

# **CORPORATE RISK REGISTER**

**January 2025**

## Summary Corporate Risk Register January 2025

| 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. |
|---|---|-------------------|--|--------------------|----------------------|--------------------|--------------------------|----------|
| <b>Workforce Risk</b>   |   |                   |  |                    |                      |                    |                          |          |
| <b>Workforce Supply Risk</b> <i>Cautious</i>                  |   |                   |  |                    |                      |                    |                          |          |
| CRRW4   | Insufficient staff to provide treatment, care and services to patients  | May 23            | Director of Human Resources, Chief Nurse & Chief Medical Officer | 16                 | Dec 24               | Jun 25             |                          | 5-21     |
| <b>Workforce Deployment Risk</b> <i>Cautious</i>              |   |                   |  |                    |                      |                    |                          |          |
| -   | -   | -                 | -  | -                  | --                   | -                  | -                        | -        |
| <b>Operational Risk</b>                                       |   |                   |  |                    |                      |                    |                          |          |
| <b>Business Continuity Risk</b> <i>Cautious</i>               |   |                   |  |                    |                      |                    |                          |          |
| CRRO1   | Risk of a viral pandemic  | May 18            | Chief Operating Officer  | 15                 | Oct 24               | Apr 25             |                          | 22-23    |
| CRRO2   | Power failure/lack of IPS/UPS resilience due to electrical infrastructure   | Aug 15            | Director of Estates & Facilities                                 | 16                 | Jan 25               | Jul 25             |                          | 24-27    |
| CRRO13  | Brotherton Wing, Blocks 11, 12 and 32 physical condition  | Jan 24            | Director of Estates & Facilities                                 | 16                 | Jan 25               | Jul 25             |                          | 28-29    |
| <b>Health &amp; Safety Risk</b> <i>Minimal</i>                |   |                   |  |                    |                      |                    |                          |          |
| CRRO3   | Harm due to clinically related behaviours that challenge linked to organic, mental health or other reasons – REMOVED FROM CRR FOLLOWING REVIEW AT DEC 2024 MEETING. | May 15            | Chief Nurse  | 16                 | Dec 24               | -                  |                          | -        |
| CRRO4   | Staff absence Health, Safety and Wellbeing  | Oct 20            | Director of Human Resources                                      | 16                 | Sep 24               | Mar 25             |                          | 30-33    |
| <b>Change Risk</b> <i>Cautious</i>                            |   |                   |  |                    |                      |                    |                          |          |
| CRRO7   | Risk of failure to deliver the hospital of the future project.  | May 20            | Director of Finance  | 20                 | Nov 24               | Feb 25             |                          | 34-40    |
| CRRO8   | Risk of failure to deliver the pathology project.   | May 20            | Director of Finance  | 20                 | Jan 25               | Feb 25             |                          | 41-45    |
| CRRO9   | Risk of failure to deliver the LGI Site Development Project   | Nov 21            | Director of Strategy   | 16                 | Nov 24               | May 25             |                          | 46       |
| <b>Information Technology Risk</b> <i>Cautious</i>            |   |                   |  |                    |                      |                    |                          |          |
| CRRO10  | Cyber-attack leading to potential loss of IT systems and/ or data   | May 22            | Chief Digital & Information Officer                              | 16                 | Oct 24               | Apr 25             |                          | 47       |
| CRRO11  | Insufficient DIT resources to maintain Trust IT estate to minimally supported standard and meet demand for DIT led projects.  | Jan 23            | Chief Digital & Information Officer                              | 15                 | Oct 24               | Apr 25             |                          | 48       |
| <b>Clinical Risk</b>  |   |                   |  |                    |                      |                    |                          |          |
| <b>Infection Prevention &amp; Control Risk</b> <i>Minimal</i> |   |                   |  |                    |                      |                    |                          |          |
| CRRC1   | Healthcare acquired infection   | Mar 19            | Chief Medical Officer  | 16                 | Oct 24               | Apr 25             |                          | 49-58    |

| Patient Safety & Outcomes Risk              |  |         |                         |    |        |        |                                 | Minimal  |
|---|--|---------|-------------------------|----|--------|--------|---------------------------------|----------|
| <b>CRRC4</b>                                | Emergency Care 95% Constitutional Standard   | May 14  | Chief Operating Officer | 20 | Jan 25 | Jul 25 | ED LGI                          | 59-62    |
| <b>CRRC5</b>                                | 18-week RTT target non-compliance  | May 14  | Chief Operating Officer | 20 | Sep 24 | Mar 25 | Ophthalmology / Cardiac Surgery | 63-69    |
| <b>CRRC6</b>                                | 62-day cancer target   | May 14  | Chief Operating Officer | 16 | Dec 24 | Jun 25 | MDT & Pancreatic Breast Only    | 70-74    |
| <b>CRRC7</b>                                | Failure to achieve 28 day cancelled operations target  | May 14  | Chief Operating Officer | 16 | Sep 24 | Mar 25 | Cardiac                         | 75-77    |
| <b>CRRC9</b>                                | Patients waiting longer than 6 weeks following referral for diagnostics tests  | May 14  | Chief Operating Officer | 16 | Jan 25 | Jul 25 | Breast cancer                   | 78-80    |
| Capacity Planning Risk                      |  |         |                         |    |        |        |                                 | Cautious |
| <b>CRRC10</b>                               | 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 | 16 | Sep 24 | Mar 25 | MMPS                            | 81-84    |
| Financial Risk                              |  |         |                         |    |        |        |                                 |          |
| Financial Management & Waste Reduction Risk |  |         |                         |    |        |        |                                 | Cautious |
| <b>CRRF1</b>                                | Failure to deliver the financial plan 2024/25  | May 14  | Director of Finance     | 20 | Nov 24 | May 25 |                                 | 85-87    |
| <b>CRRF2</b>                                | Insufficient operational capital allocations   | May 23  | Director of Finance     | 16 | Nov 24 | May 25 |                                 | 88-89    |
| <b>CRRF3</b>                                | Cash Availability  | Nov 24  | Director of Finance     | 16 | Nov 24 | May 25 |                                 | 90-91    |

## Corporate Risk Register - Key

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

## Risk Appetite Scale

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

## Risk Score

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| <b>Initial Score</b> | The score before any controls (mitigating actions) are put in place.   |
| <b>Current Score</b> | The score after the risk has been mitigated (by controls) but with gaps in controls (things we are not able to do) identified.                           |
| <b>Target Score</b>  | 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   |    |               |               |
|  | L = 4 |    | 1   | 2 | 3 | 4        | 5 | 6 | 8  | 9            | 10        | 12 | 15   | 16 | 20            | 25            |
|  |       |    |   |   |   |          |   |   |  | Target Score |           |    |  |    | Current Score | Initial Score |
| <b>Risk Description:</b><br><b>There is a risk that the organisation has insufficient staff numbers or utilises existing staff inefficiently resulting in:</b><br><div><div>1. A potential failure to provide safe care and treatment to patients</div><div>2. Staff suffering psychological and physical harm (burn-out)</div><div>3. Loss of stakeholder confidence and/or material breach of CQC conditions of registration.</div></div><br><b>This could be caused by</b><br><div><div>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</div><div>2. Failure to retain existing staff, for example due to early retirement or staff taking on roles elsewhere</div><div>3. Not utilising staff appropriately due to poor rostering / job planning or staff undertaking duties not appropriate for their role</div></div> |       |    |   |   |   |          |   |   |  |              |           |    | <b>Executive Leads</b><br><div><div>• Chief Nurse</div><div>• Chief Medical Officer</div><div>• Director of Human Resources and Organisational Development</div></div> |    |               |               |
|  |       |    |   |   |   |          |   |   |  |              |           |    | <b>Date Added to CRR:</b> May 2014<br><b>Last reviewed:</b> December 2024<br><b>Next Review:</b> June 2025   |    |               |               |
|  |       |    |   |   |   |          |   |   |  |              |           |    | <b>Committee reviewed at:</b><br>Resource Management Group<br>Workforce Management Group<br>Risk Management Committee  |    |               |               |
| Controls   |       |    | Gaps in Control   |   |   |          |   |   | Further Mitigating Actions                                   |              |           |    |  |    |               |               |
| NURSING, MIDWIFERY AND AHPs - Chief Nurse  |       |    |   |   |   |          |   |   |  |              |           |    |  |    |               |               |
| Ongoing Deep dives into Nursing & Midwifery Recruitment and retention.   |       |    | Significant vacancies nationally for specialist roles.  |   |   |          |   |   | Working with WYAAT on attraction, recruitment and retention. |              |           |    |  |    |               |               |
| Use learning from Exit Interviews to improve retention.  |       |    | Inconsistent vacancy data – data held centrally via finance ledger does not align with CSU local data.  |   |   |          |   |   |  |              |           |    |  |    |               |               |
| Development of new roles and alternative workforce models  |       |    | 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 |   |   |          |   |   |  |              |           |    |  |    |               |               |

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| Vacancy gaps monitored monthly and forecasted for the next 12 months. Trajectory for the coming years reported via RMG.<br>Successful recruitment in all safer staffing areas this year   |   |   |
| New entry routes created for those 'new to care' through apprentice CSW and trainee CSW routes.<br>Development of new roles and alternative workforce models.   |   |   |
| 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.  |   |   |
| <p>Safer staffing guidance and escalation pathway to ensure operational oversight and appropriate mitigation in safe deployment of staff. This includes the out of hours, assessment, assurance and escalation for safe nurse staffing guidance.</p> <p>Temporary wards (seasonal and surge capacity) included in external safer staffing return once opened for full roster period of six weeks.<br/>All safer staffing documentation reviewed and monitored through the Nursing, Midwifery, AHP Workforce Group (NMAWG)</p> <p>Safer staffing resources, escalations and safer staffing policy available on the Trust intranet.</p> | <p>Variance in practice across CSUs in relation to roster governance and management. Impacts on safer staffing returns (Hard Truths) and timely release of vacant shifts to bank and agency.</p> <p>Available workforce to support opening of surge capacity in response to operational pressure, including ESA escalation.</p> | Daily and Weekly management of rosters using workforce production board   |
| Utilisation of International Nurse recruitment<br>819 WTE international nurses recruited and registered as of February 2024.  | NHSE assurance meetings have raised issues around Future sponsorship for Band 2 CSWs where they have been previously working on a student visa.   | Working group established to review staff that are affected by the changes in sponsorship and legal advice being sought to determine course of action required. |

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| <p>Cohort international recruitment now paused.</p>  | <p>Further pastoral support and supervision to be provided to international recruits after 1 years' service.</p>   | <p>HR/Nursing/Medics working together to develop approach to pastoral support.</p>   |
| <p><b>Midwifery</b><br/>Centralised recruitment was launched in April 2024 across West Yorkshire &amp; Harrogate Local Maternity &amp; Neonatal System. The service has recruited 32 WTE i early career midwives.</p> <p>In addition, the service is currently recruiting 12.6 WTE band 6 midwives over a phased period concluding in April 2025. The accumulation of these recruitment cycles will facilitate closure of the vacancy gap and alignment with the 2024 clinical Birthrate Plus recommendations.</p> <p>The 3 Maternity support workers recruited to the Midwifery Apprenticeship scheme at University of Huddersfield in September 2023 are progressing well with their training and positive feedback received.</p> <p>LTHT maternity workforce leads participate in the West Yorkshire and Harrogate LMNS workforce steering group. This group has oversight of recruitment and retention across the system and offers mutual learning and support of recruitment and retention strategies.</p> <p>The rolling attrition rate for midwives has fallen from 3.6 in 2021 to 2.1 currently.</p> <p>Exit interviews offered to all staff to identify themes and trends and where possible reverse a decision to leave. Workforce lead within the Women's CSU continues to work collaboratively with the pastoral support lead</p> | <p><b>Midwifery</b><br/>Redeployment of non-clinical, specialist and management midwives at times of high acuity and increased unavailability of clinical staff due to vacancies, sickness, maternity leave and study leave.<br/>Inability of non-clinical, specialist and management midwives to complete their workload due to redeployment to support the clinical service. This directly impacts the Maternity Incentive Scheme compliance.<br/>Decrease in the specialist workforce to support timely governance processes and shared learning in a nationally high-profile/risk service.<br/>Escalation to support the clinical service includes redeployment from mandatory training. This directly impacts Safety Action 8 of the Maternity Incentive Scheme and if the evidential requirements are not met the service will fail the incentive scheme which is associated with a significant financial cost, safety concerns and reputational harm.</p> <p>Inability at times of high acuity where all mitigating actions have been exhausted to meet national KPI's of 1:1 care during the</p> | <p><b>Midwifery</b><br/>Implementation of the staff support framework facilitated by the staff psychologist and staff support leads.<br/>Fixed term appointment of a staff psychologist to support work related stress and anxiety and with an ambition to achieve a reduction in sickness and attrition.<br/>Appointment of clinical educators to support the community midwifery services.<br/>Daily staffing meetings and review of all rosters at a service level to support redeployment to areas of greatest need using workforce production board.</p> <p>Review of midwife unavailability aligned with the 23% built into the establishment budget under review.</p> |

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| <p>midwife and clinical educators to operationalise the workforce strategy.</p> <p>Collection and collation of all HR workforce KPI's and triangulation of data to inform improvement strategies. The PMA service is fully established and embedded within the service.</p> <p>As per the requirements of the Maternity Incentive Scheme, a Birthrate Plus review was commissioned to identify any changes required to support safe midwifery staffing and the recommendations have been received by the Trust Board.</p> | <p>intrapartum period and supernumerary status of the labour ward coordinator. This directly impacts on safety and achievement of the evidential requirements of the Maternity Incentive Scheme.</p> <p>Succession planning into clinical and leadership roles due to decrease in interest and aspirations to undertake these roles.</p> <p>Challenges with funding to support the Birthrate Plus (nationally recognised midwifery workforce calculation tool) recommendations for non-clinical, specialist and management roles supporting the ambition of the Royal College of Midwives campaign to strengthen midwifery leadership in response to national maternity inquiries.</p> <p>Decrease in the skill mix of midwives due to a disproportionate number of earlier career midwives, impacting on safety and support of earlier career midwives.</p> <p>No available funding to support continued allocation to the midwifery apprenticeship programme.</p> <p>Increased training requirements aligned with the national core competency 2 guidance.</p> |   |
| <p>Corporate support for areas of concern. Escalation process in place.</p>   | <p>Variance in results of quality and safety reviews.</p>  | <p>Corporate task and finish group established to identify potential impact</p> |

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| Programme of Nursing and Quality Framework reviews with CSUs   | <p>Risk of Nursing staff retiring early due to risk of high pension tax liability</p> <p>Consideration is being given to the development of a separate pay spine for nurses</p>   | Nationally work is underway and currently it is not clear where this will lead and there is potential risk for staff morale and potential IA  |
| <p><b>Adult Therapies AHPs</b><br/>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</p> <p>ToR drafted for CSU level WF committee for all Professions in CSU to be members of and agree all actions and operational activity.</p> <p><b>Adult Therapies CSU AHP Specific</b></p> <p>Development of a capacity and demand tool for AT CSU to understand available resources.</p> <p>Apprentice analyst within CSU supporting data process.</p> <p>Meeting with national C&amp;D team from NHSE September 2023 for support and challenge.</p> <p>Deep dives into AHP groups in AT CSU to support where identified retention or turnover is a concern.</p> | <p><b>Adult Therapies AHPs</b><br/>Variance in understanding of WF issues and available data.<br/>No central governance around sign off and equity in WF issues in CSU</p> <p>Only applicable at CSU not inclusive of other AHP groups</p> <p>Variance of data relating to activity across each professional group and how captured.</p> <p>Data manually collated no electronic capability.</p> <p>Acuity not part of C&amp;D tool.</p> <p>Lack of technical capability.</p> <p>Lack of national guidance re development of suitable tool.</p> | <p><b>Adult Therapies AHPs</b><br/>Corporate Task and Finish Group established to identify potential impacts.</p> <p>Ongoing work with PPM regarding capability to pull activity in contacts and duration.</p> <p>AHP professions linking with professional bodies for steer on complexity tool.</p> <p>Exit interviews results to be analysed.<br/>Rapid improvement time limited projects underway to provide strategy for a profession and light touch approach.</p> <p>Working with regional AHP faculty to implement partner strategies where appropriate.</p> |
| <p><b>Therapy Radiographers (Oncology)</b><br/>On-going recruitment.</p> <p>All four 2024 Apprentice on the course and doing well. Will shortly be advertising for four more to start in March 2025</p>  | <p><b>Therapy Radiographers (Oncology)</b></p> <p>2024 Radiotherapy census data still highlights a shortfall of staff However we have been successful in a recent</p>   | <p><b>Therapy Radiographers (Oncology)</b></p> <p>Continue to expand the apprenticeship programme into 2025 HEE have funded 4 apprentices for 2025 intake. Trust has</p>  |

