monitoring of collection spots by shift team.
Isolated electrical final circuits and covered electrical infrastructure items with water proof membrane.	Cannot isolate all electrical circuits due to supplies into occupied areas and circuits for life safety infrastructure such as fire alarm and emergency lighting.	Working to isolate as many final circuits as possible. Including working with Trust Asbestos team to remove Asbestos flash guards contained within fuses. Project plan to segregate supplies to occupied/ non-occupied areas for continuity/ resilience of supply.
Trust Building Team working to replace failed suspended ceilings in clinical areas where patient care and access to WC availability has been restricted.	As no control of flow of water there is no guarantee that the ceilings will not collapse again.	Attempts to divert flow in unoccupied areas above via drain/pumping system and sealing gaps in penetrations.
Capital Scheme in progress to produce design for removing F Floor extension and install new roof covering.	Currently only at design phase, no timescale for completion and funding of c.£7 million required.	Controls 1-3 will continue until roof covering is replaced.
Fire risk assessments and electrical fixed wire testing undertaken (statutory compliance).	Risk evolving due to external weather conditions, impact building deterioration	Actions identified from statutory assessments will be addressed/ escalated.

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			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
	L = 4								Target Score					Current Score	Initial Score	

Risk Description:	**Executive Lead:** Chief Nurse
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.	**Date Added to CRR:** July 2019 **Last Reviewed:** December 2023 **Next Review:** June 2024
	Committee reviewed at: LTHT MHLSG Workforce Committee

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
Violence Prevention and Reduction Group established – • VPR strategy agreed and in place • Board approved Violence and Aggression Policy	Conflict resolution training – • relatively low uptake at ward level • currently remains 'priority' rather than mandatory • Training needs Analysis requires review	VPR co-ordinator now in post. Post holder has a wide remit relating to violence and agression reduction is already dribving the Strategy by: • Assisting in delivering and commissioning training to staff, volunteers and other stakeholders as required.

	• Incidents continue to increase	• developing the Public Health Model for Violence Prevention and Reduction • Leading programmes of work and projects within the Trust and wider community of stakeholders • Providing expert advice to front line staff and senior • Leading on new initiatives and sharing good practice locally, regionally and nationally • Project and Action plan in place Q3 2023
Restraint and Restrictive Intervention Policy includes detailed practical guidance on prevention strategies and de-escalation strategies and meets Restraint reduction Standards 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 data shows increase in staff knowledge but a reduction in practice standards from the previous year Proposed new Elsivier 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 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 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	In reach support from MCA/MHA Team to continue. Agreed pilot of Elsevier restraint digital care plans during Q4 2023/24 and to continue use of LTHT bespoke Restraint care bundle for patients who lack mental capacity to consent to ensure compliance with duties under MCA and DoLs safeguards

	restriction/restraint not being used and monitored; also potential risk of disproportionate restraint/restriction being used without monitoring	
Enhanced Care Procedure in place	Wards report that they struggle to fill 1:1 enhanced care shifts frequently. Gaps identified in the skill mix for enhanced care provision	Enhanced Care Task and Finish Group work streams: documentation, risk Assessment, workforce, name change, Comms. All monitored through Action tracker- target completion Q4 this year • CSW vacancy gap significantly closed forecast showing <150 WTE by October 23 • Clinical Educator in post to design and deliver Band 3 Senior CSW development programme – will cover enhanced care, de-escalation, mental health awareness, therapeutic interventions • Band 2/3 work stream on target with CSU recruitment underway for 600 posts uplifted from Band 2 to 3.
24/7 service provision from Liaison Psychiatry service now meeting PLAN standards and Acute Liaison Psychiatry service 1 hour response in ED implemented	ALPS service currently only partially co-located on hospital site impact on one hour response time WTE1.0 RMN post in Urgent care – post holder left and failed to recruit to post	Consultant Psychiatrist now whole time equivalent in ALPS service Capital bid successful for - Improving the Experience of Mental Health Patients Presenting to Leeds Urgent and Emergency Care Services, including secure space at both EDs for high risk MH assessment at PLAN (Psychiatric liaison accreditation network) standard Recruited to secondment in UC – RGN with focus on MH education
De-escalation QI collaborative- supporting staff to support		Increased oversight of monitoring data from De-

patients who may present with clinically related challenging behaviours. 12 high volume areas involved in QI with support from expert faculty members. A range of interventions being tested across collaborative areas; set of KPIs / measures being tracked monthly to evidence progress. 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.	Level 1 e-learning still not live Variation of training across the organisation - leading to potential gaps in knowledge/inconsistency of application CPD funding from 22/23 for 8B MH co-ordination post – not recruited to. Financial resource transferred in Clinical education co-ordinator role for CSW project Mental Health training not consistent across medical and nursing staff or linked to a training needs analysis (TNA)	escalation Collaborative and Violence and aggression Steering Group.
CAMHS Crisis team has been operational from the beginning of 2020 the service offers - 7 day week 08.00-00.00	CAMHS not co-located in hospital and less robustly embedded into LTHT governance - leading to some variation in accessing timely psychiatric support for patients aged 0-18. CAMHS inreach crisis team – 1 of 2 nursing posts remain vacant Nationally and regionally, there has	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. Funding secured from the NHSE the CYP Mental Health and CYP Transformation Programme for Children Hospital MH Champion role in LTHT – JD with AfC for final review and expected recruitment during Q3 2023. This will be a Band 7 Post with an educational & support portfolio to work directly with our Children's wards CAMHS representatives now identified for strategic / operational governance meetings. Medical and Consultant Psychiatry enhanced support agreed for CAMHS patients who remain

	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.	inpatient for more than 6 days. Write access to PPM+ now escalated to Associate Director of Digital / DIT team for resolution
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	Business Case was presented to Execs and substantive funding for revised structure of team agreed – recruitment in progress with plan for all positions to be recruited for April 2024.

CRRO4: Staff absence Health, Safety and Wellbeing	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:	Executive Lead: Director of Human Resources
There is a risk that staff are less effective at work or absent from the workplace due to high levels of burnout and or sickness absence which will impact on operational delivery, financial sustainability and staff engagement. Our latest staff survey data (Nov 2023) tells us that 68% of staff who completed the survey report that they feel burnt out because of work, which can lead to lowered staff resilience and presentism.	Date added to CRR: June 2020 Removed from CRR: July 2022 Last reviewed: December 2023 Next Review: March 2024
	Committee reviewed at: Workforce Committee 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
Health and Wellbeing Strategy including core metrics in place to ensure robust governance of health and wellbeing activity across the Trust.		
Health and Wellbeing Committee and working group in place to assure progress against the organisational health and wellbeing strategy and core metrics.		
Supporting Attendance Policy and 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.	Differential application of the Supporting Attend ance policy across CSUs.	Leader standard work is now in place in most CSUs. The policy is under review to ensure practice that has been developed through the optimal attendance project is reflected in the policy.
	Unclear management arrangements for Junior Doctors due to their short-term	A template process for managing Junior Doctor sickness absence in large CSUs has

	employment leading to lack of proactive sickness management for this group.	been developed and piloted in one CSU and is being rolled out to other large CSUs. Smaller CSUs have a different process and a revised template process is being developed with one of these CSUs.
Support for managers to enable them to compassionately and consistently manage sickness absence, work related stress and presenteeism including: HR training on application of HR policies Health and wellbeing training for managers Leading Leeds way toolkit Support from HR Operational team, Occupational Health and HWB team.	Line manager capability and capacity to apply the Supporting Attendance policy and wellbeing conversations.	Enhanced support for managers from HR Operational team, Occupational Health and HWB team. Scheduled review of Supporting Attendance policy and guidance to improve the information available for managers.
	Line manager capacity to undertake good people management practice including 1 to 1s and wellbeing conversations in a supportive and compassionate way with their staff.	Scheduled review of stress risk assessment process and guidance underway to improve the information available for managers.
Monthly review of absence management data with Tri team /Heads of Departments / HRBPs / Operational HR / CSUs and Corporate areas with actions agreed.		
Range of initiatives to support staff to manage their HWB, including MHFA, Money Buddies, Chaplaincy, clinical psychology supported by a proactive communications plan. The usage is reviewed through HWB Committee who identify gaps and appropriate new interventions.	Some concerns with current EAP provider regarding access to planned counselling for staff requiring support.	New provider in place from 1 April 2024.
	The internal staff clinical psychology team have identified that most support services are reactive, providing interventions to address established issues. A gap in provision of therapeutic preventative work	Work underway to recruit an additional psychologist post to support corporate teams and high need individuals, anticipated start date April 2024.

	has therefore been identified, with limited organisational resources to address this.	Work on going to develop a Post Incident Support Pathway. Continue to undertake work to address cultural issues to prevent poor mental health, including increased awareness and peer support.
Occupational Health provide advice to managers on fitness to work and reasonable adjustments to support managers in effectively managing sickness absence.	Ongoing capacity issues in Occupational Health leading to a reduction in appointments.	Recruitment to vacant posts. Working with CSUs to address referral issues. Continue LIM work on triage process to increase volume of referrals which receive early intervention to enable local prompt action.
	Inadequate OH IT system not supported by supplier resulting in loss of clinical notes.	Work with DIT to procure new system.
	OH must vacate space at Brotherton Wing in November 2024.	Plans agreed with Capital Planning, subject to funding, confirmation May 2024.
Organisational immunisation programme, including on-employment vaccination and Winter vaccinations are available.	Vaccination numbers for both flu and covid are lower than in previous years but in line with the national uptake.	A roving vaccinator model is being utilised on request, to vaccinate staff in their place of work in order to increase uptake.
	OH system does not speak to ESR preventing identification of accurate records of staff vaccination at an organisational level.	Review of organisational immunisation programme to complete September 2024. Work with DIT to procure new OH system.
Suicide Prevention strategy has been updated and a post-vention guidance in place to Managers and Staff affected.		

