

# **CORPORATE RISK REGISTER**

**July 2025**

## Summary Corporate Risk Register July 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                 | Jun 24               | Dec 25              |                          | 5-18     |
| <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                 | Apr 25               | Oct 25              |                          | 19-20    |
| CRRO2   | Power failure/lack of IPS/UPS resilience due to electrical infrastructure  | Aug 15            | Director of Estates & Facilities                                 | 16                 | Jul 25               | Jan 26              |                          | 21-24    |
| CRRO13  | Brotherton Wing, Blocks 11, 12 and 32 physical condition   | Jan 24            | Director of Estates & Facilities                                 | 16                 | Jul 25               | Jan 26              |                          | 25-26    |
| <b>Health &amp; Safety Risk</b> <i>Minimal</i>                |  |                   |  |                    |                      |                     |                          |          |
| CRRO4   | Staff absence Health, Safety and Wellbeing   | Oct 20            | Director of Human Resources                                      | 16                 | Mar 25               | Sep 25              |                          | 27-29    |
| <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                 | Mar 25               | Sep 25              |                          | 30-31    |
| CRRO8   | Risk of failure to deliver the pathology project.  | May 20            | Director of Finance  | 16                 | Jul 25               | Aug 25              |                          | 32-39    |
| CRRO9   | Risk of failure to deliver the LGI Site Development Project  | Nov 21            | Director of Finance  | 16                 | May 25               | Nov 25              |                          | 40       |
| <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                              | 20                 | Apr 25               | Oct 25              |                          | 41       |
| 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                              | 16                 | Apr 25               | Oct 25              |                          | 42       |
| <b>Clinical Risk</b>  |  |                   |  |                    |                      |                     |                          |          |
| <b>Infection Prevention &amp; Control Risk</b> <i>Minimal</i> |  |                   |  |                    |                      |                     |                          |          |
| CRRC1   | Healthcare acquired infection  | Mar 19            | Chief Medical Officer  | 16                 | Apr 25               | Oct 25              |                          | 43-53    |
| <b>Patient Safety &amp; Outcomes Risk</b> <i>Minimal</i>      |  |                   |  |                    |                      |                     |                          |          |
| CRRC4   | Emergency Care 95% Constitutional Standard   | May 14            | Chief Operating Officer  | 20                 | Jan 25               | Jul 25 (Def Aug 25) | ED LGI                   | 54-57    |

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| <b>CRRC5</b>   | 18-week RTT target non-compliance  | May 14  | Chief Operating Officer | 20 | Apr 25 | Sep 25              | Ophthalmology / Cardiac Surgery | 58-63           |
| <b>CRRC6</b>   | 62-day cancer target   | May 14  | Chief Operating Officer | 16 | Jul 25 | Jan 26              | MDT & Pancreatic Breast Only    | 64-68           |
| <b>CRRC7</b>   | Failure to achieve 28 day cancelled operations target  | May 14  | Chief Operating Officer | 16 | Apr 25 | Sep 25              | Cardiac                         | 69-71           |
| <b>CRRC9</b>   | Patients waiting longer than 6 weeks following referral for diagnostics tests  | May 14  | Chief Operating Officer | 16 | Jan 25 | Jul 25 (Def Aug 25) | Breast cancer                   | 72-74           |
| <b>Capacity Planning Risk</b>                          |  |         |                         |    |        |                     |                                 | <i>Cautious</i> |
| <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 | Mar 25 | Sep 25              | MMPS                            | 75-78           |
| <b>Financial Risk</b>                                  |  |         |                         |    |        |                     |                                 |                 |
| <b>Financial Management &amp; Waste Reduction Risk</b> |  |         |                         |    |        |                     |                                 | <i>Cautious</i> |
| <b>CRRF1</b>   | Failure to deliver the financial plan 2024/25  | May 14  | Director of Finance     | 20 | May 25 | Aug 25              |                                 | 79-81           |
| <b>CRRF2</b>   | Insufficient operational capital allocations   | May 23  | Director of Finance     | 16 | Mar 25 | Nov 25              |                                 | 82-83           |
| <b>CRRF3</b>   | Cash Availability  | Nov 24  | Director of Finance     | 16 | Apr 25 | Oct 25              |                                 | 84-85           |
| <b>External Risk</b>                                   |  |         |                         |    |        |                     |                                 |                 |
| <b>Regulatory Risk</b>                                 |  |         |                         |    |        |                     |                                 |                 |
| <b>CRRE1</b>   | CQC Registration – breaches of Regulation(s) Maternity and Neonatal Services <b>NEW</b>  | Jul 25  | Chief Nurse             | 15 | Jul 15 | Aug 15              |                                 | 86-88           |

### Corporate Risk Register - Key

| Risk Type  |                  |
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| 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> June 2025<br><b>Next Review:</b> December 2025   |    |               |               |
|   |       |    |   |   |   |          |   |   |                            |   |           |    | <b>Committee reviewed at:</b><br>Resource Management Group<br>Workforce Management Group   |    |               |               |
| 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.  |   |   |          |   |   |                            |   |           |    |  |    |               |               |
| Development of new roles and alternative workforce models   |       |    | Inconsistent vacancy data – data held centrally via finance ledger does not align with CSU local data.<br><br>For some roles, the private sector offers better pay and incentives (e.g., no on-call). |   |   |          |   |   |                            |   |           |    |  |    |               |               |