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| <p>Successfully recruited 17 Band 5 Radiographers. 15 have started and 2 more due to start before Christmas. 4 out of the 15 are now signed off to work clinically.</p> <p>2 x Vacancy at Band 6 and 1 x at Band 7 due to staff retirement, transfer to medical physics and staff returning on reduced hours from maternity leave.</p> <p>First international recruitment has been a massive success so may consider more based on UK applicant number</p> | <p>recruitment exercise. Annual increase in demand for radiotherapy is 6%. There are not enough students being trained nationally. Retention of staff has massively improved in 2024 with a 50% drop in staff leaving.</p> <p>December 2023, we had lost 19 staff<br/>December 2024 we will have lost 7.<br/>No staff have left to work elsewhere in the UK. Most common reason we have lost staff is transfer to medical physics.</p> <p>Our education lead has had massive impact on staff training and support the apprentices. She is also sorting an open day on 12<sup>th</sup> October which may veld further recruits over the year. NHSE have agreed to fund this post till Feb 2026<br/>We have appointed an education lead who will help with apprentice, undergrad and IR support.<br/>In 2023/24 we lost 26 staff which is 17% of our workforce. This is the same as previous years.</p> | <p>supported 4 posts for 2025. Hopefully we will have support for four more in 2026</p> <p>The below recruitment and retention initiatives have helped. We have developed some of our band 2 staff into band 3 clinical roles. They may become radiographers possible via apprentice route. This could be a 5-year process.</p> <p>We have acted up 3 x Band 5 staff into Band 6 posts due to high maternity leave in the band 6 staff. This helps retain band 5 staff and train future band 6 staff.<br/>International recruitment may be a longer-term option – National funding of £5000 per recruit has been offered in 2025.<br/>We still have 3 x Vacancies at band 5. This increase to 7 as we have 1 going on a career break, 1 on Mat leave and 3 acting up</p> <p>We estimate we will lose 12 staff by March 2025. This is a massive drop compared to last year.</p> |
| <p><b>Radiographers (Radiology)</b></p> <p>Annual radiography recruitment event for year 3 undergraduates to attract staff prior to qualifying and build early on boarding relationships.</p> <p>Regular recruitment cycle in place for all modalities.</p>  | <p><b>Radiographers (Radiology)</b></p> <p>13 week recruitment pause impacting on some modalities less than others. For cross sectional imaging, the training time from zero experience is 20 weeks. Adding the 13 week pause to this means significant roster gaps and reliance on voluntary overtime.</p>   | <p><b>Radiographers (Radiology)</b></p> <p>Tier 2 exemption for all CT/MRI/Nuclear medicine and US posts.</p> <p>Work to modify training pathways in X-ray to improve time to competency once radiographers are qualified is in place. HEE</p>   |

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| <p>Investment in apprentice radiographer roles, apprentice assistant roles and apprentice radiographer practitioner roles.</p> <p>3 x ARPs undertaking the bridging course to enable them to gain a degree in radiography in 2027.</p> <p>Strategic review of the apprentice versus undergraduate radiography programme.</p> <p>New for March 2025, apprentice sonographer training to be undertaken by internal candidates (x2)</p> <p>Undergraduate (non-apprentice) ultrasound course to commence in Sept 2024 at Leeds unit to avoid the need to train as a radiographer first. This will increase the number of trained sonographers in 3 years' time.</p> <p>Staffing the CDC from within, CDC seen as an attractive place to work.</p> <p>CT team manager and X-ray staff appointed.</p> | <p>Retention risks due to independent sector offering more attractive salaries (Ultrasound and MRI) with no on-call commitment.</p> <p>On-going engagement with the US staff to review options to support retention.</p> <p>Band 6 CT radiographer gaps at CDC</p> | <p>funded clinical educators on 12 month FTC x 3.</p> <p>For 2025 there are 4 x funded ce posts for 1 year to reduce training time in X-ray, IR and Nuclear medicine</p> <p>Introduction of a band 4 role to undertake more 'simple' scanning procedures is being piloted in MRI – staff member due to qualify in 2025.</p> <p>Working on a plan to offer training in a second modality for interested staff on either a secondment or part time basis.</p> |
| <p><b>AHPs (Theatres)</b></p> <p>Recurring recruitment advertisements.</p> <p>Moving to 20 apprentice ODPs per year by increasing to 10 students per year from Huddersfield University and 10 from Sheffield Hallam University.</p> <p>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.</p>   | <p><b>AHPs (Theatres)</b></p> <p>National shortage of ODPs/nurses with anaesthetic skills therefore poor response to recruitment campaigns.</p> <p>Limited number of places available due to back-fill requirements.</p>   | <p><b>AHPs (Theatres)</b></p>   |

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| Successful internal anaesthetic skills course.   |   |  |
| <b>MEDICAL and SCIENTISTS - Chief Medical Officer</b>  |   |  |
| 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 – there is a need to increase capacity for educational supervision within consultant job plans | Use of international recruitment agencies. HR/Nursing/Medics working together to develop approach to pastoral support. Job planning process to include time allocation for educational supervision which must be factored into costings  |
| There are several ongoing deep dives into Medical Recruitment and retention                                |   | <p>Focus on 'growing our own' through in-house courses and apprenticeships. Development of new roles and alternative workforce models.</p> <p>Working with WYAAT on attraction, recruitment and retention.</p> <p>Discussion with HEE colleagues re impact of LTFT training – length of training to be increased pro rata – which may reduce attractiveness of option to some groups.</p> <p>Work being done on, options for rota management to reduce dependency on bank and agency</p> <p>Work being done to standardise rates across WYATT.</p> <p>Specific work to reduce bank and agency spend by ensuring effective roster</p> |

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|  |   | <p>management, collaboration and clear escalation strategies.</p> <p>Burnout group has been established – deep dives into areas where burnout risks are high with targeted interventions.<br/>Development of wellbeing strategy for senior medical staff<br/>Development of a consultant retention strategy to include pension planning, flexible working and other key actions</p> <p>In terms of retention, considerable on-going work around trainee engagement (greater visibility of the Chief Registrar, Resident 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.</p> <p>Following the publication of ‘Improving the Working Lives of Doctors’ a task and finish group has been formed to audit current compliance and set in train improvements across a number of workstreams.</p> |
| 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, 60% consultants on this and allows greater transparency and consistency. Job planning steering group with review of job planning policy.  |

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|  | <p>Lack of knowledge of demand meaning services cannot plan workforce needs effectively</p> <p>Rota management for medical workforce has not been linked to changes in service requirements – resulting in high locum and bank spend</p> <p>Annual leave for consultants is not always transparent, with potential for taking above entitlement.</p> | <p>Training being delivered in team job planning and mapping of capacity and demand, with expectation that this will become the norm for departments</p> <p>Embedding processes of standard work and financial daily management regarding rota management, cover and leave to ensure workforce responsive to the service demands</p> <p>A task and finish group was established in November 2024 to address job planning along with a number of other issues relating to medical staffing processes.</p> <p>Work being done to look at areas where leave management needs improvement. Move to e-rostering. Paper on rolled up annual leave signed off by Executives in March 2024.</p> |
| <p>Guardians of Safe Working, Resident Doctor Forum, Exception Reporting results and subsequent response from specialty.</p> <p>A review has commenced into Junior doctor absence management to maximise staffing levels</p> | <p>Reporting processes in the current Covid pandemic were disrupted but are now back on track.</p>   | <p>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.</p> <p>Standard work embedded across all CSUs for sickness management assurance processes within resident medical teams. Work being done to align this with ESR.</p>   |

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| <p>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.</p> | <p>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.</p> <p>Only have capacity to train 1 paediatric audiologist a year.</p> <p>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.</p> <p>National shortage across Medical Physics. Clinical engineering - have made good progress in filling vacancies but have another group of retirements on the horizon.</p> <p>Difficulty recruiting in haematology, blood transfusion high pressure and are so not attractive job.</p> <p>Genetics shortage. service expansion faster than university trained students.</p> | <p>Local audit and external audit completed, and no errors issues identified but national review of paediatric audiology following Lothian review.</p> <p>Using February for setting staffing levels is not the best time as levels are well below the annual level at this time. Better to use the level in September otherwise this introduces another pressure into the workforce. To be discussed within RMG</p> <p>Working with HEE etc for more training across all areas. Apprentice scheme highly successful for engineering, although lag due to training period.</p> <p>Unknown at present as impact still evolving</p> |
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|  | <p>The impact of CDCs on the workforce is unknown. The teams are actively working with colleagues in the Trusts and ICS to gain better understanding through the Operational team.</p> <p>Hyper specialist services with half of the 52 specialisms with only 5 or less staff creating sustainability risk.</p> |   |
| <b>GENERAL WORKFORCE ISSUES – Director of HR and OD</b>  |   |   |
| There is a Trustwide affordable workforce plan and progress against the plan is presented to the Workforce Management Group and Workforce Committee  | Workforce (including temporary staffing) is currently higher than the affordable plan.  | This is closely monitored at Executive level and further mitigations are under consideration. |
| Each CSU has a workforce Action plan.  |   | HRBPs and working with CSUs to deliver action plans.  |
| All CSU Workforce plans have a focus on Retention with Clear action plans  |   |   |
| Specific service level staff shortages for hard to recruit staff are captured in the CSU Workforce Action Plan and the CSU risk registers, with escalation of significant CSU risks to RMC.  |   |   |
| <p>Vacancy control panels operating in all CSUs with oversight of CSU vacancy trackers through Trust Expenditure Review Group (TERG).</p> <p>Comprehensive Financial Mitigation plan now in place to monitor variable pay, Vacancy controls, Non clinical Agency, Discretionary Pay, with agreed exemption processes for posts which are critical to patient safety.</p> |   |   |
| In year commitment on retention and participation in the exemplar programme, with regular progress updates to  |   |   |

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| the Workforce Management Group and Workforce Committee.  |   |   |
| <p>Resource Management Group meets bi-monthly to lead, support and report on activities related to resource management.</p> <p>Workforce Management Group receives monthly Workforce Metrics to ensure alignment to Finance</p> <p>Workforce Committee receives a deep dive into workforce issues 3 times per year</p> <p>Weekly HRBP huddle with Centres of Excellence and Director of HR to discuss workforce issues</p>   |   |   |
| The organisation has a Structured Approach to Winter Planning.   | Work required to look at the best ways to flex staffing numbers whilst minimising the adverse impacts on staff when ward numbers are increased/decreased due to changes in demand and/or LOS. | Steering group established to develop plans with HR representative. |
| The organisation has a structured approach to managing the risk of staff retiring early due to risk of high pension tax liability. Pension Guidance has been developed for all staff.  |   |   |
| <p>There is a Structured approach to Exit interviews using an electronic form across the Trust</p> <p>Exit Interview results and analysis forms part of the workforce planning deep dive for Workforce Management group/Committee.</p> <p>Exit interview completion rates included in the HR Metrics slides for every Workforce Management Group and form part of CSU presentations.</p> <p>Automatic email to the named CSU exit interview leads when a leaver form is submitted, which allows the lead to prompt that an exit interview is undertaken.</p> |   |   |

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| Exit interview completion rates reviewed at Workforce Management Group.   |   |   |
| Optimal Attendance Management is now embedded as business as usual. Further detail is contained within CRR04.<br>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.<br><br>Roster management metrics in relation to adherence to best practice and safer staffing guidance shared with CSU and presented to WMG and WFC.  | Roster management not embedded consistently across all clinical staff groups. | Levels of attainment steering group to determine further roll out plan. |
| Continued support for the development of new roles for example: <ul style="list-style-type: none"> <li>• Apprentice programme</li> <li>• Advanced Practitioners</li> <li>• Physician Assistants</li> <li>• Volunteer programme</li> </ul> Nursing Associate deployment reference group commenced to support governance and assurance of new role.<br><br>Future You programme implemented to create workforce plan, recruitment and retention strategy for the Nursing Associate role. Progress reviewed through NMAWG and RMG<br><br>Deputy DME overseeing PA undergraduate placement program at LTHT. |   |   |

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| Use of temporary workforce (bank and agency), including specialist agencies to provide observation, supervision and safe care to patients.   |   |   |
| Monitoring of staffing requirements through daily staffing meeting, weekly variable pay submissions, and weekly reports to Director of Finance.  |   |   |
| Locally agreed payment rates for staff, process for escalation, review and approval (Executive Director)   |   |   |
| A gap analysis has been undertaken against the National long term workforce plan.  |   |   |
| 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.   | <p>Significant vacancies nationally for specialist roles.</p> <p>For some roles, the private sector offers better pay and incentives (e.g. no on-call)</p> <p>Failure to attract candidates for some roles.</p> | <p>Continued focus on retention, 'growing our own' through in-house courses and apprenticeships, development of new roles and alternative workforce models.</p> <p>Working with WYAAT on attraction, recruitment and retention.</p> <p>Raising our advertising profile, using non-traditional media for advertising and capitalising on social media campaigns.</p> <p>Reviewing entry requirements for some roles.</p> |
| Leeds Health and Care Academy Talent Hub connecting with diverse talent pools and working across the City on advertising, screening candidates and supplying a pipeline to support workforce capacity. |   |   |
| Artificial intelligence (AI) has the potential to reduce workforce requirements for some tasks.  | The impact of AI on our workforce is not fully understood.  | Working in partnership with KPMG to scope the potential impact of AI, with a report expected before the end of the year.  |
| <b>Risk of staff absence due to potential Industrial Action</b>  |   | .   |

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| <p>Currently none of the unions have a mandate for industrial action.</p> <p>Standard work is in place for the deployment of staff and staff mitigations to support essential services in the event of industrial action as follows:</p> <p>Twice weekly steering group is established and stepped up when required to plan for potential Industrial Action with staff from Emergency Preparedness, HR, Corporate Nursing, Corporate Medical Team, Corporate Operations and CSUs triumvirates representation. Set of task and finish groups established to ensure effective delivery.</p> <p>An Incident Command Centre is put in place in the event of any Industrial action, with positive partnership working with Staff Side embedded. Standard work, including a clear understanding of whether derogations are available and what areas are derogated is established for how to manage the impact.</p> <p>Robust data analysis to ensure understanding of staffing absence in place.</p> <p>Working across West Yorks ICS (Integrated Care System) and Leeds place to ensure plans are in alignment and risk is shared across the ICS and reaches wider ICS footprints e.g., South and North Yorkshire.</p> <p>Good employee relations in place with local staff side organisations.</p> |  |  |
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| <p>The Leeds Way is well established as we manage industrial action. This also mitigates the risk of potential conflict in teams due to industrial action.</p> <p>FAQs, Ask the Expert, comms plan and guidance regularly updated to ensure understanding across the organisation as the situation develops.</p> |  |  |
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| CRRO1: Risk of a viral pandemic  | C = 5 | 15 | Very Low Risk  |   |   | Low Risk |   |   | Medium Risk   |   | High Risk |    | Significant Risk  |    |               |    |
|  | L = 3 |    | 1  | 2 | 3 | 4        | 5 | 6 | 8   | 9 | 10        | 12 | 15  | 16 | 20            | 25 |
|  |       |    |  |   |   |          |   |   |   |   |           |    | Current Score   |    | Initial Score |    |
| <b>Risk Description:</b><br>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 quality, performance and financial impacts. |       |    |  |   |   |          |   |   |   |   |           |    | <b>Executive Lead:</b> Chief Operating Officer<br><b>Date added to CRR:</b> May 2018<br><b>Last reviewed:</b> October 2024<br><b>Next Review:</b> April 2025<br><b>Committee reviewed at:</b><br>High Consequence Infectious Disease Group<br>Emergency Preparedness Coordinating Group |    |               |    |
| Controls   |       |    | Gaps in Control  |   |   |          |   |   | Further Mitigating Actions:   |   |           |    |   |    |               |    |
| Pandemic Plan in line with NHS framework for managing the response to pandemic diseases.   |       |    | <ul style="list-style-type: none"><li>There has been no update to either the national pandemic plan nor the Leeds outbreak plan post covid-19</li><li>Some specific recommendations from the 2023 EPRR core standards review in relation to PPE training and resources have not been implemented</li><li>Exercise to validate plan needed</li><li>Current workload in relation to HCID (mpox in particular) impacting on updating of pandemic plan</li></ul> |   |   |          |   |   | <ul style="list-style-type: none"><li>Plan has been updated internally based on covid-19 experience and other relevant guidance</li><li>Oversight of plan and preparedness at High Consequent Infectious Diseases group</li><li>Discussion exercise held in September 2024 and plan will be updated to reflect learning. A table top exercise will then be scheduled.</li></ul> |   |           |    |   |    |               |    |
| CSU Business Continuity Plans  |       |    | <ul style="list-style-type: none"><li>Assurance that up to date business continuity plans are in place for all services within the trust.</li></ul>  |   |   |          |   |   | <ul style="list-style-type: none"><li>CSU business continuity plans are performance managed through the business continuity sub-group to EPCG.</li><li>Support is provided to help CSU business continuity leads.</li></ul>   |   |           |    |   |    |               |    |

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| Infection Control procedures (including Personal Protective Equipment)<br>Training for 'donning' and 'doffing'          | <ul style="list-style-type: none"> <li>• Mask fit testing training levels</li> <li>• PPE training levels</li> </ul>  | <ul style="list-style-type: none"> <li>• Challenges in relation to training have been escalated through Operational IPC and more is being made available</li> </ul>   |
| Surge and Escalation Arrangements-(OPEL)<br>LTHT Incident Response Plan which would be activated in case of a pandemic. | <ul style="list-style-type: none"> <li>• Assurance that all CSU surge and escalation plans are up to date</li> </ul> | <ul style="list-style-type: none"> <li>• Surge and escalation plans form part of winter planning and preparedness.</li> <li>• Incident Response Plan has been completely re-written and is regularly being tested and exercised.</li> </ul> |

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| CRRO2: Power Failure due to Electrical Infrastructure/lack of IPS/UPS resilience   | C = 4 | 16 | Very Low Risk   |   |   | Low Risk     |   |   | Medium Risk   |   | High Risk |  | Significant Risk |    |               |               |
|  | L = 4 |    | 1   | 2 | 3 | 4            | 5 | 6 | 8   | 9 | 10        | 12   | 15               | 16 | 20            | 25            |
|  |       |    |   |   |   | Target Score |   |   |   |   |           |  |                  |    | Current Score | Initial Score |
| <b>Risk Description:</b> There is a risk of power failure at a Trust site (ward or clinical area)<br><br>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<br><br>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 |       |    |   |   |   |              |   |   |   |   |           | <b>Executive Lead:</b> Director of Estates & Facilities<br><b>Date added to CRR:</b> August 2015<br><b>Last Reviewed:</b> January 2025<br><b>Next Review:</b> July 2025<br><b>Committee reviewed at:</b> Risk Management Committee |                  |    |               |               |
| <b>Controls</b>  |       |    | <b>Gaps in Control</b>  |   |   |              |   |   | <b>Further Mitigating Actions</b>   |   |           |  |                  |    |               |               |
| 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 <b>will be without power for this period</b> . 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 has 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   |   |   |              |   |   | The handbook is reviewed annually.  |   |           |  |                  |    |               |               |