Stress Risk assessment process in place to support management of work-related stress.	Consistent identification of teams or individuals or teams who are at risk of or experiencing work related stress. Line manager capability and capacity to apply the stress risk assessment process.	Scheduled review of stress risk assessment process and guidance underway to improve the process, including a focus on identification of teams or individuals at risk of work related stress.
Moving and handling policy in place to ensure adequate training of staff to prevent MSK related sickness absence.	Do not currently have assurance that up to date and appropriate moving handling training and competency assessment to prevent Musculo-Skeletal related absence is being undertaken across the organisation.	Review of moving and handling training underway to establish legislative and organisational requirements and develop long term solution.

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:

There is a risk that the Hospitals of the Future Project fails to deliver its objectives as a result of:
- the NHP's proposed capital funding range and/or the Hospital 2.0 Model not being sufficient to deliver all of the Trust's stated requirements;
- on-going delays relating to a current lack of clarity from the New Hospital Programme (NHP) on the forward process, timescales, technical scope, budget assumptions and solutions;
- on-going delays due to NHP's requirement for the Trust to resubmit its Strategic Outline Case (SOC) in a new template and submit a revised Outline Business Case (OBC) to align with the design and construction requirements of 'the Hospital 2.0 Model' (which remains to be fully published by NHP and a national procurement approach still be defined;
- increases in costs resulting from programme delays, general inflation and increases in the costs of construction relating to raw materials, resource availability, and energy; and
- potential stand-down/re-allocation of the Design Team and loss of BtLW Programme Team members (as a result of the on-going delays).

If the project is not delivered, the Trust will:
- not be able to deliver the Trust's stated objectives for, and the scheme's anticipated benefits from, the new healthcare facilities;
- need to significantly revise its planned investment in the form of a re-design, a reduction in scope and/or the retention of retained estate;
- be unable to transform its clinical services as desired, including meeting recommendations from the statutory public consultation and commissioner requirements relating to the centralisation of maternity and neonatal services on one site;
- have to manage potential increases in transfers between sites, short notice reductions in service provision, and difficulties in covering staff rotas and changes in protocols to mitigate risks;
- not have sufficient capacity to meet service demand in required timescales;
- be unable to deliver efficiency improvements in a number of areas, including estates utilisation;
- have to address high and growing levels of backlog maintenance which present a risk to the Trust's ability to

Executive Lead: Director of Finance

Date Added to CRR: May 2020
Last reviewed: November 2023
Next Review: May 2024

Committee reviewed at:
Building Development Committee, 12 October 2023
BtLW Programme Board, 9 October 2023
HofF Project Board, 25 September 2023

maintain service delivery and wider capital budgets;
- be unable to deliver its vision to develop and establish the Innovation Village; and
- suffer reputational damage.

Controls	Gaps in Control	Further Mitigating Actions
Programme Delays Continued regular liaison between the SRO/Programme Director and NHP to understand progress relating to the NHP programme delivery, phasing, design standards, Hospital 2.0 Model, 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. 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 Trust Chair and Chief Executive. The Programme Director remains involved in networking with other Trusts in the NHP on a regular basis to understand shared/common and individual issues/scheme implications.	Lack of clarity from, and influence on, NHP on the forward process, timescales, technical scope, design standards, budget assumptions and solutions for closing the forecast funding gap. The SOC and OBC will both need to be resubmitted aligned to new templates and NHP design and funding assumptions. Lack of clarity surrounding procurement and delivery strategies.	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, Hospital 2.0 Model, funding and procurement strategy. The Communications Team to continue to liaise with the Trust Board and BDC around further communications, events and visits targeted at delivering a successful outcome. The BtLW Programme Team to continue to develop mitigations and associated communication plans in the event that the Trust's 'Preferred Way Forward' is not approved. Programme Director and BtLW Programme Team to continue to work with the NHP to support and influence the design and development of the Hospital 2.0 Model. BtLW Programme Team to continue to push forwards on designing the development of its proposals including undertaking informal market-engagement where appropriate to inform the design solution.
Funding and Cost Increases The Trust received assurance from the NHP SRO that its proposals could be delivered within the NHP funding allocation through the application of the	Written clarity surrounding the local funding contribution to be provided and NHP solutions for the delivery of the Trust's proposals within the	SRO and Programme Director to continue to undertake on-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.

Hospital 2.0 Model.

Continued regular liaison between the SRO/Programme Director and NHP to understand progress relating to the NHP programme delivery, phasing, design standards, Hospital 2.0 Model 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 is invited to attend BtLW Programme Board.

The BtLW Finance Workstream continues to support delivery through maintaining links to the Trust's wider financial management processes and consider the implications across the Trust as well as supporting the management of financial implications and risks, ensuring that integrated financial plans are in place and that performance against the Long-Term Financial Plan and Government guidance is monitored.

The BtLW Programme Team has established processes to support the identification of value-engineering and cost mitigation strategies for assessment and implementation as necessary as the project is progressed.

Robust change management/control processes established and implemented to monitor for design and cost variance against the submitted OBC.

Regular monthly updates are provided to the HofF Project Board, BtLW Programme Board and Building

gross/net funding allocation.

The SOC and OBC will both need to be resubmitted aligned to new templates and NHP design and funding assumptions.

Leeds Hospitals Charity previously agreed £30m fundraising target being adversely impacted by inflation.

External advisers to provide regular updates on known and forecast key policy/design standard changes.

Finance Workstream to review and update LTFM twice-yearly to capture any financial changes (and identify risks) in costs/income/inflation.

BtLW Equipment Team to refine equipment requirements as the project progresses in consultation with Trust clinical and non-clinical leads and update forecast costs. Capital Planning Group to monitor progress surrounding the approved £18m Transfer equipment replacement.

The BtLW Workforce Workstream and Deputy Chief Executive/Director of Estates are co-ordinating discussions with key CSUs to support the on-going development of workforce requirements ensuring they continue to be developed appropriately and are aligned with ways of working and workspaces to be implemented within the new healthcare facilities as well as meeting affordability and workforce planning requirements for the Full Business Case.

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 the £30m.

Programme Director and BtLW Programme Team to continue to work with the NHP to support and influence the design and development of the Hospital 2.0 Model.

BtLW Programme Team to continue to push forwards on

Development Committee on funding and affordability issues including quarterly inflation updates. Inflationary updates are reported to the NHP as part of the monthly Programme Director's report. The BtLW Programme Team has established a risk/contingency allowance based upon a quantified risk assessment which has informed the Outline Business Case. This is supported by a robust change control process managed by the BtLW Programme Team with approvals and further assurance by the HofF Project Board, BtLW Programme Board and Building Development Committee. Key market inflation updates are reported to the HofF Project Board, BtLW Programme Board and Building Development Committee on a quarterly basis. Financial due diligence reports are completed on key contractors prior to their recommendation of appointment. There are robust controls in place to manage supplier contracts. Business cases are reviewed by NHSE, DHSC, and HMT at each stage to ensure compliance with guidance and to provide further on-going assurance. The Charities Workstream supports work to deliver the charitable funding target of £30m towards equipment with bi-monthly reporting presented by the Programme Director to the Capital Appeal Board about progress to deliver the Project.		designing the development of its proposals including undertaking informal market-engagement where appropriate to inform the design solution.
Specification, design and quality The NHP requirements and the Trust's Design Brief/design requirements are seeking to deliver a	Lack of clarity from NHP on the forward process, timescales, technical scope, design standards and budget	SRO and Programme Director to continue liaison with key members of the NHP Team on need for clarity and

robust, flexible and agile design solution within the constraints of affordability and build upon lessons learned including the recent COVID-19 experience.