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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.</p> <p>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> <p>Daily and Weekly management of rosters using workforce production board</p> |                  |
| <b>Midwifery</b>   | <b>Midwifery</b><br>Redeployment of non-clinical, specialist and management midwives at times of   | <b>Midwifery</b> |

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| <p>Centralised recruitment was launched in April 2024 across West Yorkshire &amp; Harrogate Local Maternity &amp; Neonatal System.</p> <p>The service is 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>3 Maternity support workers recruited to the Midwifery Apprenticeship scheme at University of Huddersfield</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 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>high acuity and increased unavailability of clinical staff due to vacancies, sickness, maternity leave and study leave.</p> <p>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.</p> <p>Decrease in the specialist workforce to support timely governance processes and shared learning in a nationally high-profile/risk service.</p> <p>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 intrapartum period and</p> | <p>Review of midwife unavailability aligned with the 23% built into the establishment budget under review.</p> <p>Implementation of the staff support framework facilitated by the staff psychologist and staff support leads.</p> <p>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.</p> <p>Appointment of clinical educators to support the community midwifery services.</p> <p>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> |
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| 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 approved by the Trust Board. | <p>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>Increased training requirements aligned with the national core competency 2 guidance.</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>Corporate support for areas of concern. Escalation process in place.</p> <p>Programme of Nursing and Quality Framework reviews with CSUs</p>  | Variance in results of quality and safety reviews.  | Corporate task and finish group established to identify potential impact.   |
| <p><b>Adult Therapies AHPs</b></p> <p>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><b>Adult Therapies AHPs</b></p> <p>Variance in understanding of WF issues and available data.</p> <p>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><b>Adult Therapies AHPs</b></p> <p>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> |



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| <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>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>AHP professions linking with professional bodies for steer on complexity tool.</p> <p>Exit interviews results to be analysed. 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></p> <p>On-going recruitment.</p> <p>Apprentice programme in place.</p> <p>First international recruitment has been a massive success so may consider more based on UK applicant number.</p> <p>Retention of staff has improved.</p> <p>Education lead in place until Feb 2026. This has had massive impact on staff training and supports the apprentices.</p>   | <p><b>Therapy Radiographers (Oncology)</b></p> <p>2024 Radiotherapy census data still highlights a shortfall of staff.</p> <p>Annual increase in demand for radiotherapy is 6%.</p> <p>There are not enough students being trained nationally.</p>   | <p><b>Therapy Radiographers (Oncology)</b></p> <p>Continue to expand the apprenticeship programme. Trust has supported 4 posts for 2025. 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>International recruitment may be a longer-term option – National funding of £5000 per recruit has been offered in 2025.</p> <p>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> |
| <b>Radiographers (Radiology)</b>  | <b>Radiographers (Radiology)</b>   | <b>Radiographers (Radiology)</b>   |

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| <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>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>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>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>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 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>Theatres</b></p> <p>20 apprentice ODPs per year by increasing to 10 students per year from Huddersfield University and 10 from Sheffield Hallam University.</p>   | <p>Band 6 CT radiographer gaps at CDC</p> <p>Limited number of places available due to back-fill requirements.</p>   |  |

| MEDICAL and SCIENTISTS - Chief Medical Officer   |   |  |
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| 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 management, collaboration and clear escalation strategies.</p> |

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|  |   | <p>Burnout group has been established – deep dives into areas where burnout risks are high with targeted interventions.</p> <p>Development of wellbeing strategy for senior medical staff</p> <p>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 | <p>A recent audit has identified areas for improvement in the Trust's Job Planning arrangements.</p> <p>Lack of knowledge of demand meaning services cannot plan workforce needs effectively.</p> | <p>A detailed action plan is in place to address these issues.</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>   |

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|  | <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>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.</p> <p>Exception Reporting results and subsequent response from specialty.</p>  |  |   |
| <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.</p> <p>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>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.</p> <p>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>National shortage across Medical Physics.</p> <p>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. 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 | <p>Workforce (including temporary staffing) is currently higher than the affordable plan.</p> <p>It is estimated that the total WTE will need to reduce next year. Specific information has been provided to each CSU.</p>  |  |