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|  | power interruptions occur but does not assist with the shortcomings of the installed systems.  |  |
| Increased interleaving of circuits in Clarendon Wing i.e., there is now more flexibility as to where power to wards/departments is directed from, increasing resilience. | This interleaving work has improved the resilience in Clarendon Wing at ward/ department level but not improved the local bedhead interleaving provision.  | When wards/ departments are refurbished in the future local interleaving should be carried out as per HTM 06-01.   |
| Comprehensive review across the Trust with completed documentation detailing precise location of all key electrical infrastructure equipment.                            | The detailed electrical review information is stored in hard copy at both Silver Command positions but would require in-depth electrical knowledge to fully understand.  | Reviewed annually and updated as resilience is improved.   |
| HTMs are not retrospective, and areas were designed to comply with best guidance at the time of design and construction  | Although HTMs are not retrospective, HTM 06-01 was introduced in 2007 (current version 2021) but work to move the Trust towards full electrical compliance is slow due to shortage of decant facilities and capital shortages to carry out wholesale ward/ department/ theatre improvements. | <p>The Electrical Safety Group has updated/ 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 &amp; BS 7671 Section 710 group locations). This has been undertaken across the organisation's critical medical (patient safety) &amp; critical equipment (business continuity) locations to get a firm position on compliance &amp; a gap analysis, with a technical solution to inform/ develop a multi-year business case, to secure the required investment.</p> <p>This will formalise the E&amp;F risk management process to assess/ address the susceptibility to risk from total (or partial) loss of the electrical</p> |

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|  |  | <p>supply with the consequence of a power failure assessed and graded against a wide range of departments with complex requirements and potential risks.</p> <p>The next steps are now to cost the proposed technical solutions, assess the level of funding required &amp; timeframes (impacted by available capital/ access to areas) to become fully compliant &amp; identify the annual allocation of funds to maintain this position.</p> |
| 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 connected to the system in 2024/25.   |  |  |
| 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 1-9 and recovery); Cath Labs 1, 2, 3, 4, 5 & 6; LGI - Jubilee Wing MRI; 2no. Clarendon Wing B Floor NHS MRIs; Theatre 17 Jubilee Wing; Theatres 1 & 2 CAH.<br>L43 Neonates (Clarendon Wing); Maternity Theatres & Recovery (Gledhow Wing) and ARCU | There are still a number of Clinical category A areas without UPS/IPS systems.   | <p>£200k in programme for UPS/IPS installs in years 25/26 and 26/27, the priority order has been reviewed by the Electrical Safety Group and the plan to implement is part of the technical audit assessment/ report for Medical Location Risk Grading.</p> <p>A further £6m is allocated to electrical backlog priorities from 25/26 to <del>28/29</del> 29/30, from which</p>  |

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| <p>(Gledhow Wing) were upgraded and fitted with compliant UPS/IPS systems in 2021.<br/>IPS was installed in J1 (Neonates SJUH) in 21/22.</p> |  | <p>the mitigation of this risk is a top priority. This investment will be accelerated if funding allows.</p> <p>UPS has been installed to J54 on the central system, phasing option/s for IPS connections under review, with a view to completing in 2025/26 (subject to access).</p> |
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| CRRO13: Brotherton Wing, Blocks 11, 12 and 32 physical condition   | C = 4 | 16 | Very Low Risk   |   |   | Low Risk |   |   | Medium Risk  |   | High Risk |    | Significant Risk  |               |               |    |
|  | L = 4 |    | 1   | 2 | 3 | 4        | 5 | 6 | 8  | 9 | 10        | 12 | 15  | 16            | 20            | 25 |
|  |       |    |   |   |   |          |   |   |  |   |           |    |   | Current Score | Initial Score |    |
| <b>Risk Description:</b> <ul style="list-style-type: none"><li>There is a risk of Brotherton Wing becoming unsafe for occupying patients, staff and visitors.</li><li>Due to a failed roof covering, deteriorating building fabric and aged engineering services (impacting statutory compliance requirements).</li><li>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.</li></ul> |       |    |   |   |   |          |   |   |  |   |           |    | <b>Executive Lead:</b> Director of Estates & Facilities |               |               |    |
|  |       |    |   |   |   |          |   |   |  |   |           |    | <b>Date added to CRR:</b> Jan 2024                      |               |               |    |
|  |       |    |   |   |   |          |   |   |  |   |           |    | <b>Last reviewed:</b> January 2025                      |               |               |    |
|  |       |    |   |   |   |          |   |   |  |   |           |    | <b>Next Review:</b> July 2025                           |               |               |    |
|  |       |    |   |   |   |          |   |   |  |   |           |    | <b>Committee reviewed at:</b> Risk Management Committee |               |               |    |
| <b>Controls</b>  |       |    | <b>Gaps in Control</b>  |   |   |          |   |   | <b>Further Mitigating Actions</b>  |   |           |    |   |               |               |    |
| 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.      |   |           |    |   |               |               |    |
| Disconnected electrical services on Floors D-F to separate supplies in non-occupied areas from impacting occupied clinical areas. A Specialist Contractor has carried out Fixed Wire Installation Testing in Blocks 11,12 and 32.  |       |    | Rising mains now between A and C Floors only are non IP65.  |   |   |          |   |   | Replaced local equipment for IP65 equivalents where possible.  |   |           |    |   |               |               |    |
| 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 remove F Floor extension and install new roof covering. Business case approved and application submitted to the Building Safety Regulator (BSR). Target completion is Q4-2025/26, subject to BSR approval.   |       |    |   |   |   |          |   |   | Controls 1-3 will continue until roof covering is replaced.  |   |           |    |   |               |               |    |
| Asbestos inspection surveys have been undertaken, removals have taken place in Clinical/ occupied locations to reduce risk.  |       |    | There are remaining asbestos containing materials throughout the blocks.  |   |   |          |   |   | The condition of the known asbestos containing materials is regularly audited.                               |   |           |    |   |               |               |    |

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| <p>Operational Fire Strategy in place for blocks 11 &amp; 12.</p> | <p>Complex construction works are planned to repair the roof, this doesn't affect access, or the staff evacuation procedures.</p> | <p>The fire service will be informed and are invited to do site familiarisations and staff will be notified of the works and any potential issues as they occur.<br/>The Fire Team will continually review and monitor the works</p> |
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| CRRO4: Staff absence<br>Health, Safety and<br>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<br>score |   |           |   |  | Current<br>score | Initial<br>Score |    |  |
| <b>Risk Description:</b><br>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. |       |    |               |   |   |   |   |   |                 |   |           |   | <b>Executive Lead:</b> Director of Human Resources   |                  |                  |    |  |
|  |       |    |               |   |   |   |   |   |                 |   |           |   | <b>Date added to CRR:</b> June 2020  |                  |                  |    |  |
|  |       |    |               |   |   |   |   |   |                 |   |           |   | <b>Removed from CRR:</b> July 2022   |                  |                  |    |  |
|  |       |    |               |   |   |   |   |   |                 |   |           |   | <b>Last reviewed:</b> September 2024   |                  |                  |    |  |
|  |       |    |               |   |   |   |   |   |                 |   |           |   | <b>Next Review:</b> March 2025   |                  |                  |    |  |
|  |       |    |               |   |   |   |   |   |                 |   |           |   | <b>Committee reviewed at:</b><br>Workforce Committee<br>Workforce Management Group<br>Health and Wellbeing Committee |                  |                  |    |  |
| <b>Controls</b><br>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   |       |    |               |   |   | <b>Gaps in Control</b>  |   |   |                 |   |           | <b>Further Mitigating Actions</b>   |  |                  |                  |    |  |
| 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.<br><br>Assurance processes are rolled out to all CSUs and is supported by the Operational HR team  |       |    |               |   |   | Differential application of the Supporting Attendance policy across CSUs. |   |   |                 |   |           | The policy is under review to ensure practice that has been developed through the optimal attendance project is reflected in the policy, to be completed by Dec 24. |  |                  |                  |    |  |

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|  | Unclear management arrangements for Junior Doctors due to their short-term employment leading to lack of proactive sickness management for this group.  | <p>A template process for managing Junior Doctor sickness absence in large CSUs has been developed and piloted in one CSU and is being rolled out to other large CSUs.</p> <p>Smaller CSUs have a different process and a revised template process is being developed with one of these CSUs to be completed by Quarter 3</p>      |
| <p>Support for managers to enable them to compassionately and consistently manage sickness absence, work related stress and presenteeism including:</p> <p>HR training on application of HR policies</p> <p>Health and wellbeing training for managers</p> <p>Leading Leeds way toolkit</p> <p>Support from HR Operational team, Occupational Health and HWB team.</p> | Line manager capability and capacity to apply the Supporting Attendance policy and wellbeing conversations.   | <p>Scheduled review of Supporting Attendance policy and guidance to improve the information available for managers to be completed by Dec 24.</p> <p>Scheduled review of burnout response, stress risk assessment process and guidance underway to improve the information available for managers, to be completed December 24</p> |
| 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.   |   |  |
|  | 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 | <p>Work on going to develop a Post Incident Support Pathway by October 2024</p> <p>Continue to undertake work to address cultural issues to prevent poor mental</p>  |

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|  | has therefore been identified, with limited organisational resources to address this.  | health, including increased awareness and peer support.<br><br>Scheduled review of burnout response, stress risk assessment process and guidance underway to improve the information available for managers, to be completed December 24  |
|  | The staff clinical psychology team do not have a robust system to record interventions and manage appointments, taking considerable clinical time to complete this work. | Review of provision and funding model by Adult Therapies to be completed Dec 24.  |
| Occupational Health provide advice to managers on fitness to work and reasonable adjustments to support managers in effectively managing sickness absence. | National shortage of OH clinical staff (medics and nurses), impacting ability to recruit to vacancies  | Review options for MDT model and new training models by Dec 24.   |
|  | Inadequate OH IT system not supported by supplier resulting in loss of clinical notes.   | New system will be implemented in October 2024  |
|  | OH have insufficient clinical space after having vacated LGI to accommodate BtLW   | Plans agreed with Capital Planning, subject to funding, confirmation March 2025.  |
| Organisational immunisation programme, including on-employment vaccination and Winter vaccinations are available.  | LTHT is not currently compliant with the UKSHA schedule for occupational vaccination   | A pilot on-employment process commenced on 22nd July '24 where all new starters will be offered vaccinations in line with the UKSHA guidance, including pertussis. A review of occupational vaccinations is underway, this will review compliance with the UKSHA schedule and identify actions for consideration to ensure compliance for all existing staff. This will be completed by December 2024 |

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|   | 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.   |
|   | We are unable to provide data to demonstrate compliance with the nationally mandated vaccines for healthcare staff e.g., pertussis / MMR / Hep B.   | Standard process in place to ensure all future vaccinations are recorded in a standardised way.  |
| Suicide Prevention strategy has been updated and a postvention 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.<br><br>Line manager capability and capacity to apply the stress risk assessment process.   | Scheduled review of burnout response, stress risk assessment process and guidance underway to improve the information available for managers, to be completed December 2024. |
| 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 in compliance with legislative requirements. | Review of moving and handling training underway to establish legislative and organisational requirements and develop long term solution.                                     |
|   | Do not have permanent training facility to deliver moving and handling training to key trainers.  | Meet with capital planning to review options. Engage with organisational review of training spaces.  |
|   | Do not have a competent person in post to ensure compliance with legislative requirements.  | 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  |               |               |    |
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|   | L=4   |    | 1             | 2 | 3 | 4        | 5 | 6 | 8           | 9 | 10           | 12 | 15  | 16            | 20            | 25 |
|   |       |    |               |   |   |          |   |   |             |   | Target Score |    |   | Initial Score | Current Score |    |
| <b>Risk Description:</b><br><b>There is a risk that the Hospitals of the Future Project fails to deliver its objectives as a result of:</b> <ul style="list-style-type: none"> <li>the NHP's proposed capital funding allocation is not sufficient and/or the Hospital 2.0 Model fails to support the Trust to deliver its requirements;</li> <li>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;</li> <li>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' (whose elements continue to be iteratively published by NHP) and a national procurement approach still be defined;</li> <li>scheme costs exceeding the previously budgeted and forecast allowances as a result of (i) on-going delays relating to NHP and HM Treasury reviews and (ii) the necessity to develop and implement a revised delivery strategy involving additional Enabling Works, such as the refurbishment of Brotherton Wing;</li> <li>the cost of the main works and/or Enabling Works business cases exceeding budgeted allowances;</li> <li>delays to the delivery of critical Enabling Works business cases due to protracted discussions and internal delays;</li> <li>delays and increased costs due to multiple significant changes being proposed to the currently approved project scope and the Trust not managing the scope of the project, change and budgets in accordance with previous approvals and governance processes;</li> <li>delays and increased costs resulting from inefficient delivery and governance processes;</li> <li>increases in costs resulting from programme delays, general inflation and increases in the cost of construction in connection with raw materials, resource availability, and energy;</li> <li>insufficient contractors in the market to deliver the number of schemes being brought forwards by the New Hospitals Programme and the Trust's scheme being considered less attractive than other market schemes; and</li> </ul> |       |    |               |   |   |          |   |   |             |   |              |    | <b>Executive Lead:</b> Director of Finance<br><br><b>Date Added to CRR:</b> May 2020<br><b>Last reviewed:</b> November 2024<br><b>Next Review:</b> February 2025<br><br><b>Committee reviewed at:</b><br>Endorsed by Director of Finance, BtLW Programme SRO and Mike Bacon BtLW Programme Director |               |               |    |

| <ul style="list-style-type: none"> <li>potential stand-down/re-allocation of the Design Team and loss of BtLW Programme Team members (as a result of the on-going delays).</li> </ul> <p><b>If the project is not delivered, the Trust will:</b></p> <ul style="list-style-type: none"> <li>not be able to deliver the Trust's stated objectives for, and the scheme's anticipated benefits from, the new healthcare facilities;</li> <li>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;</li> <li>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;</li> <li>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;</li> <li>not have sufficient capacity to meet service demand in required timescales;</li> <li>be unable to deliver efficiency improvements in a number of areas, including estates utilisation;</li> <li>have to address high and growing levels of backlog maintenance which present a risk to the Trust's ability to maintain service delivery and wider capital budgets;</li> <li>be unable to deliver its vision to develop and establish the Innovation Village; and</li> </ul> <p>suffer reputational damage.</p> |   |  |  |
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| Controls   | Gaps in Control   | Further Mitigating Actions   |  |
| <p><b>Programme Delays</b></p> <p>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.</p> <p>NHP completion of a 'Sprint Review' of the Trust's scheme and its readiness to progress. The full report was issued on 14 August 2024, although the the Trust has already issued its response on 24 April 2024 to the informal feedback received as reflected in the report.</p>   | <p>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.</p> <p>Lack of clarity surrounding the detail and timing of procurement and delivery strategies.</p> <p>The Trust is awaiting the outcome of a second review being independently</p> | <p>SRO and Programme Director to continue to liaise with key members of the NHP Team and specifically the need for clarity on phasing, design standards, Hospital 2.0 Model, funding, and Procurement Strategy.</p> <p>Programme Director and BtLW Programme Team to continue to work with the NHP to support and influence (where possible) the design and development of the Hospital 2.0 Model.</p> <p>The BtLW Programme Team to continue to develop mitigations and associated communication plans in the</p> |  |

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| <p>Continued regular (as necessary) updates on the NHP are provided to the BtLW Programme SRO, the Hoff Project Delivery Board and Infrastructure Committee, with matters escalated to the Trust Board as necessary for Chair and Chief Executive action.</p> <p>The BtLW Programme Team continues to co-ordinate 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.</p> <p>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.</p> <p>As approved by the BtLW Infrastructure Committee, the BtLW Programme Team are continuing to proceed to develop and implement mitigation strategies to the risk of the existing Outline Planning Consent expiring.</p> | <p>undertaken by the NHP during September and October 2024.</p> <p>The SOC and OBC will both need to be resubmitted aligned to new templates and NHP design and funding assumptions.</p>   | <p>event that the Trust's 'Preferred Way Forward' is not approved.</p> <p>The BtLW Programme Team to continue to liaise with members of the Trust Board and Executive Management Team in connection with planning further communications, events and visits targeted at delivering a successful outcome.</p>   |
| <p><b>Funding and Cost Increases</b></p> <p>The Trust received assurance from the NHP SRO that its proposals could be delivered within the NHP funding allocation through the application of the Hospital 2.0 Model. A meeting was held with the NHP Executive on 24 July 2024, where it was reconfirmed that no major changes to the Trust's scope were currently required.</p> <p>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.</p> <p>Continued regular updates (as necessary) on the NHP are provided to the BtLW Programme SRO, the Hoff</p>   | <p>NHP to provide clarity surrounding budget allocation funding assumptions.</p> <p>Following the meeting with the NHP Executive held on 7 February 2024, the Trust has been requested to review the Hospital 2.0 Model, but this will not be published until May 2024.</p> <p>The SOC and OBC will both need to be resubmitted aligned to new templates and NHP design and funding assumptions.</p> <p>Enabling Works scope/costs and the requirement to respond to changing market factors and delays results in</p> | <p>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 July 2022 OBC and the need to fund all of its requirements.</p> <p>External advisers to provide regular updates on known and forecast key policy/design standard changes.</p> <p>Finance Workstream to review and update LTFM twice-yearly to capture any financial changes (and identify risks) in costs/income/inflation.</p> <p>BtLW Programme 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</p> |