Significant clinical engagement completed by the BtLW Programme Team in the development of design briefing documentation and the design solution. Design proposals approved by CSUs.

Robust change management/control processes established and implemented to monitor for design and cost variance against the OBC.

A comprehensive governance structure implemented to oversee and manage the co-ordination and delivery of the design development process.

Regular dialogue between SRO and Programme Director and key members of the NHP Team around the need for clarity and guidance on standards regarding single rooms, room sizes, structural grids, net zero and digital requirements. | assumptions relating to Hospital 2.0. | guidance on standards.

Programme Director and BtLW Programme Team to continue to work with the NHP to support and influence the design and development of the Hospital 2.0 Model.

BtLW Programme Team to continue to push forwards on designing the development of its proposals including undertaking informal market-engagement where appropriate to inform the design solution. |
| **Assurance**

The Trust has implemented a robust programme assurance framework for the delivery of the BtLW Programme and the Hospitals of the Future Project with internal management controls and delivery assurance supported through independent assurance provided by the Building Development Committee (and other Committees, Boards and Groups in the governance structure) and a programme of assurance activities undertaken by PwC as the Trust's auditors.

The BtLW Programme Team has regular discussions with NHS regulators, technical, financial and legal | A review of supplier assurance processes and procedures/quality plans in connection with the delivery of contracts. | BtLW Programme Team to continue to review and respond to recommendations made through the independent PwC assurance review process (on-going).

BtLW Programme Team to monitor services and works delivered by specialist/professional advisers in terms of the quality of deliverables through established project delivery arrangements.

Continue to evolve and develop local processes and assurance controls on an annual basis as part of the PEP review process. |

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.		
Stakeholder Engagement The BtLW Programme Team has established a programme-level Communications and Stakeholder Engagement Plan, supported by a specific plan to support the delivery of the Hospitals of the Future Project aligned to project and workstream delivery plans. The BtLW Programme Team has developed a Stakeholder Management Database which captures key stakeholder information and the status of engagement in supporting effective reporting. Monthly reporting of communications activities are presented at the Hospitals of the Future Project Board, the BtLW Programme Board and the Building Development Committee. A quarterly report on Stakeholder Engagement is presented to the Hospitals of the Future Project Board, BtLW Programme Board and Building Development Committee. A six-monthly BtLW Staff Surveys is completed alongside a Staff Temperature Check in-between each key six monthly survey.		

The BtLW Programme maintains information updates on the Trust's website and internal intranet including the presentation of the latest information on developments.		

CRRO8: Risk of failure to deliver the pathology project.	C = 4	12	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 & Current Score		

Risk Description:

There is a risk that the Pathology Project fails to deliver its objectives as a result of:
- delays in developing and implementing effective workforce and associated change management plans;
- delays to the implementation and delivery of associated CSU Projects, the Pathology Managed Services Contract (MSC) and new Laboratory Information Management System (LIMS) affecting the overall critical path for operationalising the new facilities.

If the project is not delivered, the Trust will:
- not deliver the benefits specified within the Full Business Case (FBC) for the New Pathology Lab at the SJUH site and the AHL at the LGI site;
- be unable to transfer all identified Pathology services into the NPL and the AHL following their commissioning;
- be unable to transform and improve the quality of its services for patients;
- not improve the Service's efficiency in line with the Naylor Report by developing affordable estates and infrastructure and reducing backlog maintenance;
- not improve recruitment and retention and attract a high-quality workforce with the right skills; and
- not contribute effectively to the implementation of the WYAAT Network Pathology Strategy.

Executive Lead: Director of Finance

Date Added to CRR: May 2020
Last reviewed: November 2023
Next Review: May 2024

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 management of financial implications and risks, ensuring that integrated financial plans are in place and that performance against the Long-Term Financial Plan is monitored. Financial risks and issues are reviewed and managed	Capital contingencies to support the management of any impact resulting from delivery issues associated with non-BtLW projects (e.g. MSC) and those risks highlighted as excluded within the approved FBCs.	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 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.

within workstreams at a project delivery level with regular monthly updates provided to the Pathology Project Board, BtLW Programme Board and Building Development Committee.

Full Business Case for the new Pathology Lab was reviewed and approved by NHSE and DHSC in February 2022 with approval provided to address the £8 million funding shortfall via NHP funding.

Full Business Case for the new AHL was reviewed and approved by the Building Development Committee in July 2022.

Robust change management/control processes established and implemented to monitor for design and cost variance against the FBC for the NPL and the AHL.

Regular monthly cost monitoring of scheme capital costs.

The BtLW Programme Team has established processes to support the identification of value-engineering and cost mitigation strategies for assessment and implementation as necessary as the project is progressed.

The BtLW Programme Team has established risk/contingency allowances within the FBC which was based upon a set of stated affordability assumptions as approved by the Trust Board. This is supported by a robust change control process managed by the BtLW Programme Team with approvals and further assurance provided by the Pathology Project Board,

BtLW Programme Board and Building Development Committee. Regular monthly updates are provided to the Pathology Project Board, BtLW Programme Board and Building Development Committee on funding and affordability issues including quarterly inflation updates. Mitigation plans identified to address impact of significant increases to inflation and project costs to deliver the NPL and the AHL.		
Managed Services Contract (MSC) Delays* Programme plan for MSC re-procurement established and mapped to New Pathology/AHL projects. Progress monitoring of the MSC Project is reported to the Pathology Project Board, BtLW Programme Board and BDC in addition to separate governance arrangements for the MSC Project linked with WYAAT. A Pathology Change Management and Dependency Working Group (PCMDWG) has been established to support the mapping and co-ordination of critical path dependencies relating to the MSC, LIMS and CSU projects and reporting to Pathology Project Board, BtLW Programme Board and BDC. Managed Service Contract awarded to Siemens, subject to contract negotiations, following withdrawal of legal challenge by unsuccessful bidder and implementation process commenced.	Knowledge of the new equipment supplier and equipment specifications to further inform the NPL and the AHL operationalisation planning and to support the completion of the works.	The unsuccessful MSC Bidder has now withdrawn their formal legal challenge. The FBC for the MSC Project has been approved by the three Trust's and the contract is planned to be signed in August. Trusts have approved the decision to award the managed service contract to Siemens and approval to sign the contract Siemens have held a technical solution walk through with LTHT Pathology Operational Teams. Siemens to commence work to plan, design and agree new equipment. The team are exploring opportunities to bring non-MSC dependent services into the new building in line with previously planned timescales, as a contingency.
WYAAT LIMS Deployment Project* A regional deployment plan for LIMS has been		

developed with LTHT-specific implementation plan in place for completion by April 2024. LIMS Project Board for Leeds facilities in place from January 2022 and meeting monthly to complement the regional WYAAT Pathology Implementation Board. Progress monitoring of the LIMS Project is reported to the Pathology Project Board, BtLW Programme Board and Building Development Committee in addition to separate governance arrangements to support the delivery of the LIMS Project linked with WYAAT. A Pathology Change Management and Dependency Working Group (PCMDWG) has been established to support the mapping and co-ordination of critical path dependencies relating to the MSC, LIMS and CSU projects and reporting to Pathology Project Board, BtLW Programme Board and BDC.		
Pathology CSU Projects The Pathology CSU is responsible for the delivery of several projects/change initiatives necessary to support the operationalisation of the new Labs and linked to the transformation of Pathology services at LTHT. These need to be aligned with the BtLW-led projects. The BtLW Programme Team are providing co-ordination and oversight support to the CSU in delivery of these projects and the management of dependencies which may impact operationalisation of the new facilities. A Pathology Change Management and Dependency Working Group (PCMDWG) has been established to support the mapping and co-ordination of critical path		

dependencies relating to the MSC, LIMS and CSU projects and reporting to Pathology Project Board, BtLW Programme Board and BDC.		
Cost Price Inflation Processes in place to continue to monitor inflationary changes and the impact on the new SJUH and AHL Works Contracts. Key market updates on economic factors are reported to the Project Board, BtLW Programme Board and Building Development Committee on a quarterly basis. Financial due diligence reports are completed on key contractors prior to their recommendation of appointment.	None	No further actions required.
Assurance The Trust has implemented a robust programme assurance framework for the delivery of the BtLW Programme and the Pathology Project with internal management controls and management assurance supported through independent assurance provided by the Building Development Committee (and other Committees, Boards and Groups in the governance structure) and a programme of assurance activities undertaken by PwC as the Trust's auditors. The Programme Team has regular discussions with NHS regulators, legal, technical and financial advisors and partners on procurement strategies and the development of business cases for the Project and subsets of the Project (on-going). Reviews are undertaken by NHSE, DHSC, and HMT at	Full implementation of local assurance controls, measures and processes through the BtLW PMO. Undertake a review of supplier assurance processes and procedures/quality plans in connection with the delivery of contracts.	BtLW Programme Team to review and respond to PwC assurance reviews and recommendations (on-going). BtLW Programme Team to monitor services and works delivered by specialist/professional advisers in terms of the quality of deliverables through established project delivery arrangements.

each key business case stage to ensure compliance with guidance and to provide further on-going assurance.		