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| Each CSU has an Operational Workforce Action Plan (OWAP). HRBPs and working with CSUs to deliver action plans.   |  |   |
| Specific service level staff shortages for hard to recruit staff are captured in the OWAP and the CSU risk registers, with escalation of significant CSU risks to RMC. | <p>Significant risks captured include:</p> <ul style="list-style-type: none"> <li>• Gaps in the Stroke service</li> <li>• Fragile Epilepsy service</li> <li>• Ongoing recruitment difficulties for Genetics Clinical Scientists, mortuary staff and BMS in Blood Sciences.</li> <li>• Gaps in resident doctor and nursing rotas in Urgent Care</li> <li>• Consultant workforce gaps in Women's and unavailability in Maternity Workforce.</li> <li>• Consultant Gaps in Paediatric Hepatology and Congenital Cardiac Surgery</li> <li>• Nursing gaps in Neonates, Haematology and Oncology</li> <li>• Retention of staff due to competition from private sector, for example paediatric audiologists</li> <li>• On-going gaps in radiotherapy prior to annual cohort joining in September.</li> <li>• Gaps in Medical Physics Clinical Scientists</li> <li>• Gaps in ultrasound</li> <li>• Paediatric general anaesthetics</li> <li>• Gaps at WGH</li> <li>• Senior clinical capacity in T&amp;O</li> <li>• Gaps in resident doctors in ACC</li> </ul> | Specific mitigation plans and actions for each of these are detailed in CSU OWAPs |

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|  | <ul style="list-style-type: none"> <li>• Respiratory Consultants</li> <li>• Entry level gaps in decontamination, security and nursery</li> </ul>  |  |
| <p>Vacancy control panels operating in all CSUs with oversight of CSU vacancy trackers through Trust Expenditure Review Group (TERG).</p> <p>Multidisciplinary, executive led weekly workforce meeting in place to oversee vacancy controls, variable pay (including non-clinical and clinical agency) and FTE reduction.</p>  | <p>Recently announced changes to immigration and visa legislation will significantly impact on the Trust's ability to recruit and retain overseas nationals in Band 2 and Band 3 positions.</p> | <p>Work is on-going to assess the impact of these changes.</p> |
| <p>In year commitment on retention for 2024/25 has now closed but maintaining current levels of turnover remains as part of the People Priorities.</p>   |   |  |
| <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> |   |  |
| <p>The organisation has a Structured Approach to Winter Planning.</p>  |   |  |
| <p>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>   |   |  |
| <p>There is a Structured approach to Exit interviews across the Trust. Exit Interview results and analysis forms reviewed by Workforce Management Group and Workforce Committee.</p>   |   |  |



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| <p>Optimal Attendance Management, including resident doctors, is now embedded as business as usual. Further detail is contained within CRR04.</p> <p>Regular review of absence management data with Tri team / HRBPs / Operational HR /CSUs with actions agreed.</p>  |  |  |
| <p>Roster management tools in place to support staff groups. New Roster metrics developed and these are reviewed through HONS meetings and also through RMG.</p> <p>Roster management metrics in relation to adherence to best practice and safer staffing guidance shared with CSU and presented to WMG and WFC.</p>   | <p>Roster management not embedded consistently across all clinical staff groups.</p> | <p>Levels of attainment steering group reviews progress and further roll out plan.</p> |
| <p>Continued support for the development of new roles for example:</p> <ul style="list-style-type: none"> <li>• Apprentice programme.</li> <li>• Advanced Practitioners</li> <li>• Physician Assistants</li> <li>• Volunteer programme.</li> </ul> <p>Nursing Associate deployment reference group commenced to support governance and assurance of new role.</p> <p>Future You programme implemented to create workforce plan, recruitment and retention strategy for the Nursing Associate role. Progress reviewed through NMAWG and RMG</p> <p>Deputy DME overseeing PA undergraduate placement program at LTHT.</p> |  |  |

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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.   |  |   |
| 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. | On going work to understand the impact and opportunities of AI. |
| <b>Risk of staff absence due to potential Industrial Action</b><br>Currently none of the unions have a mandate for industrial action, however, we have received a notification of a ballot of resident doctors from the BMA.<br><br>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: |  |   |

| CRRO1: Risk of a viral pandemic  | C = 5 | 15 | 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 = 3 |    |   |   |   |          |   |   | Target Score  |   |           |    | 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 patient and staff harm, impacting on quality, delivery of constitutional standards (performance) and finance. |       |    |   |   |   |          |   |   |   |   |           |    | <b>Executive Lead:</b> Chief Operating Officer<br><b>Date added to CRR:</b> May 2018<br><b>Last reviewed:</b> April 2025<br><b>Next Review:</b> October 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 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 training is being made available through a train the trainer programme targeted specifically on those areas most likely to be impacted (ED, J20, SIM, children's, critical care (adults and paediatrics) and women's).</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> July 2025<br><b>Next Review:</b> January 2026<br><b>Committee reviewed at:</b> Electrical Safety Group |                  |    |               |               |
| <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 applied retrospectively, HTM 06-01 was introduced in 2007 (current version 2021) so many areas remain non-compliant to current guidance but and 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 supply with the consequence of a power failure assessed and graded against a wide range of</p> |

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|  |  | <p>departments with complex requirements and potential risks.</p> <p>Medical grade A locations requiring investment have now been independently assessed to understand the level of funding required &amp; timeframes (impacted by available capital/ access to areas) to inform the business case/ become fully compliant with HTM 06-01.</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 (Gledhow Wing) were upgraded and fitted with compliant UPS/IPS systems in 2021. | There are still a number of Clinical category A areas without UPS/IPS systems.   | <p>Feasibility studies suggest that around £10m will be required to install UPS/IPS systems in Grade A locations (typically, those supporting life support or complex surgery).</p> <p>The previously approved 5-year capital plan included £6.4m for electrical backlog and compliance priorities. However, in May 2025 the Building &amp; Engineering operational capital plan for 2025/26 was cut from £21m to £11m because of reduced capital availability.</p> |