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| <p>Project Delivery Board and Infrastructure Committee, with matters escalated to the Trust Board as necessary for Chair and Chief Executive action.</p> <p>A Finance Workstream has been established to support delivery through maintaining links to the Trust's wider financial management processes and consider the implications across the Trust as well as supporting the management of financial implications and risks, ensuring that integrated financial plans are in place and that performance against the Long-Term Financial Plan and Government guidance is monitored.</p> <p>The BtLW Programme Team has established processes to support the identification of value-engineering and cost mitigation strategies for assessment and implementation as necessary as the project is progressed.</p> <p>The BtLW Programme Team has implemented robust change management/control processes for changes to the design and cost variances against the submitted OBC.</p> <p>Continued regular (as necessary) updates are provided to the BtLW Programme SRO, the Hoff Project Delivery Board, and Infrastructure Committee on funding and affordability issues, including quarterly inflation updates. Inflationary updates are reported (as appropriate) to the NHP as part of the monthly Programme Director's report.</p> <p>The BtLW Programme Team has established a risk/contingency allowance based upon a quantified risk assessment which has informed the Outline Business Case. This is supported by a robust change control process managed by the BtLW Programme</p> | <p>enabling works and scheme costs exceeding funding estimates and OBC scope.</p> <p>Leeds Hospitals Charity previously agreed £30m fundraising target being adversely impacted by inflation and on-going Programme delays.</p> <p>Continued engagement is required with the RHS to confirm funding for the landscaping requirements once a route and timeline has been confirmed by the NHP.</p> | <p>approved £18m Transfer equipment replacement necessary to support the new hospitals.</p> <p>The BtLW Workforce Workstream and Deputy Chief Executive/Director of Estates are co-ordinating discussions with key CSUs to support the on-going development of workforce requirements ensuring they continue to be developed appropriately and are aligned with ways of working and workspaces to be implemented within the new healthcare facilities as well as meeting affordability and workforce planning requirements for the Full Business Case. 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.</p> <p>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.</p> <p>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 and buildability solution.</p> |
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| <p>Team with approvals by the HofF Project Delivery Board and further assurance by the Infrastructure Committee. Financial due diligence reports are completed on key contractors prior to their recommendation of appointment. There are robust controls in place to manage supplier contracts.</p> <p>Business cases are reviewed by NHP/NHSE and HMT at each stage to ensure compliance with guidance and to provide further on-going assurance.</p> <p>The Charities Workstream supports work to deliver the charitable funding target of £30m+ towards equipment with reporting presented by the Programme Director to the Capital Appeal Board about progress to deliver the Project (this reporting is currently paused as the Capital Appeal Board remains temporarily suspended pending a route forward being confirmed by the NHP).</p>                   |  |   |
| <p><b>Specification, design, and quality</b></p> <p>The NHP requirements and the Trust's Design Brief/design requirements are seeking to deliver a robust, flexible, and agile design solution within the constraints of affordability and build upon lessons learned including the recent COVID-19 experience.</p> <p>Significant clinical engagement completed by the BtLW Programme Team in the development of design briefing documentation and the design solution. Design proposals approved by CSUs.</p> <p>Robust change management/control processes established and implemented to monitor for design and cost variance against the OBC.</p> <p>The Trust has undertaken a comprehensive review of BtLW Programme and HofF Project governance whose outcomes will be implemented during the next Corporate Risk reporting period save for any further</p> | <p>Lack of clarity from NHP on the forward process, timescales, technical scope, design standards and budget assumptions relating to Hospital 2.0.</p> | <p>SRO and Programme Director to continue liaison with key members of the NHP Team on need for clarity and guidance on standards.</p> <p>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.</p> <p>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.</p> |

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| <p>delays to the delivery of the HofF Project. This will continue to ensure robust oversight and management of the co-ordination and delivery of the design development process.</p> <p>Regular dialogue between the BtLW Programme SRO and Programme Director and key members of the NHP Team around the need for clarity and guidance on standards regarding single rooms, room sizes, structural grids, net zero and digital requirements.</p>   |  |   |
| <p><b>Governance and Assurance</b></p> <p>The Trust has undertaken a comprehensive review of BtLW Programme and HofF Project governance whose outcomes will be implemented during the next Corporate Risk reporting period save for any further delays to the delivery of the HofF Project. The revised structure will continue to ensure there is robust assurance in place for the delivery of the HofF Project with internal management controls and delivery assurance supported through the Infrastructure Committee (complemented by assurance activities undertaken by PwC as the Trust's auditors).</p> <p>The BtLW Programme Team has regular discussions with NHS regulators, technical, financial, and legal advisers and strategic partners around technical design development, procurement and commercial strategies and business case development (on-going).</p> <p>Reviews are undertaken by NHSE, DHSC, and HMT at each key business case stage to ensure compliance with guidance and to provide further on-going assurance.</p> <p>An independent review of the Project/Programme governance arrangements has been completed by the NHP and the Project achieved the highest assessment score in the NHP Programme.</p> | <p>A review of supplier assurance processes and procedures/quality plans in connection with the delivery of contracts.</p> | <p>BtLW Programme Team to continue to review and update as necessary the Programme and Project governance arrangements.</p> <p>BtLW Programme Team to continue to review and respond to recommendations made through the independent PwC assurance review process (on-going).</p> <p>BtLW Programme Team to monitor services and works delivered by specialist/professional advisers in terms of the quality of deliverables through established project delivery arrangements.</p> <p>BtLW Programme Team to continue to evolve and develop local processes and assurance controls on an annual basis as part of the PEP review process.</p> |

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| <p><b>Stakeholder Engagement</b></p> <p>The BtLW Programme Team has established a programme-level Communications and Stakeholder Engagement Plan, supported by a specific plan to support the delivery of the Hospitals of the Future Project aligned to project and workstream delivery plans.</p> <p>The BtLW Programme Team has developed a Stakeholder Management Database which captures key stakeholder information and the status of engagement in supporting effective reporting.</p> <p>Monthly reporting of communications activities is presented at the Hospitals of the Future Project Delivery Board.</p> <p>A quarterly Stakeholder Engagement report is presented to the Hospitals of the Future Project Delivery Board.</p> <p>A six-monthly BtLW Staff Survey is completed alongside a Staff Temperature Check in-between each key six monthly survey.</p> <p>The BtLW Programme maintains information updates on the Trust's website and internal intranet including the presentation of the latest information on developments.</p> |  | <p>Following a period of pause, the BtLW Programme Team revised and re-issued its staff survey to ascertain awareness levels surrounding the proposals and progress made to deliver the Hospitals of the Future Project, current perceptions and to inform further future effective communications.</p> |
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| CRRO8: Risk of failure to deliver the pathology project.   | C = 4 | 20 | Very Low Risk   |   |   | Low Risk |   |   | Medium Risk                |   | High Risk |              | Significant Risk |    |   |               |  |  |
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|  | L = 5 |    | 1               | 2 | 3 | 4        | 5 | 6 | 8                          | 9 | 10        | 12           | 15               | 16 | 20  | 25            |  |  |
|  |       |    |                 |   |   |          |   |   |                            |   |           | Target Score |                  |    | Initial Score   | Current Score |  |  |
| Risk Description:  |       |    |                 |   |   |          |   |   |                            |   |           |              |                  |    | Executive Lead: Director of Finance   |               |  |  |
| There is a risk that the Pathology Operational Readiness Project fails to deliver its objectives as a result of:   |       |    |                 |   |   |          |   |   |                            |   |           |              |                  |    | Date Added to CRR: May 2020   |               |  |  |
| ▪ changes to the agreed works scope/requirements from Siemens that would require further design and enabling works by BAM;   |       |    |                 |   |   |          |   |   |                            |   |           |              |                  |    | Last reviewed: January 2025   |               |  |  |
| ▪ the potential for unforeseen elements within the Siemens project implementation plan/programme for the implementation of the Pathology Managed Services Contract (MSC);  |       |    |                 |   |   |          |   |   |                            |   |           |              |                  |    | Next Review: February 2025  |               |  |  |
| ▪ delays to the implementation of the new Laboratory Information Management System (LIMS) onto existing Pathology equipment (Phase 1) and new MSC-provided equipment (Phase 2);  |       |    |                 |   |   |          |   |   |                            |   |           |              |                  |    | Committee reviewed at:  |               |  |  |
| ▪ delays and/or lack of additional specialist resources to support the implementation of the LIMS and MSC Projects;  |       |    |                 |   |   |          |   |   |                            |   |           |              |                  |    | Pathology Operational Readiness Board, 29 October 2024                                      |               |  |  |
| ▪ delays in the implementation of workforce and associated change management plans;  |       |    |                 |   |   |          |   |   |                            |   |           |              |                  |    | Endorsed by Director of Finance, BtLW Programme SRO and Mike Bacon BtLW Programme Director. |               |  |  |
| impacting the overall critical path for operationalising the new CFLM and AHL Pathology facilities.  |       |    |                 |   |   |          |   |   |                            |   |           |              |                  |    |   |               |  |  |
| If the project is not delivered, the Trust will:   |       |    |                 |   |   |          |   |   |                            |   |           |              |                  |    |   |               |  |  |
| ▪ be unable to transfer all identified Pathology services into the CFLM and AHL following their commissioning to the agreed timeframe;   |       |    |                 |   |   |          |   |   |                            |   |           |              |                  |    |   |               |  |  |
| ▪ not deliver the benefits specified in the Full Business Case (FBC) in terms of being able 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; 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.  |       |    |                 |   |   |          |   |   |                            |   |           |              |                  |    |   |               |  |  |
| *The Pathology OR Project notes the financial risk to the Trust arising from potential delays to the vacant possession of the Old Medical School captured in the LGI Development corporate risk: “If the project is not delivered, the Trust will potentially incur costs of between £15m and £30m to pay for damages suffered by the selected developer of the OMS if vacant possession is delayed beyond its current long stop date of June 2026”. |       |    |                 |   |   |          |   |   |                            |   |           |              |                  |    |   |               |  |  |
| Controls   |       |    | Gaps in Control |   |   |          |   |   | Further Mitigating Actions |   |           |              |                  |    |   |               |  |  |
| Governance and Assurance   |       |    |                 |   |   |          |   |   |                            |   |           |              |                  |    |   |               |  |  |

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| <p>The Trust has implemented robust programme governance and assurance frameworks 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 Infrastructure Committee (and complemented by other independent assurance activities).</p> <p>A Gate 4 Review was completed by the IPA in November 2023 which made a number of recommendations, notably around ensuring that the governance and leadership for the operational readiness phase was appropriate. Revised governance arrangements have been implemented to ensure that appropriate officers are involved with accountabilities for MSC, LIMS and other delivery projects.</p> |  | <p>BtLW Programme Team and other Directorate Project and Programme Leads to review and respond to further PwC assurance reviews and recommendations (on-going).</p>   |
| <p><b>Managed Services Contract (MSC)</b></p> <p>The MSC Implementation Plan has been provided by Siemens which details the majority of equipment delivery and installation timelines. Delivery and installation of equipment to the CfLM commenced on 7 October 2024 and is well underway.</p> <p>Progress monitoring of the MSC Project is reported to the Pathology Operational Readiness Board, the BtLW Programme SRO, and the Infrastructure Committee in addition to separate governance arrangements for the MSC Project linked with WYAAT.</p>   | <p>Understanding the detail of what the changes in interfacing for some of the MSC equipment will mean for the end-to-end testing and staff resource planning.</p> | <p>(See below under LIMS deployment)</p> <p>The CSU Senior Management Team to continue to review and identify opportunities to bring non-MSC dependent services into the new building in line with previously planned timescales, as a contingency.</p> <p>The CSU team is also exploring the potential to move certain items of existing equipment into the CfLM if that could mitigate the risk of material delays with new MSC equipment going-live.</p> |

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| <p>New governance bodies, in the form of a revised Pathology Operational Readiness Board and Pathology Operational Readiness Progress Group, continue to optimise the co-ordination of delivery and dependencies of the MSC, LIMS and CSU project.</p>  |  |   |
| <p><b>MSC Enabling Works</b></p> <p>BAM has completed the agreed scope of enabling works to the CfLM (benching and the electrical, water and drainage facilities), with only minor snagging underway.</p> <p>MSC AHL Enabling works commenced in September 2024. The enabling works which require building regulations have been decoupled from the main works. As a mitigation, temporary works are planned to enable installation and verification of equipment. Works requiring building regulations will follow once approval is received, but these are being planned so as to mitigate impact to operationalisation of the AHL.</p> |  |   |
| <p><b>Pathology LIMS Deployment</b></p> <p>A DIT-led LTHT LIMS Project Board has been in place since January 2022 and meeting monthly to complement the work of the regional WYAAT Pathology Implementation Board.</p> <p>A regional deployment plan for LIMS has been developed with LTHT-specific implementation plan in place for completion by April 2025.</p> <p>Due to concerns raised around the slow turnaround of queries by Siemens relating to</p>   | <p>Uncertainty about the quantity of work required for LIMS2 from the Pathology team, whilst work continues with Clinisys to establish the level of change from existing interfaces. It is known however, that it is less than originally anticipated. The majority of the required testing is scheduled to occur throughout Q4 2024/25.</p> | <p>Continued progression of the level of detail required to establish clear resource plans for LIMS2 in particular, and securing the additional planned locum support.</p> <p>Trust Commercial, DIT, Clinisys and Siemens Teams are jointly arranging meetings with suppliers to confirm installation pre-requisites to ensure costs are understood and reflect the interfacing work required to be undertaken by Clinisys.</p> |

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| <p>middleware/interfaces, DIT has escalated this issue to the LTH LIMS SRO.</p> <p>LIMS delivery progress is reported to the Pathology Operational Progress Group, Pathology Operational Readiness Board, BtLW Programme SRO, the Executive Team (on a weekly basis) and the Infrastructure Committee in addition to separate governance arrangements to support the delivery of the LIMS Project linked with DIT and WYAAT.</p> <p>New governance bodies in the form of a revised Pathology Operational Readiness Board and Pathology Operational Readiness Progress Group have been established to optimise the co-ordination of delivery and dependencies of the MSC, LIMS and CSU projects.</p> <p>A Trust-led Cyber Security Working Group, with Siemens and NHSE, has been established to oversee Cyber Security arrangements across participating WYAAT Trusts.</p> |  | <p>DIT maintaining line of sight ensuring adequate resourcing to support both LIMS projects.</p> <p>The Trust Commercial Team are seeking legal guidance with regard to the contract's cyber security conditions and how these can be enforced.</p>  |
| <p><b>Workforce and Staff Engagement</b></p> <p>A clear staff engagement process and timetable has been developed and implemented which addresses the change of workforce location aligned to the operationalisation programme.</p> <p>Apart from harmonisation of start/finish times for two teams who will now co-locate in the CfLM, consultation on changes to rotas etc with other teams will not take place until all staff are transferred to the new facilities.</p>   | <p>Availability of suitable BMS locums in some specialties to support the resource plans for equipment V&amp;V and remaining LIMS implementation.</p> <p>Increased BAU staff gaps in some areas (Blood Sciences / SLM in particular) increasing the risk around capacity to deliver all the required V&amp;V and LIMS work in the timescales required.</p> | <p>On-going work with an extended range of locum agencies to bring in the required resources. Also working between specialties to see how best to deploy locum staff to align with key delivery deadlines (e.g. moving staff into areas to support the Dec LIMS go-live from areas going-live in March).</p> <p>Focused HR work with the teams around attendance management &amp; recruitment.</p> |

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| <p>Monthly change management workshops continue with updates provided by Service Leads to inform the Programme Plan.</p> <p>The BtLW Programme Planner has established bi-weekly programme planning sessions with Service Leads.</p> <p>CSU Team Brief (all staff invited) used to share latest plans around operationalisation.</p>   |   | <p>Vacancies put through for exemptions from the 13 week firebreak and are being supported.</p>  |
| <p><b>Pathology CSU Projects</b></p> <p>The BtLW Programme Team is providing co-ordination and project management support to the CSU in delivery of multiple projects and the management of dependencies which may impact operationalisation of the new facilities.</p> <p>New governance bodies in the form of a revised Pathology Operational Readiness Board and Pathology Operational Readiness Progress Group have been established to optimise the co-ordination of delivery and dependencies of the MSC, LIMS and CSU projects.</p> |   | <p>Pathology CSU and its speciality managers to ensure that Pathology CSU projects are adequately resourced and aligned to the wider operationalisation critical path.</p>   |
| <p><b>Business Continuity Planning (BCP):</b></p> <p>Business continuity planning is being stepped up with corporate support (as per LIMS go-live BCP). This issue has been added to the monthly Change Management workshop agenda to capture key aspects that need to be covered.</p>   | <p>The anticipated impact for each specialty.</p> | <p>Change management workshops to identify the anticipated impact for each specialty (if any) to users at the point of the transition and how any transition delays on the change dates themselves would be mitigated.</p> |

\* 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.