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

CRRO9: Risk of failure to deliver the LGI Site Development Project	C = 4	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			Initial & Current score		

Risk Description:

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

- the NHP's proposed capital funding range and/or the Hospital 2.0 Model not being sufficient to deliver all of the Trust's stated requirements;
- on-going delays relating to a current lack of clarity from the New Hospital Programme (NHP) on the forward process, timescales, technical scope, budget assumptions and solutions resulting in delays to delivery of phase 2 of the LGI Development site;
- a failure by the Trust to reach agreement with LCC to address the future of the A58M Inner Ring Road tunnel which will allow Clarendon Wing to be developed as part of Phase 2 of the LGI Development Site project;
- uncertainty regarding the date that the developer can commence works as part of phase 1 of the LGI Development Site project due to: unclear timescales for the vacation of the Old Medical School by Pathology services; removal of all expected furniture & equipment belonging to the Pathology CSU; utilities disconnected and completion of exterior Jubilee Wing enabling works.

If the project is not delivered, the Trust will:

- continue to incur on-going operational and maintenance costs for buildings, some of which may be surplus to requirements;
- be unable to contribute as expected to the Leeds Innovation Arc;
- be unable to support the city's economic regeneration as expected;
- suffer reputational damage.
- be unable to secure investment zone funding for phase 1 of the LGI Development Site project;
- not realise its aspirations to fully deliver healthcare innovation opportunities and improvements for the West Yorkshire region.

Executive Lead: Director of Finance

Date Added to CRR: May 2020
(Removed from CRR Nov 2020
Re-added back to CRR: November 2021
Last reviewed: November 2023
Next Review: May 2024

Committee reviewed at:
Innovation District Committee, 18 September 2023
BtLW Programme Board, 9 October 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		Given the overlap in discussions at the IDC and R&I committee meetings, a joint committee is in the process being convened.

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 issues, e.g., review of OMS disposal route by legal advisors. LDS Project Team has reviewed and responded to PwC assurance reviews and recommendations incorporated in the OMS OBC. The LDS Project Team has been re-structured to reflect the multiple workstreams required for the disposal of the OMS. The rigour and monitoring of the project has been enhanced by the appointment of a project manager to assist with successful delivery of phase 1 of the project.		
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		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. Leeds City Council with the University and the Trust are working up a proposal to apply for investment zone (IZ) funding which will offer financial support for

part of the Disposal Strategy development and agreement with IDC and Trust Board. IDC has received an update on the deterioration in the market position. An alternative option has been recognised should the preferred option become unviable.		the re-development of the OMS.
Business Case Business cases are being developed aligned to the HMT 5 Case Model. 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 was reviewed by Trust Board in May 2023 and an updated version will also go to Trust Board	.	An updated OMS OBC will be reviewed by Trust Board in September 2023 to further elaborate on preferred disposal option.
Stakeholder Engagement A specific LGI Development Site Project Communications and Stakeholder Engagement plan has been developed which complements the BtLW Programme-level Communications and Engagement Plan. Engagement with Trust staff as well as a range of strategic and supplier-based stakeholders will be undertaken to support the Project (on-going). IDC receives a comms and engagement update at each meeting. The approach to the disposal of the OMS is being shared informally on a regular basis with the NHSE		

national disposals lead. An annual Communications and Engagement Plan has been developed and was approved in March 2023. Formal and informal discussion are ongoing with LCC and Leeds University regarding the Innovation Village. Frequent discussions with potential developers to assess continued interest in the OMS. An improved relationship has been achieved with the Little Woodhouse Community Association.		
Programme Delays BtLW Programme Director is undertaking regular liaison with NHP leads to understand their progress on the business case process. NHP forms a standing agenda item for the Building Development Committee and matters are escalated to the Trust Board as necessary for Chair and Chief Executive action. Progress and timetable issues for HofF and Pathology are discussed at various programme and project boards. The LDS Project Director attends BtLW Programme Board and an LDS representative attends HofF and Pathology project boards. The LDS Project Team has been re-structured to reflect the multiple workstreams required for the disposal of the OMS.		
Site Usage The IDC and Trust Board have agreed a decisive and clear strategy for the use of the OMS with the aim of		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

selecting a developer with the expectation of creating an innovation centre which will deliver the expected economic growth. The LDS Project Team has become a proactive member of other innovation initiatives within the Leeds City area to ensure alignment of objectives. Discussions ongoing with LCC to seek to resolve the A58 Tunnel constraint.		and bring best value. The Trust will influence the uses for the remaining LDS to be complementary to the delivery of HofF. The LDS Project Team will undertake soft market testing with a range of developers to identify ideas for future usage for the remaining LDS. A delivery strategy for Phase 2 of the project is being developed and is planned to be completed by November 2024.

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			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
	L = 5															

Risk Description: The management of this risk is commercially sensitive information which has been removed from the public version of the Corporate Risk Register.	Executive Lead: Chief Digital & Information Officer
	Date added to CRR: May 2022 Last Reviewed: October 2023 Next Review: April 2024
	Committee reviewed at: DIT Committee

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			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
	L = 5															

Risk Description:	Executive Lead: Chief Digital & Information Officer
The management of this risk is commercially sensitive information which has been removed from the public version of the Corporate Risk Register.	Date added to CRR: Jan 2023 Last reviewed: September 2023 Next Review: March 2024
	Committee reviewed at: DIT 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 *Clostridioides difficile* infection, Methicillin Sensitive *staphylococcus aureus* (MSSA)bloodstream infection(BSI), respiratory infections and bloodstream infections caused by multi-resistant organisms due to a reliable and effective management system not being in place to protect patients from infection due to estate constraints, compliance with infection prevention procedures, including hand hygiene, decontamination, environmental cleaning and training. There is a risk of hospital-acquired respiratory infections, including Covid-19 as a consequence of staff not following the guidance consistently.

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

Executive Lead: Chief Nurse

Date added to CRR: March 19
Last reviewed: Nov 2023
Next Review: April 2024

Committee reviewed at:
Quality Assurance Committee
Infection Prevention and Control Sub-Committee

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.	LTHT does not have a process for trust wide surgical site infection surveillance. Recent review of HCAI's in August indicates the requirement to have oversight and monitor SSI in LTHT will provide essential information to support clinical improvements.	Request for work submitted waiting to be prioritised for Impact Assessment with the solution Architects. No further progress to date - for escalation to the Project Prioritisation Group 29 September 2023
ICNET Phase 3 Surgical Module delivery.		
TRS to test proof of concept for the SSI module Q4		
HCAI reports generated weekly and circulated to clinical service units to monitor performance	Medical IPC lead for surgery/anaesthesia not in place and review of HCAI's continues to support the requirement for the role to	Funding for 2PA's to appoint a deputy IPC lead in surgery/anaesthesia is being sorted by DIPC and the interim Medical Director October2023

Covid -19 testing and management incorporated into national respiratory guidance and National Infection Prevention and control manual (NIPCM) External audit of the HCAI performance data processes completed all recommendations adopted.	lead on improving infection prevention in pathways involving surgery and invasive devices.	
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. Current national CPE guidance Implemented within Adults New National Carbapenemase Producing Enterobacteriaceae (CPE) guidance implemented in Leeds Children's hospital Quality Improvement methodology adopted with a Trust wide HCAI collaborative and LIM. LTHT has implemented the National Infection Prevention and Control Manual (NIPCM) for England . National IPC Manual implemented plan re-aligned with HCAI Annual Commitment.		
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.	LGI NNU has experienced recent outbreaks of infection related to practice and environment	Major Outbreak Control Meeting providing oversight and scrutiny of interventions required to bring outbreak under control. Robust action plan implemented including

		programme of education completed, and routine monitoring of compliance is providing assurance. Epidemiology and clinical reviews have identified environmental risks that are significant enough to require refurbishment of NNU ahead of the planned BTLW. Rapid action tender out to scope building work October 2023
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 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.	Rolling programme of whole ward HPV decontamination paused as current decant facility is providing winter bed capacity.	A programme of HPV bay by bay for wards within SIM led by the COO team is underway completion date scheduled for October 2023.
Rolling programme of HPV decontamination commenced in areas where temporary access to vacant areas occurs, the first of these wards in Beckett Wing ,to HPV all other wards in Beckett Wing was completed in August 2023.		
Hierarchy of controls completed by clinical teams which details controls, risks, and mitigations for Covid-19.		
All adult haematology en suite side rooms redesigned 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	Learning from the haematology *Pseudomonas aeruginosa* outbreak has highlighted the need to have active surveillance in all augmented care, and regular multi-disciplinary *Pseudomonas aeruginosa* risk assessments and evaluation of probable water-borne infection in all augmented care units at LTHT.	Review of each immunosuppressed and critical care unit is underway to establish and collate information that will inform local regular assurance checks, environmental improvement and a set of Trust wide safe water hygiene standards Ten reviews completed to date 32 Augmented care areas across LTHT - learning shared across this patient population whilst visits to the remaining areas are delivered September 2023