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| <p>IPS was installed in J1 (Neonates SJUH) in 21/22.</p> |  | <p>The overall Trust 5-year capital programme is under review based on the Trust Risk Appetite Framework. The funding request for this investment will form part of this prioritisation review and will form part of the revised draft capital plan to be submitted to Finance &amp; Performance Committee in Q3 2025/26.</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 and funding).</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 |
|  |       |    |   |   |   |          |   |   |  | Target Score |           |    |   | 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> July 2025                         |               |               |    |
|  |       |    |   |   |   |          |   |   |  |              |           |    | <b>Next Review:</b> January 2026                        |               |               |    |
|  |       |    |   |   |   |          |   |   |  |              |           |    | <b>Committee reviewed at:</b> Building Safety Group     |               |               |    |
| <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).. BSR application has been approved today, works can now proceed, target completion Q1 2026/27.  |       |    |   |   |   |          |   |   | Controls 1-3 will continue until roof covering is replaced.  |              |           |    |   |               |               |    |

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| 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.   |
| Operational Fire Strategy in place for blocks 11 & 12.  | Complex construction works are planned to repair the roof, this doesn't affect access, or the staff evacuation procedures. | 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 |

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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 |    |                  |                  |
|   | L = 4 |    | 1  | 2 | 3 | 4        | 5 | 6 | 8  | 9               | 10        | 12  | 15               | 16 | 20               | 25               |
|   |       |    |  |   |   |          |   |   |  | 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 staff survey data tells us that staff who completed the survey report that they feel burnt out because of work, which can lead to lowered staff resilience and presenteeism. |       |    |  |   |   |          |   |   |  |                 |           | <b>Executive Lead:</b> Director of Human Resources  |                  |    |                  |                  |
|   |       |    |  |   |   |          |   |   |  |                 |           | <b>Date added to CRR:</b> June 2020   |                  |    |                  |                  |
|   |       |    |  |   |   |          |   |   |  |                 |           | <b>Last reviewed:</b> March 2025  |                  |    |                  |                  |
|   |       |    |  |   |   |          |   |   |  |                 |           | <b>Next Review:</b> September 2025  |                  |    |                  |                  |
|   |       |    |  |   |   |          |   |   |  |                 |           | <b>Committee reviewed at:</b><br>Health and Wellbeing Group<br>Workforce Management Group |                  |    |                  |                  |
| <b>Controls</b><br><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. 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 31 <sup>st</sup> May 2025. |                 |           |   |                  |    |                  |                  |
| Medical and Dental template process for managing medical and dental sickness absence has been rolled out including  |       |    | Unclear management arrangements for Junior Doctors due to their short-term employment leading to lack of proactive |   |   |          |   |   | Further action by all CSUs to achieve full compliance with the new standard.   |                 |           |   |                  |    |                  |                  |

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| where appropriate warranted variation for CSU specific arrangements.   | sickness management for this group. Not all CSUs are at 100% maturity of implementation yet.  |   |
| <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> <p>Review of burnout response, stress risk assessment and guidance completed. Action plan agreed.</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 31 March 2025.</p> <p>Implementation of agreed action plan is being monitored by the Burnout Group and Workforce Management Group</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 has therefore been identified, with limited organisational resources to address this. | <p>Work on going to develop a Post Incident Support Pathway by-March 2025.</p> <p>Review of provision and funding model by Adult Therapies to be completed March 2025.</p>  |
|  | 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 <del>Dec-24</del> March 2025   |
| Occupational Health provide advice to managers on fitness to work and reasonable adjustments to support managers in effectively managing sickness absence.   | OH, have insufficient clinical space after having vacated LGI to accommodate BtLW.  | Plans agreed with Capital Planning, subject to funding, confirmation March 2025.  |

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| Organisational immunisation programme, including on-employment vaccination and Winter vaccinations are available is delivered in accordance with the UKHSA schedule for occupational vaccination for all new starters. | The Trust is currently not compliant with new guidance issued from UKHSA in August 2024 recommending organisations to vaccinate staff in high-risk areas for pertussis transmission.  | Pertussis vaccination programme for staff in high-risk areas to start in January 2025.   |
|  | 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.   |
| Suicide Prevention strategy has been updated and a post-vention guidance in place to Managers and Staff affected.  |   |  |
| Stress Risk assessment process in place to support management of work-related stress.  |   |  |
| 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. Long term solution to be delivered when competent person in post (see below). |
|  | 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.  | Recruitment to competent person agreed and will commence by February 2025.   |