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| CRRO9: Risk of failure to deliver the LGI Site Development Project   | C = 4 |  | Very Low Risk   |   |   | Low Risk |   |   | Medium Risk                |   | High Risk |    | Significant Risk   |    |    |    |
|  | L = 4 |  | 1               | 2 | 3 | 4        | 5 | 6 | 8                          | 9 | 10        | 12 | 15   | 16 | 20 | 25 |
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| <b>Risk Description:</b><br>The management of this risk is commercially sensitive information which has been removed from the public version of the Corporate Risk Register. |       |  |                 |   |   |          |   |   |                            |   |           |    | <b>Executive Lead:</b> Director of Strategy (NB post November 2024, the executive lead will be Director of Finance)  |    |    |    |
|  |       |  |                 |   |   |          |   |   |                            |   |           |    | <b>Date Added to CRR:</b> May 2020<br><b>(Removed from CRR</b> Nov 2020<br><b>Re-added back to CRR:</b> November 2021  |    |    |    |
|  |       |  |                 |   |   |          |   |   |                            |   |           |    | <b>Last reviewed:</b> November 2024<br><b>Next Review:</b> May 2025  |    |    |    |
|  |       |  |                 |   |   |          |   |   |                            |   |           |    | <b>Committee reviewed at:</b><br>Endorsed by James Goodyear, LGI Development Site Project SRO and<br>Tori Critchley, Development Director, Innovation (28/10/24) |    |    |    |
| Controls   |       |  | Gaps in Control |   |   |          |   |   | Further Mitigating Actions |   |           |    |  |    |    |    |
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| CRRO10: Cyber-attack leading to potential loss of IT systems and/ or data  | C = 4 |  | Very Low Risk |   |   | Low Risk        |   |   | Medium Risk |   | High Risk |                            | Significant Risk   |    |    |    |  |
|  | L = 5 |  | 1             | 2 | 3 | 4               | 5 | 6 | 8           | 9 | 10        | 12                         | 15   | 16 | 20 | 25 |  |
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| <b>Risk Description:</b><br>The management of this risk is commercially sensitive information which has been removed from the public version of the Corporate Risk Register. |       |  |               |   |   |                 |   |   |             |   |           |                            | <b>Executive Lead:</b> Chief Digital & Information Officer |    |    |    |  |
|  |       |  |               |   |   |                 |   |   |             |   |           |                            | <b>Date added to CRR:</b> May 2022                         |    |    |    |  |
|  |       |  |               |   |   |                 |   |   |             |   |           |                            | <b>Last Reviewed:</b> October 2024                         |    |    |    |  |
|  |       |  |               |   |   |                 |   |   |             |   |           |                            | <b>Next Review:</b> April 2025                             |    |    |    |  |
|  |       |  |               |   |   |                 |   |   |             |   |           |                            | <b>Committee reviewed at:</b><br>DIT Committee             |    |    |    |  |
| Controls   |       |  |               |   |   | Gaps in Control |   |   |             |   |           | Further Mitigating Actions |  |    |    |    |  |
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| CRRO11: Insufficient DIT resources to update the Trust IT estate to a minimally supported standard, maintain it, and meet demand for DIT led projects.                       | C = 4 |  | Very Low Risk   |   |   | Low Risk |   |   | Medium Risk                |   | High Risk |    | Significant Risk  |    |    |    |
|  | L = 4 |  | 1               | 2 | 3 | 4        | 5 | 6 | 8                          | 9 | 10        | 12 | 15  | 16 | 20 | 25 |
|  |       |  |                 |   |   |          |   |   |                            |   |           |    |   |    |    |    |
| <b>Risk Description:</b><br>The management of this risk is commercially sensitive information which has been removed from the public version of the Corporate Risk Register. |       |  |                 |   |   |          |   |   |                            |   |           |    | <b>Executive Lead:</b> Chief Digital & Information Officer                  |    |    |    |
|  |       |  |                 |   |   |          |   |   |                            |   |           |    | <b>Date added to CRR:</b> Jan 2023  |    |    |    |
|  |       |  |                 |   |   |          |   |   |                            |   |           |    | <b>Last reviewed:</b> October 2024  |    |    |    |
|  |       |  |                 |   |   |          |   |   |                            |   |           |    | <b>Next Review:</b> April 2025  |    |    |    |
|  |       |  |                 |   |   |          |   |   |                            |   |           |    | <b>Committee reviewed at:</b><br>DIT Committee<br>Risk Management Committee |    |    |    |
| Controls   |       |  | Gaps in Control |   |   |          |   |   | Further Mitigating Actions |   |           |    |   |    |    |    |
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| CRRC1: Risk of exposure to HCAI   | C = 4 | 16 | Very Low Risk  |   |   | Low Risk |   |   | Medium Risk  |   | High Risk |    | Significant Risk  |               |               |    |
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|   |       |    | 1  | 2 | 3 | 4        | 5 | 6 | 8  | 9 | 10        | 12 | 15  | 16            | 20            | 25 |
|   | L = 4 |    |  |   |   |          |   |   | Target Score   |   |           |    |   | Current Score | Initial Score |    |
| <b>Risk Description:</b><br>There is a risk of patients developing hospital-acquired <i>Clostridioides difficile</i> infection, Methicillin Sensitive <i>staphylococcus aureus</i> (MSSA)bloodstream infection(BSI), respiratory infections and bloodstream infections caused by multi-resistant organisms , additionally there is a risk to staff and patient of being exposed to an infectious disease, due to a reliable and effective management system not being in place to protect patients and staff 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.<br><br>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. |       |    |  |   |   |          |   |   |  |   |           |    | <b>Executive Lead:</b> Chief Medical Officer<br><br><b>Date added to CRR:</b> March 19<br><b>Last reviewed:</b> October 2024 (Updated Nov 24)<br><b>Next Review:</b> April 2025<br><br><b>Committee reviewed at:</b><br>Quality Assurance Committee<br>Infection Prevention and Control Sub-Committee<br>22.04.24, 22.07.24<br>Risk Committee 3.10.24 |               |               |    |
| Controls  |       |    | Gaps in Control  |   |   |          |   |   | Further Mitigating Actions   |   |           |    |   |               |               |    |
| <b>Risk Assessment:</b> 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+). Staff level assessment of risk<br><br>Staff vaccinations offered on employment<br><br>A comprehensive mechanism for recoding staff immunisation assessment for childhood infectious diseases, such as measles and pertussis has commenced for all new starters. July 2024.  |       |    | Documentation of staff immunisation assessment for childhood infectious diseases, such as measles and pertussis, is not comprehensively recorded.<br>If there is a surge in cases, we do not currently have the resources to vaccinate large numbers of staff. |   |   |          |   |   | Following presentation of an options appraisal paper at OIPC July 24, for implementation of staff immunisation assessment for current employed staff in high-risk areas, Work is now being undertaken to understand the resource requirements. |   |           |    |   |               |               |    |

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| <p>Close surveillance of the current number of community cases is provided by our Virologists with an escalation plan to the Medical IPC Lead should there be a sudden rise in cases.</p> | <p>Current number of staff trained in High Consequence Infectious Diseases (HCID) PPE would not support an outbreak response for mpox clade 1</p>   | <p>Communication about the current increase in the circulation of measles and pertussis within the community has been briefed nationally and locally. Specific communications have been sent to Urgent Care, Children's and Women's CSUs explaining how staff can find out about their current vaccination status and where to go for immunisation.</p> <p>There have currently been no mpox clade 1 cases in the UK. A process for single case assessment, testing and care awaiting result has been established in LTHT. Staff on the infectious Disease ward are trained and a process for providing mutual aid established.</p> <p>HCID patient pathways established and appropriate clinical areas assessing the minimum number of staff needed to be trained to support an outbreak response. Numbers requested by end of Sep. 24</p> |
| <p>Laboratory Information System (LIMS) 'WinPath' is replacing 'Telepath' for all pathology specialties</p>   | <p>Reconfiguration of ICNET, required as part of WinPath implementation, has not yet commenced and the current proposed time frame and clinical development introduces a risk to delivering accurate and timely results from the LIMS impacting on the IPC team's ability to prevent the transmission of infection.</p> | <p>Proposed new date for LIMS implementation with microbiology and ICNET March 2025 November 2024</p>   |

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| <p>CPE national framework adopted at LTHT.<br/>Major outbreak Control Guideline activated. CPE Outbreak in Speciality Integrated Medicine brought under control.</p> <p>Updated surveillance software installed.</p> <p>ICNET Phase 3 Surgical Module delivery.</p> <p>TRS to test proof of concept for the SSI module Q4 paused</p> <p>HCAI reports generated weekly and circulated to clinical service units to monitor performance</p> <p>Medical IPC lead for surgery/anaesthesia appointed Dec 2023- this role to lead on improving infection prevention in pathways involving surgery and invasive devices.</p> <p>Covid -19 testing and management incorporated into national respiratory guidance and National Infection Prevention and control manual (NIPCM)</p> <p>External audit of the HCAI performance data processes completed all recommendations adopted.</p> | <p>LTHT implemented the National Framework of Actions to contain CPE, but not in its entirety due to the significant financial and operational implications to the Trust. Major Outbreak of CPE identified in SIM.</p> <p>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.</p> | <p>Number of cases falling, monitoring and oversight managed locally by CSU</p> <p>Given several recent outbreaks of CPE, and the enduring risk of CPE endemicity within the Leeds elderly care population, a review of our approach has been presented to the Executive Team and a proposal of the testing modality for CPE, in light of new local epidemiology is to be presented to DIPC August 2024 and a request for a paper to be submitted to TERG made .</p> <p>Request for work submitted waiting to be prioritised for Impact Assessment with the solution Architects.<br/>Reconfiguration of ICNET, required as part of WinPath implementation, is impacting on delivery of this priority proposed date for LIMS implementation March 2025</p> |
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| <p><b>Training, Policies and Guidelines:</b> Essential and Mandatory infection prevention and control training to all staff, with an overarching Infection Prevention and Control Policy and a suite of Guidelines and SOPs.</p> <p>Current national CPE guidance Implemented within Adults</p> <p>New National Carbapenemase Producing Enterobacteriaceae ( CPE) guidance implemented in Leeds Children's hospital</p> <p>Quality Improvement methodology adopted with a Trust wide HCAI collaborative and LIM.</p> <p>LTHT has implemented the National Infection Prevention and Control Manual (NIPCM) for England.</p> <p>National IPC Manual implemented plan re-aligned with HCAI Annual Commitment.</p> |   |  |
| <p>Environmental Controls: Environmental decontamination programme and standards, segregation and safe disposal of waste process, programme of water safety, ventilation safety and IPC design incorporated into refurbishments and new builds.</p> <p>NNU Major Outbreak Control closed. Oversight and scrutiny of interventions required to sustain control provided by CSU. Robust action plan implemented including programme of education completed, and routine monitoring of compliance is providing assurance.</p> <p>Refurbishment of NNU ahead of the planned BTLW agreed.</p> <p>Rapid action tender to scope building work commenced October 2023</p> <p>Formalised cot numbers produced .</p>     | <p>LGI NNU has experienced new outbreaks of infection related to practice and environment</p> | <p>Epidemiology and clinical reviews have identified environmental risks that are significant enough to require environmental changes. A task and Finish group has been convened to include Associate Director of Corporate planning ,the Director Infection Prevention and Control ,Children's CSU and the lead clinicians to work through the clinical risk and mitigations.</p> |

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| <p>L43 Ventilation plant requires replacement as part of asset management. Progressing with capital funding assessment. March 2024.</p> <p>L43 NNU external visit by NHSE and UKHSA occurred 5 June 2024. Awaiting evaluation report.</p> <p>Rolling programme of HPV decontamination instigated in response to the CPE outbreak in SIM</p> <p>Continue to HPV infections of CDI &amp; CPE, taking the opportunity to HPV all patient shared equipment where possible. HPV ongoing in Oncology CSU admissions ward.</p> <p>Rolling programme of HPV decontamination commenced where temporary access to vacant areas occurs.</p> <p>Hierarchy of controls completed by clinical teams which details controls, risks, and mitigations for Covid-19.</p> <p>All adult haematology en suite side rooms redesigned to reduce risk from water borne infection.</p> <p>All patients in adult haematology receive written information about reducing risk of infection related to water hygiene and safety.</p> <p>Antimicrobial stewardship in adult haematology including weekly patient screening</p> <p>Active <i>Pseudomonas aeruginosa</i> surveillance in all augmented care is in place, and regular multi-disciplinary <i>Pseudomonas aeruginosa</i> risk assessments and evaluation of probable water-borne infection is occurring in all augmented care units at LTHT.</p> | <p>Rolling programme of whole ward HPV decontamination paused as current decant facility is providing winter bed capacity.</p> | <p>The CPE rolling programme of HPV within SIM is monopolising Trust resource and a review is being undertaken to identify ways to support other CSU'S with a proactive HPV resource and incident response service.</p> |
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| <p>A multidisciplinary task and finish group has been formed to deliver an assurance programme for the trust based on the learning in haematology.</p> <p>IPC involvement in design, refurbishment, and new builds.<br/>Live bed state test phase completed</p> <p>Side Room Management eForm designed to facilitate oversight and optimise isolation of infectious patients and clinically appropriate stepdown of side-room available</p> <p>Side room capacity increased in ED, ARCU and Critical Care, with additional 12 side rooms across LGI, SJUH and CAH Feasibility study completed on the ability for 3 extra side rooms in Gledhow wing, namely J15,16 and J17 A further increase of 3 side rooms have been provided on J33 in December 2022.</p> <p>Capital planning programme for 2024/25 includes the redevelopment on J42/43.<br/>this would increase the number of side rooms within the Trust.</p> <p>Corporate planning review supports increasing side room capacity in Beckett Wing.</p> <p>Respiratory patient pathway areas reviewed to understand where further mechanical ventilation or increased side room capacity is required.</p> <p>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.</p> | <p>Limited side room capacity in the unplanned pathway.</p> | <p>Live bed state currently being rolled out across the Trust followed by side room utilisation test phase.</p> <p>Side room Management Eform report being generated to support CSU's to understand utilisation, compliance and improve patient flow.</p> |
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| <p>Working group to review the estate, clinical requirements and ventilation capital investment formed. First meeting held September 8 2023. Risk matrix under development.</p> <p>A monthly Trust-wide ventilation safety group has been established from September 2021 to provide monitoring, oversight and assurance around our current ventilation and enhance the use of new technologies.</p> <p>Options appraisal identified opportunities to provide two Redi-rooms in Becket Wing to provide isolation with inbuilt mechanical ventilation.</p> <p>Portable air scrubbers provided following impact assessment by the clinical team and ventilation group.</p> <p>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.</p> | <p>Large parts of the estate have natural ventilation only.</p> |  |
| <p>Antimicrobial Stewardship: Policies and Standards, City Wide Group, Ward Rounds and day 3 IV antimicrobial review.</p>   |   |  |
| <p><b>Detection:</b> Monthly surveillance monitoring and assurance through monthly Perfect Ward meetings and additional hand hygiene audits and ward assurance visits.</p> <p>IPC Leadership team continued to review the HCAI performance at Trust CSU and ward level.</p> <p>Consultant Microbiologists provided ward and CSU level review and feedback.</p> <p>HCAI assurance monitoring through the Perfect Ward</p>  |   |  |

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| <p>expanded to include all national HCAI objectives by January 2022.</p> <p>IQPR expanded to include all national HCAI objectives by January 2022.</p>  |   |  |
| <p><b>Recovery and lessons Learned:</b> Outbreak Management. Incident investigations. City wide Outbreak response group.</p> <p>CSUs manage individual root cause analysis reviews and Outbreak Meetings with support from Consultant Microbiologists, IPCT, Antimicrobial Pharmacists and DIPC/DDIPC.</p> <p>Kaizen office supporting implementing PSIRF for HCAI. Rapid process Improvement Workshop 30 day report out March 2024, 60 day report out April, with planned phased roll out in Cardio-respiratory CSU.</p> <p>Trial areas increased to understand impact in other specialties. Oncology CSU and two wards within Adult Critical care participating with Abdominal Medicine and Surgery and Leeds Children's Hospital scheduled to participate mid July 2024</p> <p>Development of CSU microbiologist role to include reporting of themes and trends from RCAs to CSU clinicians, reporting to IPCT to allow trust-wide learning- consultation completed implementation as part of annual commitment.</p> <p>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.</p> | <p>Feedback of lessons from RCAs to clinicians is variable across LTHT, in some areas learning may not be shared effectively. Not all CSU's have a designated Consultant Microbiologist to support.</p> | <p>Successful recruitment to Microbiologist role. post holder commencing December 24</p> <p>PSIRF trial now live in 66% of bed holding CSU'S Planned for Trust wide launch in Q3. Request for work submitted to digitalise the post infection proforma-no progress to date current mitigation to upload paper copy of document onto PPM</p> <p>HCAI MDT review clinics to commence in PSIRF trial areas led by Microbiologists and IPC team. First clinic held 16/9/24 .</p> |

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| <p>Stop the line investigation process instigated for single COVID-19 nosocomial investigations.</p> <p>The new process for clinical review included in the HCAI PSIRF CSU consultation October 2023</p> <p>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.</p> <p>Revised and strengthened the IPC governance committee structure to enable the Trust to ensure monitoring and oversight occurs and assurance is reported and recorded through the appropriate IPC structure and integrated within the Trust Quality and Safety governance structure.</p> |  |  |
| <p><b>Assurance:</b> HCAI assurance is monitored through the Infection Prevention and Control Governance Structure.</p> <p>Latest BAF and Health and Social Care Act 2008: Code of 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 &amp; BAF.</p> <p>Recruitment for Medical AMS lead role completed.</p> <p>Covid-19 assurance is monitored through the Trust OIPC group and IPC governance structure.</p>   |  |  |