A multidisciplinary task and finish group has been formed to deliver an assurance programme for the trust based on the learning in haematology.		
IPC involvement in design, refurbishment and new builds.		COO Team leading on utilisation of side rooms through tactical operational response group reviewing in flow oversight of side room usage for infectious patients and clinically appropriate stepdown of side-room need.
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.	Limited side room capacity in the unplanned pathway.	Live PPM side room bed state is in development, planned test phase in October 2023.
Capital planning programme for 2024/25 includes the redevelopment on J42/43. this would increase the number of side rooms within the Trust. Corporate planning review supports increasing side room capacity in Beckett Wing.		
Respiratory patient pathway areas reviewed to understand where further mechanical ventilation or increased side room capacity is required. Four working groups 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.		Working group to review the estate, clinical requirements and ventilation capital investment formed. First meeting held September 8 2023. Risk matrix under development.
A monthly Trust-wide ventilation safety group has been established from September 2021 to provide monitoring,	Large parts of the estate have natural ventilation only.	

oversight and assurance around our current ventilation and enhance the use of new technologies. Options appraisal identified opportunities to provide two Redi-rooms in Becket Wing to provide isolation with inbuilt mechanical ventilation. Portable air scrubbers provided following impact assessment by the clinical team and ventilation group. CSUs have completed 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.		
Antimicrobial Stewardship: Policies and Standards, City Wide Group, Ward Rounds and day 3 IV antimicrobial review.		
Detection: Monthly surveillance monitoring and assurance through monthly Perfect Ward meetings and additional hand hygiene audits and ward assurance visits. IPC Leadership team continued to review the HCAI performance at Trust CSU and ward level. Consultant Microbiologists provided ward and CSU level review and feedback. HCAI assurance monitoring through the Perfect Ward expanded to include all national HCAI objectives by January 2022. IQPR expanded to include all national HCAI objectives by January 2022.		
Recovery and lessons Learned: Outbreak Management.	Feedback of lessons from RCAs to clinicians	The new process for clinical review will be

Incident investigations. City wide Outbreak response group. CSUs manage individual root cause analysis reviews and Outbreak Meetings with support from Consultant Microbiologists, IPCT, Antimicrobial Pharmacists and DIPC/DDIPC. 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. Consultation between Medical IPC Lead, Clinical directors and Medical directors to identify a process that will facilitate Consultants to participate in HCAI Patient Safety Incident reviews has been completed and process for clinical review agreed. Stop the line investigation process instigated for single COVID-19 nosocomial investigations. Revised and strengthened the IPC governance committee structure to enable the Trust to ensure monitoring and oversight occurs and assurance is reported and recorded through the appropriate IPC structure and integrated within the Trust Quality and Safety governance structure.	is variable across LTHT, in some areas learning may not be shared effectively	included in the HCAI PSIRF CSU consultation October 2023 DIPC requested a clinically led thematic review of HCAIs following an increase in cases in August to expedite learning. CSU thematic led review returns September 30 2023. Review by DDIPC and Medical IPC Lead October- learning incorporated into the HCAI Annual Commitment report outs.
Assurance: HCAI assurance is monitored through the Infection Prevention and Control Governance Structure. Latest BAF and Health and Social Care Act 2008: Code of 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.		

Recruitment for Medical AMS lead role completed. Covid-19 assurance is monitored through the Trust OIPC group and IPC governance structure. Board oversight is provided through the Infection Prevention and Control Annual Programme and combined Board Assurance Framework, published by NHSE in May 2020. **Cross-ref: CRR04-** Integration of the IPC Annual programme and new Board Assurance Framework within the reset work streams completed, and CSU's are invited to provide an assessment of their position against the programme at the operational infection prevention and Control Group (OIPC) and HCAI group. **C**ontrol now intergrated into CRR01**,** and workstreams have now moved into transforming services workstream. CSU's presenting assurance to OIPC against the annual programme and BAF. Medical Workforce redesign completed. New Medical IPC Lead role appointed 1 September 2022. Review of current medical leadership to support the Medical IPC Lead completed recommendations adopted in principle. IPCN development plan in place. IPCN vacancy -recognised national shortage of IPCNS- New JD to include AHP approved secondment opportunity in place whilst substantive recruitment underway.	IPCN vacancy -recognised national shortage of IPCNS. Consultant Microbiologist vacancy- not all CSU's have a designated Consultant Microbiologist to support the HCAI reduction strategy	IPCN Interviews in October Pathology CSU Tri Team to describe workforce plan and support required at Operational IPC meeting October 2023 Recruitment to Trust wide IPC Medical AMS post September 2023

CRRC3: Patient harm – falls and hospital acquired pressure ulcers	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					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 2024 **Next Review:** August 2024
	Committee reviewed at: Quality Assurance Committee

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. This will reduce the mixed paper v digital model currently in place. Trial completed in Paediatrics June 2023. Elsevier currently paused in Adults and awaiting further work on paper picnic analysis and prioritisation of top 10 nursing documents for digitisation, which includes falls and pressure ulcers. 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 Control 2 completed 10.1.24	Capacity of Professional Practice Safety Standards team to respond to increased assurance visits due to increased workload.	Falls in-reach reviews undertaken in clinical areas where there is an increase in falls reported (with moderate harm) by CSU staff New Collaborative Ward Healthcheck monthly review meeting, attended by corporate leads to share intelligence and to triangulate patient safety data to better support wards, whilst reducing overall visits from different teams. 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. Medical and nursing reviews commenced 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). Piloted in TRS AMS SIM. Further rolled out across parts of the Trust, PU and falls at different stages of implementation. Process change agreed at QSAG to replace panel with thematic review presentations at relevant steering groups. Aiming to roll out April 2024
Quality Improvement Faculty falls/pressure ulcers Control completed 10.1.24	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.

		Collaborative group to be established to look at enhanced care workstreams including process documentation education and QI work
Specialist support – Tissue Viability Team	Capacity to provide support to all clinical areas.	Quarterly assurance report to QSAG detailing pressure ulcer RCA outcomes and update against the Trusts internal pressure ulcer reduction trajectory
	Increase in patients admitted with existing pressure ulcers	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 them to concentrate on specialist and educational role
		Additional team members recruited to enhance team
		Monthly city wide meeting to discuss relevant cross working and data sharing. Standardised criteria for 'admitted with' pressure damage. Education to ward staff regarding assessment of skin on admission.

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

Risk Description:

Failure to achieve the Constitutional Standard of 95% compliance threshold against the 4-hour Emergency Care Standard and/or the 76% Emergency Care Standard required by March 2024 as referenced in the national annual planning guidance for 2023/24. This failure is caused by increases 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 and patients in the department for longer than 12 hours. Respiratory infections including COVID19 is unpredictable with any certainty. Challenges with inpatient flow continue with discharge to city pathways causing delay for patient who no longer require inpatient hospital care.. Hospital occupancy levels remain above 95% reflecting patient demand.