| CRRO7: Risk of failure to deliver the hospital of the future project.  | C = 5 | 25 | Very Low Risk |   |   | Low Risk |   |   | Medium Risk |   | High Risk    |    | Significant Risk  |               |    |               |
|--|-------|----|---------------|---|---|----------|---|---|-------------|---|--------------|----|---|---------------|----|---------------|
|  | L=5   |    | 1             | 2 | 3 | 4        | 5 | 6 | 8           | 9 | 10           | 12 | 15  | 16            | 20 | 25            |
|  |       |    |               |   |   |          |   |   |             |   | Target Score |    |   | Initial Score |    | Current Score |
| <b>Risk Description:</b><br>There is a risk that the Hospitals of the Future Project fails to deliver the objectives and benefits as described in the 2022 Outline Business Case in a timely manner, the scope of the Project is materially reduced/changed, the timescales to deliver the Project fail to meet the Trust's critical requirements, and/or there is a need to redevelop the site in a piece-meal manner affecting the clinical and site efficiency of the original site masterplan. This is as a result of: <ul style="list-style-type: none"> <li>The Secretary of State for Health and Social Care announcement on 20 January 2025 confirming:</li> <li>that the Trust's Hospitals of the Future Project would be placed in Wave 2 of the New Hospital Programme (NHP).</li> <li>no project delivery funding is expected to be made available until 2030/31.</li> <li>construction is not expected to commence before 2033-35; and</li> <li>the NHP requires, from 2030/31, the full redesign from of the Trust's scheme to align fully with Hospital 2.0 and the requirement for a new planning application.</li> <li>Insufficient future funding to deliver the Trust's requirements and any future Trust/project scope and requirements.</li> <li>If the project is not delivered, is further delayed and/or there is insufficient future funding, the Trust will:</li> <li>not be able to deliver the Trust's stated objectives and benefits that seek to address critical operational, clinical, estate, and financial stability risks.</li> <li>be required to retain and invest in its existing estate for a longer period of time presenting a risk to the Trust's ability to maintain service delivery and wider capital budgets.</li> <li>be limited in its ability to transform clinical services including in support of meeting recommendations from statutory public consultation and/or other clinical service reviews and/or in meeting commissioner requirements.</li> <li>need to vacate areas/estate currently occupied by clinical services due to poor condition and/or health and safety reasons.</li> <li>not have sufficient capacity to meet service demand in required timescales.</li> </ul> |       |    |               |   |   |          |   |   |             |   |              |    | <b>Executive Lead:</b> Director of Finance  |               |    |               |
|  |       |    |               |   |   |          |   |   |             |   |              |    | <b>Date Added to CRR:</b> May 2020<br><b>Last reviewed:</b> March 2025<br><b>Next Review:</b> September 2025  |               |    |               |
|  |       |    |               |   |   |          |   |   |             |   |              |    | <b>Committee reviewed at:</b><br>Hospitals of the Future Project Board<br>(Wednesday 26 February 2025)<br>Endorsed by Director of Finance and BtLW Programme SRO) |               |    |               |

| <ul style="list-style-type: none"> <li>• delay the delivery of its vision to develop and establish an Innovation Village and realise the benefits that this will deliver; and</li> <li>• suffer reputational damage.</li> </ul>  |                 |                            |
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| Controls   | Gaps in Control | Further Mitigating Actions |
| <b>Stakeholder Engagement</b><br>Affected CSU and Directorate Teams to undertake a comprehensive local risk register review identifying where the Hospitals of the Future Project was described as a mitigation and document the impact of delayed delivery and proposed new risk score(s), controls and mitigation actions directly to the Risk Management Committee.   |                 |                            |
| <b>Clinical, Operational &amp; Estates Strategy</b><br>The Trust will undertake a comprehensive review of its Clinical, Operational and Estates Strategy to assess the impact of the delayed investment and to identify any changes to the existing 2022 Hospitals of the Future Project OBC Strategy and the need for any interim and/or revised and updated long-term strategies (i.e. this should take the form of an interim strategy should funding be made available in addition to the review and development of the long-term strategy should funding not be available). |                 |                            |