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| <p>Board oversight is provided through the Infection Prevention and Control Annual Programme and combined Board Assurance Framework, published by NHSE in May 2020.</p> <p><b>Cross-ref: CRR04-</b> Integration of the IPC Annual programme and new Board Assurance Framework within the reset work streams completed, and CSU's are invited to provide an assessment of their position against the programme at the operational infection prevention and Control Group (OIPC) and HCAI group. Control now integrated into CRR01, and workstreams have now moved into transforming services workstream. CSU's presenting assurance to OIPC against the annual programme and BAF.</p> <p>Medical Workforce redesign completed. New Medical IPC Lead role appointed 1 September 2022. Review of current medical leadership to support the Medical IPC Lead completed recommendations adopted. Trust wide IPC Medical appointments made to AMS post September 2023 IPC Medical Anaesthetic and Surgical Lead December 2023 IPC Medical High Consequence Infectious Disease post February 2023 supporting wider IPC plan.</p> <p>IPCN development plan in place.<br/>Pathology CSU Tri Team to describe workforce plan and support given at Operational IPC meeting October 2023<br/>New JD to include AHP approved. IPCT Successfully recruited too. Team now at full establishment</p> | <p>Consultant Microbiologist vacancy- not all CSU's have a designated Consultant Microbiologist to support the HCAI reduction strategy</p> | <p>IPC consultant microbiologist/virologist CSU collaboration reduced. Successful recruitment to Microbiologist role commencing December 2024</p> |
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| CRRC4: Emergency Care 95% Constitutional Standard   | 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 |    |
| <b>Risk Description:</b><br>Failure to achieve the 95% 4 hour emergency care Constitutional Standard caused by increases in department attendances, insufficient rostered workforce to meet the needs of patients and long delays in patient placement into the hospital bed base. This can lead to a congested department resulting in patient harm, impacting on patient outcomes, patient experience, increased infection risk and staff morale. |       |    |   |   |   |          |   |   |   |   |           |    | <b>Executive Lead:</b> Chief Operating Officer                   |               |               |    |
|   |       |    |   |   |   |          |   |   |   |   |           |    | <b>Date Added to CRR</b> May 2014                                |               |               |    |
|   |       |    |   |   |   |          |   |   |   |   |           |    | <b>Last Reviewed:</b> January 2025                               |               |               |    |
|   |       |    |   |   |   |          |   |   |   |   |           |    | <b>Next Review:</b> July 2025                                    |               |               |    |
|   |       |    |   |   |   |          |   |   |   |   |           |    | <b>Committee reviewed at:</b><br>Finance & Performance Committee |               |               |    |
| <b>Controls</b>   |       |    | <b>Gaps in Control</b>  |   |   |          |   |   | <b>Further Mitigating Actions:</b>  |   |           |    |  |               |               |    |
| Daily management established including 8.30 am huddle, CSM status reviews and report and patient flow and discharge huddles, escalation meetings chaired by Director of Operations or Deputy Chief Nurse and silver meeting as required aligned to the operational response guidance in place.<br>-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.<br>Early identification and escalation of patients awaiting repatriation to other hospitals and any patients awaiting transfer into LTHT.<br>Escalation process ensures director presence at the 8.30 am huddle and escalation of patient delays to bronze and then tri team members as daily management.<br>When demand for inpatient beds outstrips capacity there is a suite of requested actions as per the Operational flow guidance document for standard work and certain pre agreed triggers. |   |           |    |  |               |               |    |
| Daily monitoring and reporting of 4-hour performance<br>Implementation of the 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  |   |   |          |   |   | The daily monitoring and RAIDR real time reporting enables real time responsiveness to developing delays across several urgent and emergency care areas.  |   |           |    |  |               |               |    |

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|  | <p>Absence of real time electronic bed state and real time bed and patient placement overview.</p> <p>Current process is 2 hourly safety rounds commence at 4 hours in department. Gap in control for frailer/ more vulnerable patients that may need safety rounds from arrival.</p> <p>Gap in control is the 2 hourly safety round compliance and 12 hours from decision to admit and 24 hours in department is not currently clinically reviewed outside the CSU.</p> | <p>Weekly director review of ECS weekly Key Line of Enquiry report on 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.</p> <p>Twice daily meetings held by the Urgent Care team to ensure capacity and demand met.</p> <p>New trajectory to deliver 78% ECS by March 2025 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.</p> <p>ED Patient 2 hourly safety rounds completed and recorded with assurance checks completed. Long waiting patients within the ED for more than 12 hours from bed request are escalated as per the patient flow guidance document. Daily, weekly and monthly report and review by Directors at weekly huddle.</p> <p>Patients over 24 hours in ED reported on the weekly Executive score card and through NHSE KLOE daily reports.</p> |
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| <p>Patients with mental health conditions with long waits for a mental health bed are flagged on the Daily Operation report within LTHT.</p> <p>There is an escalation process to LYPFT (mental health Trust) and ICB.</p>              | <p>There is insufficient mental health inpatient bed capacity to meet demand.</p> <p>Limited impact from current escalation process.</p> <p>SOP for care of patients with mental health conditions to be developed which describes necessary clinical monitoring and actions required for maintenance of patient safety including escalation process for patient or staff safety concerns.</p> | <p>All patients awaiting over 24 hours in the ED will be reported on the NHSE KLOE for SCC engagement</p> <p>Review of current escalation process is planned for July 2024</p> <p>SOP for care needs of patients with mental health conditions to be developed by July 2024 including escalation processes</p>   |
| <p>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).</p> | <p>The estate footprint constraints and adjacency for universal SDEC offer.</p>  | <p>Continued monitoring of ED attendance profile and 95% compliance and breach analysis for patients streamed away from ED.</p> <p>24/7 medical and elderly SDEC at SJUH with a programme board in place to continue to develop same day ambulatory offers and PCAL for all patient cohorts. in place</p>  |
| <p>Business continuity plans in place for times of high acuity/ attendances to ensure safe patient placement when ED capacity is inadequate for demand.</p>   | <p>The estate footprint constraints within EDs</p>   | <p>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.</p> <p>Nurse and medical staffing reviewed to ensure patient safety and timeliness of care across a larger footprint.</p> <p>Agreed surge plans for extremis developed as part of a Decision Management Tool to space within or adjacent to the ED's</p> <p>Minor injury straight to test is routine practice to support rapid test and treat/decision</p> |

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| System Gold action plan developed through Active System Leadership Group.  | Community capacity to support timely transfer of patients from acute bed base.<br>Complexity of discharge pathways.<br><br>Measurable impact of system actions. | Implementation and monitoring against the key objectives through Active System Leadership Group.   |
| Seasonal planning with CSU's and system partners for 2024/25 including Respiratory Infections, COVID19, RSV and flu modelling. | Unpredictable activity levels and demand.   | Annual review of the operational response guidance and impact at CSU level is developed and monitored through daily operational processes. Overall impact is reviewed as part of the winter review process with learning taken forward to inform the next round of seasonal planning. System owned schemes monitored for implementation and impact at Active System leadership meetings. Modelling versus actuals is reviewed to enable responsive configuration of services, state of readiness and discussed pan city. |

| CRR5: 18-week<br>RTT Constitutional<br>Standard   | C = 4 | 20 | Very Low Risk |   |   | Low Risk   |   |   | Medium Risk     |  | High Risk |    | Significant Risk  |    |                  |                  |
|---|-------|----|---------------|---|---|--|---|---|-----------------|--|-----------|----|---|----|------------------|------------------|
|   | L = 5 |    | 1             | 2 | 3 | 4  | 5 | 6 | 8               | 9  | 10        | 12 | 15  | 16 | 20               | 25               |
|   |       |    |               |   |   |  |   |   | Target<br>Score |  |           |    |   |    | Initial<br>Score | Current<br>Score |
| <b>Risk Description:</b><br>There is a risk that the Trust will not deliver 18-week RTT constitutional standard 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, and reduced levels of productivity across some specialities in outpatients, diagnostics and theatres. This is made more challenging by the reduction in activity that has occurred as a result of periods of industrial action and periods of staff absence.<br><br>This results in a poor experience for patients. There is a risk that some patients may experience harm, including deteriorating symptoms and condition and impacts on health and wellbeing 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. |       |    |               |   |   |  |   |   |                 |  |           |    | <b>Executive Lead:</b> Chief Operating Officer                |    |                  |                  |
|   |       |    |               |   |   |  |   |   |                 |  |           |    | <b>Date Added to CRR:</b> May 2014                            |    |                  |                  |
|   |       |    |               |   |   |  |   |   |                 |  |           |    | <b>Last Reviewed:</b> September 2024                          |    |                  |                  |
|   |       |    |               |   |   |  |   |   |                 |  |           |    | <b>Next Review:</b> March 2025                                |    |                  |                  |
|   |       |    |               |   |   |  |   |   |                 |  |           |    | <b>Committee reviewed at:</b> Finance & Performance Committee |    |                  |                  |
| Controls  |       |    |               |   |   | Gaps in Control  |   |   |                 | Further Mitigating Actions:  |           |    |   |    |                  |                  |
| The 2024/25 priorities and operational planning guidance set the challenge that NHS organisations reduce the longest waits for patients to 65 weeks by 30 <sup>th</sup> September 2024. -This recognises that delivery of 18 weeks will not be achieved   |       |    |               |   |   | 18-week RTT remains a constitutional standard  |   |   |                 |  |           |    |   |    |                  |                  |
| 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   |       |    |               |   |   | Validation does not deliver any additional capacity in areas where backlog continues to grow                   |   |   |                 | CSUs are working through PIFU protocols to support the validation outcomes and embedding wider PIFU options in specialities.   |           |    |   |    |                  |                  |
| Robotic Process Automation (RPA) supports the administrative validation of the entire RTT waiting list and is further supported by targeted clinical validation   |       |    |               |   |   | Volume of patients means that capacity to undertake reviews is limited and may require cancellation of clinics |   |   |                 | This is further supported by <ul style="list-style-type: none"><li>- the roll out of GIRFT: Further Faster handbooks across 15 specialties.</li><li>- e-Outcomes</li><li>- Reduction of low clinical outcome activity</li><li>- Clinic Utilisation</li></ul> |           |    |   |    |                  |                  |

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| <p>Implementation of telephone and video conferencing facilities have enabled non-face-to-face appointments to be delivered.</p>                               | <p>Not suitable for patients where investigation or examination is required</p> <p>Virtual activity does not clock stop as many patients RTT pathways as face to face activity.</p>   | <p>Face to face activity is restored where clinically required. Alternatives to follow-up (PIFU) and remote monitoring of patients continue to be developed, but uptake is not as rapid as hoped.</p> <p>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</p> <p>LTHT is currently reviewing the current contract for video conferencing</p> |
| <p>Triage of referrals enables identification of some patients at risk of harm if appointments are delayed.</p>  | <p>Quality of referrals from GPs can vary.</p> <p>Primary Care collective action may reduce uptake of Advice and Guidance</p>   | <p>Delivering easier access to consultant opinion for GPs ahead of referral through enhanced advice and guidance systems</p> <p>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.</p>   |
| <p>Delivery contracts have been revised to link to 2024/25 planning guidance to focus on key outcomes. 65 week delivery trajectories agreed with each CSU-</p> | <p>Demand variation from winter modelling / Covid modelling will impact elective delivery</p> <p>Continued impact of Industrial Action reduces available capacity</p> <p>Some specialties have larger waiting lists and / or more constrained</p> | <p>LTHT Winter Plan approved to manage capacity through anticipated spikes in non-elective demand and to protect elective capacity.</p> <p>Chief Operating Officer / Deputy Chief Operating Officer and Director of Operations meet with CSUs that are unable to meet agreed trajectory. Additional support identified and recovery actions agreed.</p>  |

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|  | capacity to deliver 78 & 65 week trajectories   |  |
| 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.  | Go live of CDCs (Community Diagnostic Centres) in 2023/24 and 2024/25 will increase funded capacity for some specialties particularly in imaging and physiological assessments/tests.  |
| Effective advice and guidance can support primary care decision making and reduce unnecessary referrals  | Absence of standardised system/approach to support the capture, recording and reporting of advice and guidance into EPR prevents roll-out to all specialties.<br><br>Primary Care collective action may reduce uptake of Advice and Guidance  | Standardised approach to receiving, recording and reporting advice and guidance in development and to be implemented by Q2, 2024/25.   |
| 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.<br><br>There is insufficient capacity in specialties that are prioritised to reduce risks: <ul style="list-style-type: none"> <li>• Cardiac surgery</li> <li>• Max Facs surgery</li> <li>• Endocrine surgery</li> <li>• Neuro surgery</li> <li>• Plastic surgery</li> </ul> | All P4 patients above 80 weeks to be considered as P3 patients to support booking of long waiting patients<br><br>Additional theatre capacity sourced 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 and development of two additional theatres at WDH, going live in <del>November</del> September 2024 |

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| 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 or reduction of longest waiting patients.  | Patient safety, quality or governance risks are escalated through CSU Governance Meetings in line with Quality Governance Framework.  |
| 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 process for the clinical and administrative review of P2 patients was approved by QAC in October 2023, as well as the process for monitoring compliance and risks via the creation of standard agenda item of P2s at Clinical governance meetings and speciality access meetings.  | CSUs may not have the capacity to deliver the frequency of clinical validation required for P2 patients.  | CSUs to create risk register entry for any specialty where they are unable to treat P2 patients within 28 days and their mitigations to patient harm. Now a standard item on CSU access meetings and clinical governance meetings   |
| 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<br><br>BMA rate card has reduced the number of sessions provided by consultant staff                         | 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<br>The ICB has increased capacity for the IPT of additional non-admitted and admitted activity in Orthopaedics, General Surgery, Spinal, Ophthalmology, Plastics, Urology, Gastroenterology, ENT and Gynae. |

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|  | There is currently no capacity for paediatric elective activity at tariff in the Independent Sector  |  |
| 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   | Available WYAAT capacity is often at additional cost due to local provider payment mechanisms  | Agreement that additional activity will be delivered and only material costs recovered   |
| Develop Elective hub at WDH to increase elective activity that can be delivered.   | WDH site won't be operational until September 2024<br><br>Re-allocation reduces capacity for other specialties                                 | Allocations linked to WL position as well as ability to treat P2 patients, and ability to utilise overnight stays so reducing demand on inpatient capacity at SJUH and LGI           |
| 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   | Critical Care capacity can change overnight due to staffing absence or high numbers of unplanned admissions and result in on day cancellations |  |
| The Planned Care Programme, and Outpatient P & T Programme within the Transforming Services Programme is focussed on workstreams that enable best use of resources, productivity, efficiency, and the optimisation of elective patients for surgery through a number of workstreams to keep increasing performance against key KPIs such as utilisation / Day case rate / Elective LoS / | Impact of unplanned pressures on elective bed base<br><br>Willingness of clinicians to do extra work due to pension / tax issues               | 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. |

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| <p>Average Case per session / DNA/WNB rate / cancellation (patient and hospital) rates / first to follow up rate / advice and guidance provision</p>   | <p>Capacity to focus on improvement work alongside operational pressures</p> <p>Impact of Industrial Action</p>  | <p>A specific Theatre productivity and efficiency PID for 2024/25 has been developed to deliver an increase in list utilisation and cases per session by individual specialities and theatre suite.</p> <p>A specific Outpatients productivity and Transformation 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).</p> <p>These projects will report through the Waste Reduction Board chaired by the CEO and will increase the elective activity delivered by the Trust.</p> |
| <p>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. A 6-monthly report is provided to Quality Assurance Committee.</p> | <p>The process approved is time consuming, and requires forms to be completed manually and uploaded to PPM+.</p>   |   |
| <p>PIDMAS (Patient Initiated Digital Mutual Aid System) live as of November 2023. All adult, non tertiary patients over 40 weeks were contacted to ask if they would move provider for quicker treatment.</p>  | <p>ICB identifies available capacity, but this does not guarantee this capacity is available for the patient or the provider will accept the patient</p> | <p>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.</p>  |

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|  |  | 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 |
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| CRR6: 2WW, 31 Day and 62-Day Cancer Constitutional Standard   | C = 4 | 16 | Very Low Risk  |   |   | Low Risk |   |   | Medium Risk  |              | High Risk |    | Significant Risk  |    |               |               |
|---|-------|----|--|---|---|----------|---|---|--|--------------|-----------|----|---|----|---------------|---------------|
|   | L = 4 |    | 1  | 2 | 3 | 4        | 5 | 6 | 8  | 9            | 10        | 12 | 15  | 16 | 20            | 25            |
|   |       |    |  |   |   |          |   |   |  | Target Score |           |    |   |    | Current Score | Initial Score |
| <b>Risk Description:</b><br>There is a risk that the Trust will not meet the 28 day, 31 day and 62 day constitutional standards related to cancer diagnosis and treatment due to increasing referral rates from primary care, insufficient capacity that is not flexible to respond to peaks in demand, diagnostic pathways.<br><br>This results in a poor patient experience. Some patients may experience harm, including deteriorating symptoms and condition and impacts on health and wellbeing 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.  |       |    |  |   |   |          |   |   |  |              |           |    | <b>Executive Lead:</b> Chief Operating Officer<br><br><b>Date added to CRR:</b> May 2014<br><b>Last Reviewed:</b> Dec 2024<br><b>Next Review:</b> June 2025<br><br><b>Committee reviewed at:</b><br>Finance and Performance Committee |    |               |               |
| Controls  |       |    | Gaps in Control  |   |   |          |   |   | Further Actions Planned:   |              |           |    |   |    |               |               |
| <p>Operational plans to meet the waiting time standards set out in the NHS Constitution (2012) and revised cancer waiting standards (October 2023).</p> <ul style="list-style-type: none"><li>As part of the NHS Constitutional Standards, the patient has a <b>right</b> A maximum 28 day wait from receipt of an urgent referral for suspected cancer, receipt of urgent referral from a cancer screening programme, or receipt of urgent referral of any patient with breast symptoms (where cancer not suspected) to the date the patient is informed of a diagnosis or that cancer is ruled out</li></ul> <p>a maximum one month (31-day) wait from a decision to treat, or earliest clinically appropriate date, to treatment of cancer</p> <p>a maximum 2-month (62-day) wait from receipt of an urgent GP (or other referrer) referral for urgent</p> |       |    | <p>Variation in capacity requirement</p> <p>Demand controlLack of micro-management of pathways</p> |   |   |          |   |   | <p>Monthly accountability meetings with the COO and Deputy COO by Cancer Pathway.</p> <p>Task and finish groups looking at LIM work to streamline pathways.</p> <p>Project Manager posts funded by the Alliance have been appointed and working with H&amp;N, Pathology, Skin, Radiotherapy.</p> <p>Reviewed PTL process implemented</p> |              |           |    |   |    |               |               |