Executive Lead: Chief Operating Officer

Date Added to CRR May 2014
Last Reviewed: January 2024
Next Review: July 2024

Committee reviewed at:
Finance & Performance Committee

Controls	Gaps in Control	Further Mitigating Actions:
CSM status reports and Patient Flow huddles, 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 bed base 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 surge and the Exceptional Surge Area (ESA) escalation framework is evoked to balance clinical risk for patients across the ED's and inpatient areas. Medical Escalation Policy reviewed by CD's in

		November 2023 to increase medical reviews of patients to support reducing length of stay and increasing discharges.
Daily monitoring and reporting of 4-hour performance Implementation of the new National OPEL with data feed to the RAIDR app for local and regional oversight of key ED pressures.	Timeliness of bed allocation by CSUs to ED Absence of real time electronic bed state and real time bed and patient placement overview.	Focus through the ECS weekly Key Line of Enquiry report on key enablers to timely care and alternatives to admission where appropriate. Tracking of OPEL and "Front Door" ED and ambulance waits using the RAIDR within the operational centre. 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. 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 and is monitored through the CSU service delivery framework. 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 quality meeting. Patients over 24 hours in ED reported on the weekly Executive score card and through NHSE KLOE daily reports
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 developed and reviewed through the system resilience and operational

		Group. All patients awaiting over 24 hours in the ED will be reported on the NHSE KLOE for SCC engagement
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).		Continued monitoring of ED attendance profile and 95% compliance and breach analysis for patients streamed away from ED. New footprint and opening of 24/7 medical and elderly SDEC commenced in December 2023 with KPI to measure additional delivery established. Continue to maximum opportunity for ED streaming from the new SJUH ED front door for self-presenting patients and SDEC pathways for other specialities as alternatives to admission as clinically appropriate.
Creation of flow to support increased numbers of patients in the Emergency Departments through business continuity of SDEC's across Surgery, oncology, children's and multi-speciality areas (MSAA)	The estate footprint constraints and adjacency for MSAA delivery.	St James's ED has "yellow area" as a surge plan at times of pressure. LGI ED has the surge area for children or adults opposite the children's ED. Nurse and medical staffing reviewed to ensure patient safety and timeliness of care across a larger footprint. Agreed surge plans for extremis developed as part of a Decision Management Tool to space within or adjacent to the ED's Minor injury straight to test is routine practice to support rapid test and treat/decision
System Gold action plan being implemented and monitored through SROG / System Coordination Group.	Community capacity to support timely transfer of patients from acute bed base. Complexity of discharge pathways. Measurable impact of system actions.	Implement work plan and monitor against the key objectives through weekly SROG and System Coordination Group. LTHT Transforming Services-Unplanned Care programme has an established number of agreed work streams with increased focus on LTHT opportunities to improve early decision making,

		alternatives to attendance and /or admission and reducing delays for inpatients and improving outcomes. These are reviewed against the Trust Goals and the 7 annual commitments. City Same Day Response Board chaired by LTHT Medical Director. City System Flow Programme Board established with LTHT engagement.
System level mutual aid actions (system wide agreed tactical options to be considered during periods of escalating pressures)	Ability of system partners to respond in a timely fashion and with known effect.	Monitoring of Mutual Aid actions through System Resilience Operational Group and System Coordination Group.
Seasonal planning with CSU's and system partners for 2023/24	Unpredictable activity levels	Annual review of the operational response guidance developed and monitored through daily operational processes completed November 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			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
	L = 5								Target Score					Initial Score	Current Score	

Risk Description:	Executive Lead: Chief Operating Officer
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.

Periods of higher prevalence of respiratory infections (including COVID) will result in increased admissions and longer lengths of stay for patients admitted in all specialties. This and associated increases in staff absences can impact 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. | **Date Added to CRR:** May 2014 **Last Reviewed:** Sept 2023 **Next Review:** March 2024

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

Final priorities and operational planning guidance for 2024/25 not yet published | |
| 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.

GIRFT Further Faster best practice shared with CSUs to maximise non face to face activity. Delivery to be reviewed through |

		service delivery accountability meetings with Directors of Operations
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 and the outpatients productivity and efficiency PID for 2024/25.
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	GIRFT Further Faster best practice includes guidance on the use of PIFU which will support ongoing efforts to develop PIFU pathways.

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 to be considered 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. 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.	Pension taxes had reduced number of additional sessions provided by consultant staff BMA rate card has reduced the number of sessions provided by consultant staff Additional requirement for consultants to cover Jr Dr Industrial Action periods has reduced the number of additional sessions provided	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 and funding arrangements are not yet clear for 2024/25	
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 November 2024 for WDH. The CHOC capital development has been postponed due to the withdrawal of TIF2 funding by NHSE 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	Allocations linked to WL position as well as ability to treat P2 patients

| Planned Care Programme is focussed on theatre productivity through a number of workstreams to keep increasing performance against key KPIs such as theatre utilisation / Day case rate / Elective LoS / Average Case per session
 - British association of day case (BADs)
 - Enhanced Care Beds
 - Theatre Productivity & Efficiency
 - Preoptimisation
 - Elective Hubs | Impact of unplanned pressures on elective bed base
 Willingness of clinicians to do extra work due to pension / tax issues
 Capacity to focus on improvement work alongside operational pressures | Recognising the pressures on teams, and the pressures on the organisation, the improvement work through theatres has focussed on those areas less impacted by loss of elective beds.

 A specific Theatre productivity PID has been developed to deliver an increase in list utilisation and cases per session by individual specialities and theatre suite. This project will report through the Waste Reduction Board chaired by the CEO and will increase the elective activity delivered by the Trust

 A specific Outpatients productivity and efficiency PID for 2024/25 has been developed to deliver increases in advice and guidance, clinic utilisation and activity (focusing on clearing the backlog and repurposing capacity to deliver more new outpatient appointments). This project will report through the Waste Reduction Board chaired by the CEO and will increase the elective activity delivered by the Trust. |

CRRC6: 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, which may result in harm to patients.

There are specific challenges in the delivery of this constitutional target a few of our pathways

This is due to multiple factors such as increasing referral rates from primary care, inadequate capacity that is nor flexible to respond to peaks in demand, inefficient pathways particularly diagnostics, and the impact of reduced capacity due to Industrial Action.

The result is the challenge to meet the individual elements of a cancer pathway such as 2ww, 28 day FDS, 31 day, and ultimately the 62 day cancer standard.

Executive Lead: Chief Operating Officer

Date added to CRR: May 2014
Last Reviewed: December 23
Next Review: June 2024

Committee reviewed at:
Finance and Performance Committee

Controls	Gaps in Control	Further Actions Planned:
The Trust Board has a named Executive Director responsible for delivering the national cancer waiting time standards.	None	None
The Board receives 62 day cancer wait performance reports for each individual cancer tumour pathway, as well as overall and will scrutinise actions to improve performance.	None	None
The Trust has a cancer operational policy in place which has been approved by the Trust Board.	None	Annual review in line with required updates
Cancer Strategy in development and will be signed off by January 2024 and launched in February 2024		
The national guidance on reporting methodology being consistently applied. The national methodology for reporting cancer performance across the cancer standards has been updated and is now implemented at	None	None

LTHT		
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	Referrals from other providers do not always occur in a timely manner to support delivery of 62 performance. LTHT capacity does not match the demand to deliver treatment within 62 days.	New governance structure in place for oversight of cancer services with a New Trust board chaired by COO and Medical Director, underpinned by a new monthly assurance board, chaired by Deputy Medical Director and ADOP for Cancer. Multidisciplinary site specific cancer pathway meetings are in place with robust action plans Weekly PTL meetings reviewing long waiting patients clear documented actions. Overview of tracking by CSU and cancer site of the total number of patients waiting throughout their pathway to ensure clear weekly understanding of the position and actions are being taken.
The Trust maintains a valid cancer specific PTL and carries out a weekly review for all cancer tumour pathways to track patients and review data for accuracy and performance. PTL meetings reviewing long waiting patients with clear documented actions that are reviewed weekly. Pathology KPIs and PTL dashboards now live Harm review process now live Performance reviewed at Service Delivery Meetings and	None	

Integrated Accountability Meetings		
Appropriate management of cancer referrals	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	Dermatology are meeting with ICB and GP Confederation to agree process to reduce number of referrals with no or unusable images. Proposal to write back to patients and copying in the GP to advise that the referral is unable to be triaged as it doesn't contain appropriate images and to advise the patient to return to primary care for images to be retaken. Gynaecology are also meeting with GPs to discuss referral pathways.
Capacity and demand analysis and reporting for key pathway elements to support timely delivery is carried out systematically and routinely. 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. Radiotherapy capacity has improved with additional workforce and continues to improve through the final quarter of this year	Capacity & demand modelling has been completed for all elements of every pathway, however this is not easily repeatable or routinely reported to support early intervention/ planning Radiotherapy capacity is currently not sufficient due to planning staff gaps and impact of delivering new expansion plan	Actions and trajectories agreed with CSU's (by specialty) in relation to 2ww, 28-day FDS and 62 day backlog reduction. Pathology agreed recovery actions /KPIs in place with Radiology being developed (to be agreed end of May 2022). Capacity and demand predictor tool now in use within dermatology. To be monitored and updated based on conversion rates and feedback from clinical team.
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	NONE	NONE

Turnaround KPIs are in place with the MDT team, staffing structures reviewed and inplace		
Weekly review of the longest (over 104 day) waiting patients is in place with escalation to Associate Medical Director for Cancer/ Treating Clinician or Lead Clinician/Clinical Director where required.	Volume can be challenging	To focus on those pathways where patients are at higher risk of cancer progression due to wait (e.g. bladder) and those patients where care is not progressing
Root cause breach analysis is carried out for each pathway not meeting current standard.	Root cause analysis is not always carried out for the 10 previous breaches across all non performing pathways	Due to continued volume of current breaches, a weekly cancer team review of all patients on the 2ww, 31day and 62day cancer pathway has been introduced with challenge by the Associate Medical Director of Cancer where required.