| CRRO8: Risk of failure to deliver the Pathology Transformation Programme  | C = 4 | 16 | Very Low Risk |   |   | Low Risk |   |   | Medium Risk |   | High Risk |              | Significant Risk |    |                         |  |  |  |  |
|---|-------|----|---------------|---|---|----------|---|---|-------------|---|-----------|--------------|------------------|----|-------------------------|--|--|--|--|
|   | L = 4 |    | 1             | 2 | 3 | 4        | 5 | 6 | 8           | 9 | 10        | 12           | 15               | 16 | 20                      | 25   |  |  |  |
|   |       |    |               |   |   |          |   |   |             |   |           | Target Score |                  |    | Initial & Current Score |  |  |  |  |
| <b>Risk Description:</b><br><br><b>There is a risk that the Pathology Transformation Programme fails to deliver its objectives as a result of:</b> <ul style="list-style-type: none"><li>the potential for unforeseen elements within the Siemens project implementation plan/programme for the implementation of the Pathology Managed Services Contract (MSC);</li><li>delays to the implementation of subsequent Tranches of the new Laboratory Information Management System (LIMS) onto new MSC-provided equipment (Phase 2);</li><li>delays to the delivery and commissioning of outstanding equipment.</li><li>the failure of any mitigation controls implemented to support the transition of services to the new CfLM and AHL.</li><li>delays and/or lack of additional specialist resources to support the implementation and post-implementation activities of the LIMS and MSC Projects.</li><li>delays and/or issues arising through the delivery of critical works to support the transfer of services and/or issues arising through the physical transfer of Services.</li><li>ineffective implementation of workforce and associated change management plans.</li></ul><br>impacting the timeline to vacate the Old Medical School (OMS) and the critical path to operationalising the new CFLM and AHL Pathology facilities.<br><br><b>If the project is not delivered, the Trust will:</b> <ul style="list-style-type: none"><li>be unable to transfer all identified Pathology services into the CfLM and AHL following their commissioning to the agreed timeframe.</li><li>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</li><li>not contribute effectively to the implementation of the WYAAT Network Pathology Strategy.</li></ul> |       |    |               |   |   |          |   |   |             |   |           |              |                  |    |                         | <b>Executive Lead:</b> Director of Finance |  |  |  |
| <b>Date Added to CRR:</b> May 2020<br><b>Last reviewed:</b> July 2025<br><b>Monthly Review:</b> August 2025<br><b>Next Full Review:</b> December 2025   |       |    |               |   |   |          |   |   |             |   |           |              |                  |    |                         |  |  |  |  |
| <b>Committee reviewed at:</b><br>Pathology Transformation Programme Board, 3 June 2025<br>Endorsed by Jenny Ehrhardt, Pathology Transformation Programme SRO<br>Beth Barron, Delegate SRO and Director of Operations  |       |    |               |   |   |          |   |   |             |   |           |              |                  |    |                         |  |  |  |  |



| <p><i>*The Pathology Transformation Programme 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".</i></p> <p><i>Due to the fast-paced nature of resolutions to the issues emerging following the implementation of LIMS1 Release 2—and with all items having planned fixes and dedicated resources assigned—it is proposed that the likelihood score be reduced from 5 to 4 (bringing the overall score from 20 to 16). Continued confidence in the effectiveness of the planned fixes, along with sustained on-site support from Clinisys, suggests that the likelihood score may decrease further (from 4 to 3) in the coming week.</i></p> |   |  |
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| Controls   | Gaps in Control   | Further Mitigating Actions   |
| <p><b>Governance and Assurance</b></p> <p>The Trust has implemented robust programme governance and assurance frameworks for the delivery of the Pathology Transformation Programme 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 several recommendations, notably around ensuring that the governance and leadership for the operational readiness phase was appropriate. Revised governance arrangements have since been implemented to ensure that appropriate officers are involved with accountabilities for MSC, LIMS and other delivery projects.</p>   | <p>Clarity surrounding the governance and reporting arrangements to support the management and resolution of outstanding matters and mitigating controls transferred to BAU to support the full realisation of benefits and intended operational state.</p> | <p>Continuation of the additional governance and management arrangements until the planned vacation of the OMS on 31 July 2025.</p> <p>Develop governance and reporting arrangements to support the management and resolution of outstanding matters and mitigating controls transferred to BAU to support the full realisation of benefits and intended operational state.</p> <p>Undertake a Lessons Learned Workshop at the conclusion of the Transformation Programme as a proactive step to identify successes and opportunities for improvement, ensuring continuous enhancement and best practice in the delivery of similar future programme and projects.</p> |

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| <p>On 6 March 2025, the Executive Team approved changes to the governance and management arrangements of the Pathology Transformation Programme to support the operationalisation of the new Pathology facilities as the programme entered a critical final phase. The changes focused upon the development, implementation and effective management of a 12-week plan (from Monday 10 March through to Friday 30 May 2025) and specifically increased collaboration, closer-working, streamlined delegated decision-making and an increased agile way of working.</p> <p>Pathology Project Leads report weekly on progress, key issues and decisions every Monday, Wednesday, and Friday at stand-up meetings and reviews. Alongside the weekly stand ups and review meetings the Pathology Transformation Programme Board remains active and has been rescheduled to occur every fortnight. The Board is accountable to the Trust's Executive Team and Infrastructure Committee. It has been delegated with the authority to oversee, review and report the co-ordination of all activities necessary for the successful transfer and operationalisation of the Trust's Pathology services intended to be located within the Centre for Laboratory Medicine (CfLM) and Acute Hospital Laboratory (AHL) facilities. It has, subject to assurance by the Executive Team, the decision-making authority over all activities necessary to operationalise the CfLM and AHL.</p> |  |  |
| <b>Managed Services Contract (MSC)</b>   |  | (See also below under LIMS deployment) |