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| suspected cancer or breast symptomatic referral, or urgent screening referral, or consultant upgrade, to first definitive treatment of cancer   |   |  |
| The 2024/25 Cancer National Priorities and operational planning guidance to improve the 62 day position sets out a recovery of 70% by March '25 This recognises that the delivery of 85% will not be achieved nationally. | 85% of patients should receive their cancer treatment within 62 days.   | Full organisational pathway management of cancer pathways with support from LIM.   |
| 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 was launched in February 2024 which sets out ambitions for improvement of cancer services over the next 3 to 5 years.   |   | Transformation of Cancer service for ongoing LIM and support work.<br>Action tracker to be updated<br>CSU ownership through the 7 commitments  |
| Radiotherapy Task and Finish group established to review Capacity and Demand.   | <p>Radiotherapy are currently experiencing delays for radiotherapy treatment. This is a combination of an increase in referrals this year , by 8% since January, alongside a significant reduction in workforce capacity.</p> <p>It has become necessary to prioritise radiotherapy referrals across all tumour types to minimise harm associated with increased waiting times, the current waiting times (as of 23<sup>rd</sup> May 2024) by categorisation of acuity are:</p> <p>Category A referrals - 29-30 days<br/>Category B referrals - 31days<br/>Category C referrals - 47-51 days<br/>Category D referrals - 64 days</p> | <p>Task and Finish Group established to focus on:</p> <p>Workforce<br/>A full review of all patient flow reviewing of service pathways and bottlenecks (LIM methodology), benchmarking of service.<br/>Digital – Review of digital systems and progression to full utilisation to release capacity<br/>Recovery Plan in place and trajectory agreed<br/>Additional planners recruited via Tiering funding<br/>Requirement to embed in SDAM process</p> |

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| Pathology turn around times across cancer pathways   | Turn around of samples within 7 days (Trust standard) is currently not achieving   | Alliance funded Project Manager appointed and developing a Improvement plan<br>Task and Finish Group established to focus on: Workforce<br>A full review of all patient flow reviewing of service pathways and bottlenecks (LIM methodology), benchmarking of service  |
| Recovery plan in place for the skin backlog position   | Reliant on additional activity and conversion of existing routine capacity in dermatology to improve 1 <sup>st</sup> OP performance.<br><br>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.<br>Long term workforce plan being developed to create sustainable service.<br>Review of Pathology capacity for pulling the patients through their pathway<br>Capacity review for Plastic Surgery for timely treatment from decision to treat and treatment within 31 days.<br>Alliance Funded Project manager has been appointed. |
| MDT Review   | Capacity within MDT due to volume of patients for review.  | Review of all MDTs to ensure that they are in line with recommended standards, where a patient does not need to go through MDT this is clearly recorded and patient proceeds to treatment following a standard of care. This will ensure capacity is released for patient review offering more timely care.  |
| Breach review to be undertaken for all patients that breach 62 days<br>Harm reviews undertaken for patients waiting longer than 104 days | Delays in treatment for patients waiting longer than national standard   | Breach review learning to be completed with action plans developed.<br>The RCAs are completed by the Corporate Cancer team but where there is suspicion of harm this is devolved to CSUs for   |

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|  |  | review/assessment for greater learning and implementation of change.   |
| 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.<br><br>LTHT capacity does not match the demand to deliver treatment within 62 days.   | Maintain oversight at Cancer Centre Trust Board and report through IQPR.<br>Weekly PTL meetings reviewing long waiting patients clear documented actions.<br>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.                  |
| Delivery Contracts with CSUs have been updated in line with the 24/25 agreement and are reflected within the Service Delivery Meetings and Integrated Accountability Meetings  | Demand modelling for capacity and impact from Industrial Action  | -Recovery plans and trajectories are in place with joint accountability meetings across CSUs to reflect management of the full patient pathway   |
| 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<br>Late referrals from other organisations. | Skin GPSI has been appointed to streamline referral process between primary and secondary care.<br>Gynaecology and Head and Neck are also meeting with GPs to discuss referral pathways.<br>Escalation report for late IPT pts with direct conversation with referring Trusts via Cancer Management team   |
| 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 | Bed, theatre, HDU staffing and patient priorities not optimally aligned due to continuing acute bed pressures.   | 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 Reviewed through the CSUs 6-4-2 process for booking of elective procedures Linking of Optimal Pathways transformational work with |

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|   |   | referring trusts work programmes to improve timely transfers.  |
| <p>Down time of Chemocare system presents risks to timely delivery of Chemotherapy services. A business continuity plan is in place and a recovery plan has been created to allow the service to return to normal delivery as soon as possible.</p> <p>No episodes of downtime exceeding 24 hours have occurred</p> | <p>Unplanned downtime of the Chemocare system presents a significant risk to both adult and paediatric chemotherapy services. This could result in disruption and the cancellation of patient treatments, less favourable patient outcomes and an adverse impact on cancer survivorship as well as reputational damage to the organisation.</p> | <p>Reverting to paper process only suitable for first 24 hours of downtime. New patients will not be able to start treatment.</p> <p>Recovery time from downtime not commensurate with period of down time. It is anticipated that recovery to business as usual state from one week of downtime would take 4-6 weeks. This would also have impact on Radiology, phlebotomy and Pathology services due to need for imaging and blood testing.</p> <p>Procurement of laptops to support business continuity should allow the risk score to be reduced in Q3 2024/25</p> |

|  | C = 4 |  | 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 |

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| CRR7: Failure to achieve 28 days cancelled operations Constitutional Standard  | L = 4 | 16 |  |  |  |  |  |   | Target Score |  |  |  |  | Initial Score | Current Score |  |
| <b>Risk Description:</b><br>There is a risk that the Trust does not achieve the 28 day cancelled operations constitutional standard 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. This may also lead to reputational consequences, increased scrutiny and increased costs to treat patients. |       |    |  |  |  |  |  |   |              |  |  |  | <b>Executive Lead:</b> Chief Operating Officer                     |               |               |  |
|  |       |    |  |  |  |  |  |   |              |  |  |  | <b>Date added to CRR:</b> May 2014                                 |               |               |  |
|  |       |    |  |  |  |  |  |   |              |  |  |  | <b>Last Reviewed:</b> September 2024                               |               |               |  |
|  |       |    |  |  |  |  |  |   |              |  |  |  | <b>Next Review:</b> March 2025                                     |               |               |  |
|  |       |    |  |  |  |  |  |   |              |  |  |  | <b>Committee reviewed at:</b><br>Finance and Performance Committee |               |               |  |
| Controls   |       |    |  | Gaps in Control  |  |  |  | Further Mitigating Actions Planned:   |              |  |  |  |  |               |               |  |
| The Planned Care Programme is focussed on workstreams that enable best use of resources, productivity, efficiency, and the optimisation of elective patients for surgery through a number of workstreams to keep increasing performance against key KPIs such as utilisation / Day case rate / Elective LoS / Average Case per session / DNA/WNB rate / cancellation (patient and hospital) rates  |       |    |  | Focussed on transformation programmes and long term developments       |  |  |  | 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  |              |  |  |  |  |               |               |  |
|  |       |    |  | Impact of unplanned pressures on elective bed base                     |  |  |  | A specific Theatre productivity and efficiency PID for 2024/25 has been developed to deliver an increase in list utilisation and cases per session by individual specialities and theatre suite.                                    |              |  |  |  |  |               |               |  |
|  |       |    |  | Willingness of clinicians to do extra work due to pension / tax issues |  |  |  | This project will report through the Waste Reduction Board chaired by the CEO and will increase the elective activity delivered by the Trust thus increasing the available theatre capacity available to rebook cancelled patients. |              |  |  |  |  |               |               |  |
|  |       |    |  | Capacity to focus on improvement work alongside operational pressures  |  |  |  |   |              |  |  |  |  |               |               |  |
|  |       |    |  | Impact of Industrial Action  |  |  |  |   |              |  |  |  |  |               |               |  |

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| <p>Prompt starts for all elective theatre lists to automatically send for patients requiring inpatient or day case capacity<br/>All ACC SJUH patients are automatically sent to theatre and Priority 1-4 patients at LGI are automatically sent to theatre</p>  | <p>Co-ordination of theatre/ ward and critical care capacity does not always align leading to greater risk of cancellations</p> <p>Not all Critical Care patients can be automatically sent for</p> | <p>Daily circulation of planned TCIs and previous cancellation status the day prior to surgery</p>  |
| <p>All CSUs have weekly access meetings to identify available theatre capacity for additional sessions, manage risks and review cancellations and discharge and theatres KPI's using the LTHT scheduling tool.</p> <p>Collaborative CSU process to 'book' patients into an admission area by appointment and lock down of list order to improve patient flow and reduce risk of late starts and subsequent on day patient cancellations.</p> <p>Daily email prompt to CSUs highlighting their 28 day breach risks</p> <p>Weekly collaborative critical care clinical prioritisation review by LGI and SJUH CSUs to support listing of clinically urgent patients and to match listed activity to anticipated capacity</p> <p>The number of 28 day cancellations has continued to reduce and performance has been sustained.</p> | <p>Critical Care capacity can change overnight due to staffing absence or high numbers of unplanned admissions and result in on day cancellations</p>   | <p>LTHT trialling upgrade of scheduling tool in four specialties to improve scheduling accuracy and theatre efficiency</p> <p>Deep dive into themes of patients cancelled on the day, recording accuracy, and 28 day breaches to identify further areas for improvement</p> |
| <p>Multidisciplinary BADs Daycase project identifying CSUs and individual procedures through PLICS and Model Hospital that could be treated as day case to reduce need for IP beds and risk of cancellation</p>   | <p>Theatre staff and surgeons are not always available to undertake additional activity in response to peaks in demand</p>  | <p>BTLW at LGI will design bespoke admission and discharge areas for day case pathways.</p> <p>SJUH estate strategy reviewing options to consolidate day case estate and pathways at SJUH</p>   |

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| <p>Use of Independent sector to increase available capacity and treatment options for patients</p> <p>Monthly focus on 6-4-2 process and Specialty level performance within Theatre Board.</p> <p>Increase theatre and day case capacity available over the weekend to spread demand and offer more opportunities to rebook patients.</p> | <p>Independent sector contract restricts type of patient able to be transferred for treatment.</p> | <p>Planned Care Dashboard developed to highlight BADs / Day case opportunity by procedure</p> <p>2 additional theatres will come online at WDH in September 2024 as well as increased overnight stay capacity to increase amount and complexity of activity that can be listed at WDH.</p> <p>6-4-2 process revised and relaunched in September 2024</p> <p>GIRFT handbooks to be embedded into theatre productivity programme</p> |
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| CRR9: Failure to achieve 6 weeks diagnostics test Constitutional Standard  | C = 4 | 16 | Very Low Risk   |   |   | Low Risk |   |   | Medium Risk   |   | High Risk |    | Significant Risk   |    |                               |    |
|  | L = 4 |    | 1   | 2 | 3 | 4        | 5 | 6 | 8   | 9 | 10        | 12 | 15   | 16 | 20                            | 25 |
|  |       |    |   |   |   |          |   |   | Target Score  |   |           |    |  |    | Initial Score & Current Score |    |
| <b>Risk Description:</b><br>There is a risk that the Trust does not achieve the 6 weeks diagnostics test constitutional standard for the defined basket of 15 tests due to capacity constraints from increasing demand and workforce challenges plus the need to recover a backlog generated during the covid-19 pandemic and several periods of industrial action.<br><br>Delays in achieving the diagnostics tests waiting times may have an impact on patient safety, experience and outcomes, resulting in harm. |       |    |   |   |   |          |   |   |   |   |           |    | <b>Executive Lead:</b> Chief Operating Officer<br><b>Date Added to CRR:</b> May 2014<br><b>Last Reviewed:</b> January 2025<br><b>Next Review:</b> July 2025<br><b>Committee reviewed at:</b> Finance & Performance Committee |    |                               |    |
| <b>Controls</b>  |       |    | <b>Gaps in Control</b>  |   |   |          |   |   | <b>Further Actions Planned:</b>   |   |           |    |  |    |                               |    |
| Weekly review of current diagnostic operational pressures at service delivery meeting chaired by Corporate Directors of Operations and Deputy COO.<br><br>The purpose of this meeting is to identify current delivery of standard, identify key actions to recover deteriorating positions.<br><br>Actions are monitored by an action tracker  |       |    | For each diagnostic service there is limited forward visibility of fluctuations in demand available at weekly service delivery, resulting in an inability to predicted increases in capacity when required. |   |   |          |   |   | Continuation of weekly review of operational status - shortfalls to be flagged as soon as possible to facilitate additional capacity/actions to mitigate.<br>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.<br><br>Paediatric Endoscopy proposals to improve productivity through sessions have been developed and implemented.<br><br>Development of a demand modelling tool, understand future clinic templates, estimated conversion from clinic to diagnostic test enabling |   |           |    |  |    |                               |    |

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|  |   | diagnostic services to respond effectively in advance.  |
| To support operational pressures across the organisation, diagnostic inpatient activity will continue to be prioritised. This is managed through daily operational responses facilitated by LHTs Operations Centre with escalation processes in place for inpatient diagnostics.                                 | Lack of visibility of status of Inpatient requests and investigations due to patients level information being held and booked on several different systems (ICE, PPM, CRIS, TMS)  | Request for work submitted to PPM Prioritisation group (DiT) to create a diagnostics visibility column on PPM.<br><br>Development and implementation of production boards across diagnostic services.<br><br>Review of Radiology consultant workforce and resilience to manage fluctuations in demand.  |
| Monthly Diagnostic recovery escalation meeting has been established in December 2024 for CSUs to discuss their recovery plans and trajectories.<br><br>Template packs have been provided to CSUs for completion of actions to recovery their diagnostic position.<br><br>CSUs to be asked to attend by exception | In month increases in demand or acute staffing problems are unpredictable and may cause deterioration in position.  | Recovery trajectories with clear action plans for delivery of the national standards are being developed or are in place.<br><br>CDC activity included in SDAM packs for each CSU providing diagnostics activity for each CDC site to ensure maximising capacity.<br><br>Development and implementation of production boards across diagnostic services.<br><br>Workforce models reviewed and LIM reviews for streamline pathways are undertaken. |
| To Ensure we have a sufficiently trained workforce available to meet the demands of our patients   | A number of diagnostic services report workforce challenges. Including loss of specialist staff to the private sector, and increase non availability due to long term and short term sickness and Maternity leave.<br><br>Not all CSUs have completed workforce plans for growth in service demand. | Trajectories under development detailing mitigating actions and additional workforce need to mitigate gaps in establishments.<br><br>Continued review of further Insourcing and outsourcing opportunities across Radiology.   |

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|  | Modelling out of workforce plans for diagnostic services in line with 25/26 activity growth from CSU requiring use of diagnostics. | Early review of trust wide 25/26 activity plans to enable capacity and demand planning for diagnostics to be completed in Q4 24/25.  |
| Equipment replacement programmes agreed for MRI, CT and Cath Laboratories during 2020/21 to 2024/25. | Loss of MRI Scanner at Seacroft, no further funding secured through the national CDC programme.                                    | <p>MRI capacity and demand reviews underway to mitigate the loss of the mobile scanner.</p> <p>CT scanner at Seacroft now operational,</p> <p>Continued review of Insourcing and outsourcing opportunities across Radiology.</p> |

| CRRC10: High occupancy levels and insufficient capacity and flow across the health and Social care system causing impact on patient safety, outcomes and experience  | C = 4 | 16 | Very Low Risk  |   |   | Low Risk |   |   | Medium Risk   |   | High Risk    |  | Significant Risk |               |    |               |
|--|-------|----|--|---|---|----------|---|---|---|---|--------------|--|------------------|---------------|----|---------------|
|  | L = 4 |    | 1  | 2 | 3 | 4        | 5 | 6 | 8   | 9 | 10           | 12   | 15               | 16            | 20 | 25            |
|  |       |    |  |   |   |          |   |   |   |   | Target Score |  |                  | Current Score |    | Initial Score |
| <b>Risk Description:</b><br>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. Current planning guidance describes occupancy should be at 92% or below (85% is generally accepted as being required for efficient flow). Efficiency of patient flow and placement, due to periods of high occupancy impact 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.<br><br>Cross-referenced to Corporate risks <b>CRRC4, CRRC5, CRRC6, CRRC7, CRRC8, CRRC9, CRRC11.</b> |       |    |  |   |   |          |   |   |   |   |              | <b>Executive Lead:</b> Chief Operating Officer<br><b>Date Added to CRR:</b> September 2015<br><b>Last Reviewed:</b> September 2024<br><b>Next Review:</b> March 2025<br><b>Committee reviewed at:</b><br>Finance & Performance Committee |                  |               |    |               |
| Controls   |       |    | Gaps in Control  |   |   |          |   |   | Further Mitigating Actions:   |   |              |  |                  |               |    |               |
| <b>Operational:</b><br>Established Operations Centre with 24/7 clinical site manager’s oversight to maximise capacity use and support patient flow and best patient placement.<br><br>Weekend on-call team are briefed every Friday with the plan to meet expected demand.<br><br>Daily operational huddles at 08:30 to assess site-specific pressures and mitigate any safety concerns, led by Directors of Operations and Deputy Chief Nurses 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.<br><br>Patient flow and discharge co-ordinators hosted by CSU’s. Devolved model does not enable standard 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 begun in SIM with a training roll out programme being developed with focus on real time admission and discharge compliance. Full roll out planned for end of September 2024<br><br>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. |   |              |  |                  |               |    |               |