This alternates between the 10 longest waiting patients and the 10 patients that have just missed the standard and a revised process will be introduced where the CCT feed this information back to CSUs for review and action via their Governance meetings |
| Weekly surgical/ HDU prioritisation processes continue to be in place, with additional operating accessed in the Independent sector where possible/ appropriate.

Clinical triage process established and continues weekly for HDU/HOBS cases should any further surges result in the requirement to reduce/ suspend cancer surgical activity

Capacity for cancer surgery and key pathway steps is prioritised for access/ listing and in line with most recent NHSE/I guidance. Pre-op COVID testing/preparation | 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) | 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. |

guidelines in place.		
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.	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	Escalation report for late IPT pts with direct conversation with referring Trusts via Cancer Management team Review at the CSU PTL meetings weekly to support pulling patients through the system Linking of Optimal Pathways transformational work with referring trusts work programmes to improve timely transfers.
Recovery plan in place for the skin backlog position	Reliant on additional activity and conversion of existing routine capacity in dermatology to improve 1st OP performance. Additional activity creates additional pathology and surgical demand	Additional funding request developed to improve backlog position through use of the independent sector for dermatology, plastics and pathology capacity. Long term workforce plan being developed to create sustainable service. Timeout with the dermatology team and stakeholders identified pathway improvements that are being developed.

CRRC7: Failure to achieve 28 days cancelled operations 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					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:** Sept 2023 **Next Review:** March 2024
	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 The programme reports monthly to the Tactical Sponsorship	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

group chaired by the COO		
Prompt starts for all elective theatre lists to automatically send for patients requiring inpatient or day case capacity All ACC SJUH patients are automatically sent to theatre and Priority 1-4 patients at LGI are automatically sent to theatre	Co-ordination of theatre/ ward and critical care capacity does not always align leading to greater risk of cancellations Not all Critical Care patients can be automatically sent for	Daily circulation of planned TCIs and previous cancellation status the day prior to surgery
All CSUs have weekly access meetings to identify available theatre capacity for additional sessions, manage risks and review cancellations and discharge and theatres KPI's using the LTHT scheduling tool. Collaborative CSU process to 'book' patients into an admission area by appointment and lock down of list order to improve patient flow and reduce risk of late starts and subsequent on day patient cancellations. Daily email prompt to CSUs highlighting their 28 day breach risks Weekly collaborative critical care clinical prioritisation review by LGI and SJUH CSUs to support listing of clinically urgent patients and to match listed activity to anticipated capacity LTHT scheduling tool has been updated with the 'Monte Carlo' simulation to improve scheduling accuracy and theatre efficiency The number of 28 day cancellations has continued to reduce and performance has been sustained.	Critical Care capacity can change overnight due to staffing absence or high numbers of unplanned admissions and result in on day cancellations	

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

Use of Independent sector to increase available capacity and treatment options for patients

Monthly focus on 6-4-2 process and Specialty level performance within Theatre Board. | Theatre staff and surgeons are not always available to undertake additional activity in response to peaks in demand

Independent sector contract restricts type of patient able to be transferred for treatment. | BTLW at LGI will design bespoke admission and discharge areas for day case pathways. SJUH estate strategy reviewing options to consolidate day case estate and pathways at SJUH Planned Care Dashboard developed to highlight BADs / Daycase opportunity by procedure Business case approved for additional 2 theatres at WDH Increase theatre and day case capacity available over the weekend to spread demand and offer more opportunities to rebook patients.

GIRFT project embedded in Theatre efficiency project to ensure appropriate patient pathway is followed. |

CRRC8: Patients waiting over 52, 65 & 78 weeks for treatment across a range of services.	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 & Current Score	

Risk Description:	Executive Lead: Chief Operating Officer
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).	**Date Added to CRR** May 2015 **Last Reviewed:** December 2023 **Next Review:** June 2024
	Committee reviewed at: Finance and Performance Committee

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 or D 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 Industrial Action reduces available outpatient and elective capacity	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. Patient safety, quality or governance risks are escalated through CSU Governance Meetings in line with Quality Governance Framework. CSUs will highlight specific risks through their CSU risk registers. Longest waits prioritised for validation. Specialties with known risks already prioritise. Planned Care focus on, and increasing the productivity of all elective capacity

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 Robotic Process Automation (RPA) supports the administrative validation of the entire RTT waiting list and is further supported by targeted clinical validation	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	CSUs are working through PIFU protocols to support the validation outcomes and embedding wider PIFU options in specialities. This is further supported by the roll out of GIRFT: Further Faster handbooks across 15 specialties.
Recovery planning recognises the need to deliver capacity for long waiting patients. Theatre, admission and inpatient capacity has been focussed on specialities requiring additional capacity Service Delivery Contract's developed at CSU level which include focussed KPI on reducing longest admitted and non-admitted waits LIM standard work used to support corporate monitoring of performance against CSU and Specialty agreed 78 & 65 week trajectories.	Some specialties have larger waiting lists and / or more constrained capacity to deliver 78 & 65 week trajectories	Chief Operating Officer and Director of Operations meet with CSUs that are unable to meet agreed trajectory with the relevant ADOP. Additional support identified and recovery actions agreed.
Above pre pandemic theatre and inpatient bed capacity may be provided by re-allocation of theatre sessions and bed capacity to those with longest waits Adult Spines elective lists at CHOC	Existing surgeons must be allocated to cover additional sessions, which can stretch teams if more sites need cover. Reallocation of capacity may result in	

Elective schedule reallocated in WGH & DBDU to support specialties with longest waiting lists (Urology & Colorectal) Overnight stays reinstated at WDH for 1-2 nights per week. Enhanced Care beds opened at CHOC to increase case complexity of patients able to be treated at the elective Hub. All P4 patients above 80 weeks as P3 patients to support booking of long waiting patients	growing waits in other services.	
Additional outpatient sessions are relatively easy to schedule and outpatient waiting lists can reduce quickly if clinicians are available	Reliant on staff willing to do overtime/additional hours. Request for BMA rate card reduces uptake	Roll out of alternative working models (e.g. virtual reviews) can deliver additional capacity. Service Delivery Contract's includes KPI on reducing longest outpatient waits – this will be monitored on monthly basis
Established arrangements in place to allow additional outpatient and inpatient activity to be scheduled outside normal working hours.	Relies on staffing throughout overtime and additional hours. Request for BMA rate card reduces uptake	Saturday outpatient clinics are routinely being held to support specialities. Bookwise (new clinic scheduling tool) is being implemented across adult clinics areas which should support identifying clinic room efficiency and allow additional weekday clinics to be held. Children's CSU delivered pilot of Bookwise from 28 February 2022 creating additional clinic capacity of an additional 200 clinics per month equating to an additional circa. 1000 appointments per month. Expecting Bookwise to be implemented by March 2023 Enhanced rate available to staff to support activity 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 2023/24 means 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 at WGH to increase elective activity that can be delivered. Scheme approved and work commenced October 2023 with a completion date of November 2024		
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.
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
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	Non elective pressures and high bed occupancy preventing full return to pre-covid elective efficiency. Ongoing Covid peaks through the year	TSG will now align with the 2024/25 financial productivity workstream, utilising the existing programmes to go further with identified efficiency and productivity schemes and utilising service delivery meetings and integrated accountability meetings to measure progress and

- SJUH elective recovery - LGI elective recovery - Outpatients - Diagnostics - Patient Placement 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.	and subsequent impact on Covid inpatients and staff availability	delivery against key performance indicators. SDEC due to open December 2023 which will reduce further number of admissions via ED and supporting better patient placement and use of IP capacity at SJUH
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.
PIDMAS (Patient Initiated Digital Mutual Aid System) live as of November 2023. All adult, non tertiary patients over 40 weeks have been contacted to ask if they would move provider for quicker treatment.	ICB identifies available capacity, but this does not guarantee this capacity is available for the patient or the provider will accept the patient	All patients who request to transfer and who are willing to travel more than 50 miles are placed on the DMAS system (Digital Mutual Aid System) whereby providers nationwide can offer capacity to treat the patient. The national roll out of this system expects all patients (including paediatrics) waiting more than 18 weeks to be contacted and offered the opportunity to move provider by September 2024

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			
			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: Chief Operating Officer
There is a risk that the Trust has more than 1% of patients waiting more than 6 weeks at month end following referral for the defined basket of 15 tests against this standard.		
During wave 1 of COVID-19, there was a significant growth is diagnostic backlog as all routine work, other than urgent, was suspended. This backlog has been significantly reduced since the recovery restart in June 2020, however capacity remains lower than required in some modalities to clear backlogs especially those which require General Anaesthetic and paediatric services.		**Date Added to CRR:** May 2014 **Last Reviewed**: January 2024 **Next Review:** July 2024
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 prioritisation of long RTT waits for those requiring Diagnostic tests under GA.		**Committee reviewed at:** Finance & Performance Committee
Delays in achieving the diagnostics tests waiting times may have an impact on patient safety. Ongoing strikes impact on Diagnostic capacity resulting in cancelled lists.		