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| <p>The MSC Implementation Live Plan continues to be updated by the Programme Planner in collaboration with Siemens that details the equipment delivery and installation timelines. Delivery and installation of equipment to the CfLM commenced on 7 October 2024 and is well underway and anticipated to be complete by the end of June.</p> <p>Progress monitoring of the MSC Project is reported at the weekly stand-up meetings and reviews (established as part of the 12-week Pathology Transformation Programme governance), to the fortnightly Pathology Transformation Programme Board, the Programme SRO and delegate SRO via the weekly Executive Report, and the Infrastructure Committee in addition to separate governance arrangements for the MSC Project linked with WYAAT.</p> | <p>There is a potential impact on the timely delivery of LIMS 2 interfacing following post go-live issues with reporting in Virology which may delay the end-to-end testing on the new MSC equipment. Clinisys are anticipated to fix the reporting issue by early June.</p>  | <p>Siemens have allocated additional support to expedite interface developments in readiness for early end-to-end testing on the new MSC equipment.</p>  |
| <p><b>AHL MSC Enabling Works</b></p> <p>The Main AHL Enabling works have been completed as the works requiring Building Regulations approval have been decoupled from the main works.</p> <p>The remaining permanent works necessary that require Building Regulations consent will be completed once approval has been granted. The Trust continues to await approval from the Building Safety Regulator. Approval is anticipated on or before 5 June.</p>  | <p>Following an initial delay to the original determination date on 13 February 2025, an extension to the review period made by the Building Safety Regulator until the 10 April, however BSR have requested a further additional 8 weeks to review the application, which results in an impact to operationalisation. The new date for a decision is on or before 5 June 2025.</p> <p>Whilst it is expected the application will be approved, the decision will be communicated on the day it is made,</p> | <p>Anticipating the approval on or before the 5 June, Siemens Contractors are prepared to commence works on 9 and 10 June.</p> <p>Mitigating options (in the event of a further delayed or unsuccessful application) that are being reviewed include: a temporary alternative solution to the compressor to enable operationalisation of the AHL and subsequent vacation of the OMS.</p> |

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|   | limiting the ability to anticipate and prepare for subsequent actions.   |  |
| <p><b>Pathology LIMS Deployment</b></p> <p>The Pathology LIMS1 Release 2 deployment proceeded as planned on 19 May 2025 following review of patient safety incidents and clinical oversight from the December 2024 LIMS1 Release 1 to ensure application of learning from the previous release.</p> <p>Following the implementation in May 2025, the focus of the work has shifted to post go-live activities including:</p> <ul style="list-style-type: none"> <li>• Monitoring and resolution of any raised support tickets and change requests in the immediate post go-live period, led by the on-site Clinisys support team.</li> <li>• Completion of all essential WinPath training modules, over the 75% threshold that was required for Clinical Safety sign off (obtained 16 May).</li> <li>• Ensuring accurate pathology activity data is able to be reported for billing and income purposes.</li> </ul> <p>On 6 March 2025, the Pathology Transformation Programme entered a final 12-week period that will enable it to take a material step forwards towards achieving operationalisation. The LIMS Project Board was assumed as part of the Pathology Transformation Programme Board and all recommendations requiring approval presented to this Board.</p> | <p>A lack of consistent engagement from third party suppliers via the MSC Contract to obtain required information to progress the install and testing of prioritised analysers.</p> <p>Post LIMS1 Release 2 Go-Live issues raised by both internal and external stakeholders continue to be reviewed and prioritised on a daily basis via a dedicated email address.</p> | <p>Escalation of third-party issues raised with Siemens via the Trust Commercial Team</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>DIT maintaining line of sight ensuring adequate resourcing to support both LIMS projects.</p> |

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| <p>LIMS delivery progress is reported to the Weekly Stand-up meetings every Monday, Wednesday, and Friday, the Pathology Transformation Programme Board, the 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>Regarding Cyber Security/Assurance, there has been agreement from the CDIO to proceed with MSC Supplier solutions acknowledging the cyber security risk due to the MSC contract's cyber security conditions for all related equipment to mitigate further delays. Ongoing management of Trust Cyber Security and Assurance Framework will be managed through DIT BAU.</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>Fortnightly change management workshops continue with updates provided by Service Leads to inform the Integrated Programme Plan.</p> <p>Additional locum support appointed in April to support the LIMS End to end testing (Blood Sciences and Clinical Immunology)</p> <p>The Programme Planner continues with established bi-weekly programme planning sessions with Service Leads.</p>  | <p>Specialist resource challenges remain in Clinical Immunology impacting the ability to support timely end-to-end testing and clinical validation, whilst also maintaining BAU operations.</p> | <p>The Service seek to free up specialist time through supporting the reallocation of more junior duties to appropriate resource.</p> |

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| <p>A Welcome Pack has been developed to provide staff who are relocating to the CfLM with information on the building, wayfinding, and wellbeing support.</p>   |  |  |
| <p><b>Pathology CSU Projects</b></p> <p>The Pathology 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 Transformation Programme Board, continue to optimise the co-ordination of delivery and dependencies of the MSC, LIMS and CSU project.</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>Emergency Planning Response (EPR):</b></p> <p>Emergency Planning response has been established and is led by the Head of Resilience, working with the LIMS Project Team, CSU Management Team, Communications Team and Pathology Programme Management Team.</p> <p>Weekly EPR Team meetings were established to plan EPR in the 8-week period prior to the LIMS go-live, which was successful on 19 May and the period that follows. Separately the EPR ensures appropriate command and control for the physical service relocations occurring from May through to July.</p> |  |  |