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| <p>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.</p> <p>Agreed Full Capacity Protocols (FPC) for surge and Temporary Escalation Spaces (TES)-implementation capture and assurance process measures. <u>This includes utilisation of the Exceptional Surge Area (ESA) plan.</u></p> <p>Bed modelling analysis to identify expected activity surges based on public health intelligence for COVID, Flu, RSV and Norovirus with a planned local and system response</p> | <p>Insufficient space and staff to meet expected surges if inpatient numbers increase above expected population growth.</p> <p>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 trajectory not sustained</p> <p>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 at times of pressure.</p> <p>Overall patient experience impacted by use of TES beds</p> <p>Bed modelling for this winter is not based on prevalence as accurately as previous years due to reduction in COVID testing.</p> <p>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.</p> | <p>Tracking of DMT actions taken at times of pressure.</p> <p>Weekly report to weekly Quality meeting to understand the frequency of use of TES and safety checks. Monthly report provided to the Quality &amp; Safety Assurance Group (QSAG)</p> <p>External audit of LOS analysis commissioned and completed in August 2023. Key findings identified and action plans for CSU's developed. LOS Programme to reduce LOS by 0.9 days across the Trust for 2024/25 established with a monthly summary of achievement and opportunity by CSU against peer.</p> <p>Additional 3 wards currently open in LTHT to meet the need of patients no longer requiring hospital</p> |
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| <p>Management of long length of stay patients</p><br><br><br><br><br><br><br><br><br><br>Protected elective capacity at SJUH, CAH and Wharfedale Hospitals to support elective (planned patient) capacity<br><br><br><br><br><br><br><br><br><br>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 | <p>Dr Foster data set identifies further opportunity for length of stay reduction</p> | <p>in patient care. With seasonal plans to meet additional demand</p><br><br><br><br><br><br><br><br><br><br>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. Newly implemented All patients on an admitted pathway are given a clinical prioritisation status at the point of decision to admit reflecting the expected treatment timeframe and to support TCI of patients by clinical priority rather than chronological booking. Where those patients are waiting longer than the expected treatment, these patients are reviewed by the clinical and administrative teams to ensure the clinical prioritisation status is accurate, and to escalate patients to be seen more urgently if required. |
| <p><b>Tactical:</b></p><br><br>Alternatives to admission-<br><br><br><br><br><br><br><br><br><br>Established Same Day Emergency Care unit 7 days per week  |   | <p>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.</p>  |

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| <p>Primary Care Access Line receives calls for primary care colleagues, GPs and ambulance services to navigate as clinically appropriate away from ED and admissions to a series of rapid access clinics, specialist advice of a consultant, SDEC or assessment area - Nationally recognised for its success</p> <p>Developed Virtual Ward for respiratory and frailer adults to support early discharge and alternative care for lower acuity admissions</p>                  |  | <p>LGI multi- speciality SDEC and enhancement of MSSA unity planned test of change for September 2024.</p> <p>Review of a Single Point of Access across the city planned for September 2024 to maximise alternatives to admission and patient in right place, right speciality first time.</p> <p>Home telemetry ward developed and delivered by LTHT is evidencing reducing number of bed days for patients on pre agreed pathways</p>  |
| <p><b>Strategic:</b></p> <p>Established of Leeds urgent community response group with delivery of 2-hour community response 8am till 8pm to avoid ED and admission conveyance.</p> <p>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.</p> | <p>National requirement for 24/7 offer not currently delivered</p> <p>HomeFirst programme not currently consistently delivering to agreed trajectory of no more than 160 no reason to reside inpatients by July 2024</p> | <p>HomeFirst has resulted in a reduction in the number of inpatients without a reason to reside compared with the previous financial year.</p> <p>Across the city system a reduction in length of hospital inpatient stay has been evidenced through use of a city discharge case manager role. This has been implemented in SIM, Respiratory and Urgent Care and is due to roll out to Neurosciences, CAH and AMS CSUs in September 2024.</p> <p>System visibility data set achieved-shared understanding of capacity and impact of changes</p> |

| CRRF1: Failure to deliver the financial plan for 2024/25  | C = 5 | 20 | Very Low Risk  |   |   | Low Risk |              |   | Medium Risk  |   | High Risk |    | Significant Risk   |    |    |               |
|---|-------|----|--|---|---|----------|--------------|---|--|---|-----------|----|--|----|----|---------------|
|   | L = 4 |    | 1  | 2 | 3 | 4        | 5            | 6 | 8  | 9 | 10        | 12 | 15   | 16 | 20 | 25            |
|   |       |    |  |   |   |          | Target Score |   |  |   |           |    |  |    |    | Current Score |
| <b>Risk Description:</b><br>There is a risk that the Trust does not achieve its planned control total in 2024/25. This would have the following impacts: <ul style="list-style-type: none"><li>Reducing the internal funding for the Trust’s ambitious Five Year Capital programme, including Building the Leeds Way leading to:<ul style="list-style-type: none"><li>Limiting the capital programme/not replacing equipment</li><li>Relying on external sources of funding</li><li>Cash shortfall and risk to supplier payment</li><li>Potential non-compliance with new medical devices regulation (Regulation EU 2017/45)</li></ul></li><li>Reputational damage, as the Trust fails to deliver on a key statutory duty</li><li>Potential to cause the Integrated Care System to miss its overall control total</li></ul> |       |    |  |   |   |          |              |   |  |   |           |    | <b>Executive Lead:</b> Director of Finance                         |    |    |               |
|   |       |    |  |   |   |          |              |   |  |   |           |    | <b>Date added to CRR:</b> November 2020                            |    |    |               |
|   |       |    |  |   |   |          |              |   |  |   |           |    | <b>Last reviewed:</b> November 2024                                |    |    |               |
|   |       |    |  |   |   |          |              |   |  |   |           |    | <b>Next Review:</b> May 2025                                       |    |    |               |
|   |       |    |  |   |   |          |              |   |  |   |           |    | <b>Committee reviewed at:</b><br>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   |       |    | <ul style="list-style-type: none"><li>Re-introduction of National Variable Payment System (Payment by Results).</li><li>No reason to reside issue is not resolved</li><li>Restrictions on capital allocation due to funding formula.</li></ul> |   |   |          |              |   | <ul style="list-style-type: none"><li>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</li><li>Executive review of Backlog work. Development of an in-house mitigation plan.</li><li>Detailed review of underlying cost base and associated savings plans.</li><li>Regular updates to the Executive Team and Finance and Performance Committee including Exec lead on financial risk and associated mitigations</li></ul> |   |           |    |  |    |    |               |

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|  |   | <ul style="list-style-type: none"> <li>Regular communication with ICS to assess and mitigate risks</li> </ul>   |
| Annual Financial Plan covering Income and Expenditure, Capital and Cash implications is signed off by the Board. In addition to this the Finance and Performance Committee are sighted on the progress of the overall financial plan and detailed delivery of the Waste Reduction plan.  | None  | <ul style="list-style-type: none"> <li>Regular updates to the Executive Team and Finance and Performance Committee including Exec lead financial mitigations</li> <li>Regular communication with NHSE/I to identify and adapt to changes</li> </ul>   |
| Quarterly Fundamental Review of the Trusts Financial Position to Finance and Performance Committee setting out the risk range of the in-year financial position and executive owned mitigations  |   | <ul style="list-style-type: none"> <li>Development on in-house mitigation plan</li> <li>Detailed review of underlying cost base and associated savings plans.</li> <li>Regular updates to the Executive Team and Finance and Performance Committee including Exec lead financial mitigations</li> </ul> |
| Weekly reporting of the Waste Reduction position CSU to the Director and Deputy Director of Finance which in turn feed into Finance Performance Framework CSU meetings   | Waste reduction is not delivered in full                                  | <ul style="list-style-type: none"> <li>Development of in-house mitigation plan</li> <li>Regular meetings with the PMO to assess risks to the programme</li> </ul>   |
| CSU ownership of realistic control targets and run rate based forecasts linked to the Integrated Accountability Framework.   |   | <ul style="list-style-type: none"> <li>Development of in-house mitigation plan</li> <li>Regular updates to the Executive Team and Finance and Performance Committee including Exec lead financial mitigations</li> </ul>  |
| Operation of the financial performance framework with: <ul style="list-style-type: none"> <li>Monthly Clinical Director signed off forecasts and a RAG rating against CSU agreed Control Totals</li> <li>Escalation meetings with Director of Finance for RED rated CSUs and with the Deputy Director of Finance for AMBER CSUs</li> <li>Financial sustainability board, including the Chief Executive and other Executive Directors, for those CSUs on Amber and Red for multiple months</li> </ul> | None  | <ul style="list-style-type: none"> <li>Regular updates to the Executive Team and Finance and Performance Committee including Exec lead financial mitigations</li> </ul>   |
| Fixed Income allocations through the negotiation of Aligned incentive contracts with ICS and NHSE  | Re-introduction of National Variable Payment System (Payment by Results). | <ul style="list-style-type: none"> <li>Regular meetings with commissioners and attendance at all ICS finance forums</li> </ul>  |

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|  | <p>The cultural shift required moving from the Aligned Incentive Payment system to Variable Payment System (PbR).</p> <p>Insufficient capacity in the coding team impacting on the implementation of PbR</p> | <ul style="list-style-type: none"> <li>• Regular communication with NHSE/I to identify and adapt to changes</li> <li>• Strategic group has been established in the Trust to support the move to PbR.</li> <li>• This will include improvements in recording and coding.</li> <li>• Application of Leeds Improvement Methodology to enhance processes and capacity.</li> </ul> |
| Implementation of Finance the Leeds Way Improvement Plan   | None   | <ul style="list-style-type: none"> <li>• Response to the work undertaken across WYAAT by PwC, working with other Trusts to identify, share and implement good practice.</li> <li>• Use of the NHSE Improvement and Intervention checklist to ensure good quality controls are in place across the Trust.</li> </ul>   |
| 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: Insufficient operational capital allocations  | C = 4 | 16 | Very Low Risk   |   |   | Low Risk     |   |   | Medium Risk   |   | High Risk |    | Significant Risk   |    |               |               |
|--|-------|----|---|---|---|--------------|---|---|---|---|-----------|----|--|----|---------------|---------------|
|  | L = 4 |    | 1   | 2 | 3 | 4            | 5 | 6 | 8   | 9 | 10        | 12 | 15   | 16 | 20            | 25            |
|  |       |    |   |   |   | Target score |   |   |   |   |           |    |  |    | Current score | Initial score |
| <b>Risk Description:</b><br>Operational capital allocations to address the Trust’s capital risks are insufficient to meet expected programme plans for 2024/25 and future years. This will have the following impacts: <ul style="list-style-type: none"><li>Reducing the internal funding for the Trust’s ambitious Five-Year Capital programme, including Building the Leeds Way leading to:<ul style="list-style-type: none"><li>Limiting the capital programme / not replacing equipment</li><li>Greater reliance on external sources of funding</li><li>Potential non-compliance with regulatory requirements</li></ul></li><li>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.</li><li>Inability to invest in required strategic developments to support clinical services.</li><li>Reputational damage, as the Trust fails to invest in equipment, estate and digital infrastructure to support service development.</li></ul> |       |    |   |   |   |              |   |   |   |   |           |    | <b>Executive Lead:</b> Director of Finance                         |    |               |               |
|  |       |    |   |   |   |              |   |   |   |   |           |    | <b>Date added to CRR:</b> May 2023                                 |    |               |               |
|  |       |    |   |   |   |              |   |   |   |   |           |    | <b>Last reviewed:</b> November 2024                                |    |               |               |
|  |       |    |   |   |   |              |   |   |   |   |           |    | <b>Next Review:</b> May 2025                                       |    |               |               |
|  |       |    |   |   |   |              |   |   |   |   |           |    | <b>Committee reviewed at:</b><br>Finance and Performance Committee |    |               |               |
| <b>Controls</b>  |       |    | <b>Gaps in Control</b>  |   |   |              |   |   | <b>Further Mitigating Actions</b>   |   |           |    |  |    |               |               |
| 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.  |       |    | <ul style="list-style-type: none"><li>Other ICB Trusts show a preference towards top slicing the ICB allocation reducing operational capital budgets for all Trusts</li></ul> |   |   |              |   |   | <ul style="list-style-type: none"><li>Regular updates provided to Director of Finance and Director of Strategy immediately following the meeting</li><li>Regular updates provided to Capital Planning Group and any necessary escalations to Finance and Performance Committee.</li></ul> |   |           |    |  |    |               |               |
| 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 specific prioritisation for the MSE, BME and DIT programmes.   |       |    | <ul style="list-style-type: none"><li>None</li></ul>  |   |   |              |   |   | <ul style="list-style-type: none"><li>CPG puts increasing focus through the year on strength of programme managers forecasts and ability to complete. Confidence levels and risks are specifically addressed.</li></ul>   |   |           |    |  |    |               |               |

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| <p>Development of in-house mitigation plan allows for the Trust to respond to changes in funding allocations or utilise slippage in other Trusts.</p> | <ul style="list-style-type: none"> <li>• Restrictions on capital allocation due to funding formula.</li> <li>• Restrictions on capital allocation due to lack of New Hospitals Programme funding certainty places additional pressure on operational capital.</li> </ul> | <ul style="list-style-type: none"> <li>• 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.</li> <li>• Regular updates to Finance and Performance Committee including Exec lead on financial risk and associated mitigations</li> <li>• Regular communication with ICB to assess and mitigate risks</li> <li>• Regular communications with New Hospitals Programme to assess and mitigate risks</li> </ul> |
| <p>External funding opportunities monitored closely with bid and applications submitted wherever possible</p>   | <ul style="list-style-type: none"> <li>• Constrained by available opportunities</li> <li>• Bids and applications not always successful</li> </ul>  | <ul style="list-style-type: none"> <li>• Capital Planning Group regularly discuss opportunities to maximise external funding opportunities.</li> </ul>   |

|   |       |    |   |   |   |          |   |   |   |   |           |               |   |               |    |    |
|---|-------|----|---|---|---|----------|---|---|---|---|-----------|---------------|---|---------------|----|----|
| CRRF3: Cash Availability  | C = 4 | 16 | Very Low Risk   |   |   | Low Risk |   |   | Medium Risk   |   | High Risk |               | Significant Risk  |               |    |    |
|   | L = 4 |    | 1   | 2 | 3 | 4        | 5 | 6 | 8   | 9 | 10        | 12            | 15  | 16            | 20 | 25 |
|   |       |    |   |   |   |          |   |   | Target Score  |   |           | Initial Score |   | Current Score |    |    |
| <b>Risk Description:</b><br>There is a risk that the Trust’s cash balance is severely depleted resulting in it not being able to meet its financial obligations resulting in financial and reputational damage for the Trust.                       |       |    |   |   |   |          |   |   |   |   |           |               | <b>Executive Lead:</b> Director of Finance<br><b>Date added to CRR:</b> Nov 2024<br><b>Last reviewed:</b> Nov 2024<br><b>Next Review:</b> May 2025<br><b>Committee reviewed at:</b> Finance and Performance Committee |               |    |    |
| <b>Controls</b>   |       |    | <b>Gaps in Control</b>  |   |   |          |   |   | <b>Further Mitigating Actions</b>   |   |           |               |   |               |    |    |
| Cashflow forecasting outlines the income expected and cash payments. Effective forecasting allows for actions to be taken to manage the cash position. There is a monthly meeting with the income team to help understand the cash income position. |       |    | The accuracy of the cashflow forecast is based on information from others such as timing of receipts and expenditure. |   |   |          |   |   | Additional meetings will be held to improve the understanding of others of the information needed to ensure the accuracy of the cashflow forecast.        |   |           |               |   |               |    |    |
| The Trust's I&E position has a direct impact on the cash position. A deficit will result in net cash outgoing for the financial year. The Trust's I&E position is managed through its financial management framework.                               |       |    | Other NHS organisations are also carefully managing cash which may result in slower payments to LTHT                  |   |   |          |   |   | Revenue cash support is available from NHS England. However, there are strict guidelines on what cash can be drawn down and what it can be used to cover. |   |           |               |   |               |    |    |
| The cash position and forecast is reported to the Finance & Performance Committee   |       |    |   |   |   |          |   |   | Capital cash support is being sought to support the 24/25 capital programme. This is still in discussion with NHSE and is not yet certain.                |   |           |               |   |               |    |    |
| The Trust's capital plan includes the use of internal cash. This is reviewed when developing the capital plan.  |       |    |   |   |   |          |   |   | Cash availability is a standing item on the CPG agenda  |   |           |               |   |               |    |    |
| Quarterly fundamental review sets out risks and mitigations. The risk to the cash position is reported in the fundamental review highlighting best case, most likely case and worst case scenarios.   |       |    |   |   |   |          |   |   | Cash savings plan to save £20m is in development. A current plan is in place to deliver £8m.  |   |           |               |   |               |    |    |

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| The Accounts Receivable department closely monitors debt and seeks to minimise outstanding debt.        |  | Significantly aged debt is escalated for personal intervention by the Director of Finance |
| Standing Financial Instructions in place and financial policies that cover cash management              |  |   |
| The 'Finance the Leeds Way' improvement programme reviews and improves systems and procedures in place. |  |   |
| Where capital schemes are supported through PDC, cash drawdowns are promptly made.                      |  |   |