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. Ongoing targeted work with theatres and paediatrics 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 ongoing with outsourcing/additional outpatient capacity sourced where possible.
Weekly Tactical meetings now moved into the	Data available to all diagnostics teams is not	Monthly Service Delivery Accountability

weekly Service Delivery meeting.-Processes in place to support recovery and sustainability.	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.	Meetings with CSUs and ADOPs introduced from December 2023.
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 through Service Delivery and Corpoparte Performance.
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.	CT and MRI mobile capcity in place through the Leeds Community Diagnostics Centre at Seacroft Hospital, while redevelopment work has commenced at Seacroft to install 2 fixed CT scanners (one of the scanners will support service delivery and the second will support research activity and service delivery). Redevlopment and remodelling wok will commence in january 2024 to further expand the cath labs Use of independent sector/ AQPs continues for CT, MRI, Ultrasound and Endoscopy.

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			
			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 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: September 2023
Next Review: March 2024

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. Daily operational huddles at 08:30 to assess site-specific pressures and mitigate any safety concerns, led by Directors of Operations and Directors of Nursing with clinical support from site managers and Clinical Director.	Fully operationally implemented Live bed state not yet in place – limited real time admission and discharge data to support understanding of all available capacity. Patient flow and discharge co-ordinators hosted by CSU's. Devolved model does not enabletandard work and maximum efficiency not currently met- plan for a central model being explored	Live bed state product developed in December 2023. Staged roll out plan of implementation began in December 2023 with focus on real time admission and discharge compliance Team of Patient flow co-ordinators and discharge co-ordinators across the organisation with three daily capacity huddles established to monitor admission and discharges throughout the 24 hour period. 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 complete bay door in Beckett wing J30 by April 2024
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.

Agreed Full Capacity Protocols (FPC) for surge and Exceptional Surge Areas (ESA'S) with implementation capture and assurance process measures. This includes utilisation of the Exceptional Surge Area (ESA) plan. | Weekly report of use and associated audit of use compliance for FCP

Insufficient space and staff to meet expected surges f inpatient numbers increase above expected population growth.
There is a city trajectory to reduce the number of inpatients with No Reason to reside in hospital to less than 160 in July- currently above trajectory

Some areas identified for FCP 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.

Overall patient experience impacted by use of ESA beds | Weekly tracking of DMT actions taken. Weekly report to weekly Quality meeting to understand the frequency of use of ESA and safety checks. Monthly report provided to the Quality & Safety Assurance Group (QSAG) External audit of winter planning and governance. 3 recommendations implemented. Patient experience question used as part of audit of patients in ESA Apology letter given to patients |
| Bed modelling analysis to identify expected activity surges based on public health intelligence for COVID, Flu, RSV and Norovirus with a planned local and system response | Bed modelling for this winter is not based on prevalence as accurately as previous years due to reduction in COVID testing. | |

Management of long length of stay patients	Continue with high numbers of inpatients with over 21 days length of inpatient stay for both reason and no Reason to Reside patients within hospital bed base. Dr Foster data set identifies further opportunity for length of stay reduction	External audit of LOS analysis commissioned and completed in August 2023. Key findings identified and action plans for CSU's developed. LOS reduced by 0.5 days as per annual commitment. -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 Structure established to ensure a weekly review of the longest waiting patients with no reason to reside to ensure timely escalation of patients and to identify suitable alternative pathways that will result in earlier discharge.
Protected elective capacity at SJUH,CAH and Wharfedale Hospitals to support elective (planned patient) capacity All patients on an active elective waiting list receive regular correspondence from the Trust advising them that they are still on a waiting list, and what to do / who to contact if their condition has changed etc		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. When critical care capacity is limited, and elective procedures are at risk of delay, patients who are ready to step down from Critical Care settings are

		prioritised for the next available ward bed by Clinical Site Managers and Patient Flow Co-ordinators. This process has significantly reduced the number of elective cases cancelled due to a lack of critical care capacity in 2023/24.
Tactical: Alternatives to admission- Established Same Day Emergency Care unit 7 days per week		Newly refurbished and extended medical and elderly SDEC established alongside the SJUH Emergency Department with a focus on increasing admission avoidance and early senior decision making for patients was established in mid-December 2023. This SDEC includes overnight stay for patients who do not need to be admitted but need a short period of observation or treatment through the night. Scoping of maximum opportunity for LGI multi-speciality SDEC in progress.
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		PCAL in association with Yorkshire Ambulance Service have developed pathways 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 to increase the number of redirections.
Developed Virtual Ward for respiratory and frailer adults to support early discharge and alternative care for lower acuity admissions		Home telemetry ward developed and delivered by LTHT is evidencing reducing number of bed days for patients on pre agreed pathways
Strategic: Established of Leeds urgent community response group with delivery of 2-hour community response 8am till 8pm to avoid ED and admission conveyance.	National requirement for 24/7 offer not currently delivered	HomeFirst has resulted in a reduction in the number of inpatients without a reason to reside compared with the previous financial year.

Intermediate Care redesign called Home First programme and the city opportunity analysed and collectively understood. To reduce length of inpatient stay and number of patients with no reason to reside in hospital Work agreed to transform and maximise this opportunity by 2024.	HomeFirst programme not currently delivering to agreed trajectory of no more than 160 no reason to reside inpatients by July 2024	Agreement reached across the system to implement the learning from a PDSA evidencing a reduction in length of inpatient stay relating to a discharge case manager model. Implementation plan in progress. System visibility data set achieved-shared understanding of capacity and impact of changes

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			
			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 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: November 2023
Next Review: May 2024

Committee reviewed at: Emergency Preparedness

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. Following the recent request to re-review RAAC and the plans a West Yorkshire exercise to test the response is currently being planned and any learning will be incorporated into WY and LTHT plans.

CRRF1: Failure to deliver the financial plan for 2023/24	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								Current Score	Initial Score

Risk Description:	Executive Lead: Director of Finance

There is a risk that the Trust does not achieve its planned control total in 2023/24. This would have the following impacts:
 	
• Reducing the internal funding for the Trust's ambitious Five Year Capital programme, including Building the Leeds Way leading to:
   o Limiting the capital programme/not replacing equipment
   o Relying on external sources of funding
   o Cash shortfall and risk to supplier payment
   o Potential non-compliance with new medical devices regulation (Regulation EU 2017/45)
• Reputational damage, as the Trust fails to deliver on a key statutory duty
• Potential to cause the Integrated Care System to miss its overall control total
	Date added to CRR: November 2020
	Last reviewed: November 2023
	Next Review: May 2024

	Committee reviewed at: Finance and Performance Committee

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

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

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

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

Risk Description:

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

- Reducing the internal funding for the Trust's ambitious Five-Year Capital programme, including Building the Leeds Way leading to:
  - Limiting the capital programme / not replacing equipment
  - Greater reliance on external sources of funding
  - Potential non-compliance with regulatory requirements
- Increased clinical risk due to inability to replace capital assets within agreed replacement schedules, 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: November 2023
Next Review: May 2024

Committee reviewed at:
Finance and Performance Committee

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	• Other ICB Trusts show a preference towards top slicing the ICB allocation reducing operational capital budgets for all Trusts	• Regular updates provided to Director of Finance and Director of Strategy immediately following the meeting • Regular updates provided to Capital Planning Group and any necessary escalations to Finance and Performance Committee.
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	• 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.	• 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.	• 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	• Constrained by available opportunities • Bids and applications not always successful	• 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.	• Would still reduce LTHT allocation	• Influence NHSE to identify route for medium to major schemes to be considered for central funding.