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| <b>Business Continuity Planning (BCP):</b><br><br>Business continuity planning is stepped up with corporate support (as per LIMS go-live BCP). This issue has been added to the fortnightly Change Management workshop agenda to capture key aspects that need to be covered. |  | 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. |
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| CRRO9: Risk of failure to deliver the LGI Site Development Project   | C = 5 |  | Very Low Risk |   |                 | Low Risk |   |   | Medium Risk |                            | High Risk |    | Significant Risk                            |    |    |    |
|  |       |  | 1             | 2 | 3               | 4        | 5 | 6 | 8           | 9                          | 10        | 12 | 15  | 16 | 20 | 25 |
|  | L = 3 |  |               |   |                 |          |   |   |             |                            |           |    |   |    |    |    |
| <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. |       |  |               |   |                 |          |   |   |             |                            |           |    | Executive Lead: Director of Finance         |    |    |    |
|  |       |  |               |   |                 |          |   |   |             |                            |           |    | Date Added to CRR: May 2020                 |    |    |    |
|  |       |  |               |   |                 |          |   |   |             |                            |           |    | Last reviewed: May 2025                     |    |    |    |
|  |       |  |               |   |                 |          |   |   |             |                            |           |    | Next Review: November 2025                  |    |    |    |
|  |       |  |               |   |                 |          |   |   |             |                            |           |    | Committee reviewed at:<br>LDS Project Group |    |    |    |
| 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 |
|  |       |  |               |   |                 |          |   |   |             |                            |           |    |  |    |    |    |
| <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> April 2025                           |    |    |    |
|  |       |  |               |   |                 |          |   |   |             |                            |           |    | <b>Next Review:</b> October 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> January 2023                     |    |    |    |
|  |       |  |                 |   |   |          |   |   |                            |   |           |    | <b>Last reviewed:</b> April 2025                           |    |    |    |
|  |       |  |                 |   |   |          |   |   |                            |   |           |    | <b>Next Review:</b> October 2025                           |    |    |    |
|  |       |  |                 |   |   |          |   |   |                            |   |           |    | <b>Committee reviewed at:</b><br>DIT Committee             |    |    |    |
| Controls   |       |  | Gaps in Control |   |   |          |   |   | Further Mitigating Actions |   |           |    |  |    |    |    |
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| CRR1: Risk of exposure to HCAI  | C = 4 | 16 | Very Low Risk  |   |   | Low Risk |   |   | Medium Risk   |   | High Risk |    | Significant Risk  |               |               |    |
|---|-------|----|--|---|---|----------|---|---|---|---|-----------|----|---|---------------|---------------|----|
|   |       |    | 1  | 2 | 3 | 4        | 5 | 6 | 8   | 9 | 10        | 12 | 15  | 16            | 20            | 25 |
|   | L = 4 |    |  |   |   |          |   |   | Target Score  |   |           |    |   | Current Score | Initial Score |    |
| <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><b>Date added to CRR:</b> March 19<br><b>Last reviewed:</b> April 2025<br><b>Next Review:</b> October 2025<br><b>Committee reviewed at:</b> Quality Assurance Committee<br>Infection Prevention and Control Sub-Committee |               |               |    |
| 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)<br>IPC/Microbiology risk assessment completed electronically in PPM. IPC alert mechanism incorporated into electronic patient record (PPM+). Staff level assessment of risk at induction<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.<br>Communication about the current increase in the circulation of measles and pertussis within the community has been briefed national regionally and locally. Close surveillance of  |       |    | 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.<br>Specific communications have been sent to Urgent Care, Children’s and Women’s CSU’s explaining how staff can find out about their |   |           |    |   |               |               |    |

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| <p>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>Staff on the infectious Disease ward are trained and a process for providing mutual aid established.<br/>A process for Mpox clade 1 single adult case care pathway for assessment, testing and care awaiting result, has been established in infectious diseases at SJUH.</p> <p>Laboratory Information System (LIMS) 'WinPath' is replacing 'Telepath' for all pathology specialties.</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>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</p> | <p>current vaccination status and where to go for immunisation. Specific communications have been sent to Urgent Care, Children's and Women's CSU's explaining how staff can find out about their current vaccination status and where to go for immunisation.</p> <p>Measles Outbreak: Local and City Response in place, mutual aid required within LHTT to bring under control. Emergency Preparedness response stood up. Shadow rotas for infection medics and Paediatricians to provide post exposure prophylaxis.</p> <p>Mpox clade1 case in Leeds Nov 2024. Process for single case assessment, testing and care awaiting result was described as exemplary both locally and nationally. Debrief and learning underway.</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. Training compliance from Childrens, ED and Critical Care demonstrates an improving picture with the main gap within ED.</p> <p>Proposed new date for LIMS implementation with microbiology and ICNET May 2025. ICNET will not be available for approximately two weeks and then a further two weeks test phase, an interim solution is being developed.</p> |
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| <p>Carbapenemase producing Enterobacterales (CPE) national framework adopted at LTHT.</p> <p>Major outbreak Control Guideline activated. CPE Outbreak in Speciality Integrated Medicine brought under control.</p> <p>Major Outbreak of CPE in SIM formally closed Dec 2024.</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. Trust project lead appointed; proof of concept phase completed.</p> <p>HCAI reports generated weekly and circulated to clinical service units to monitor performance.</p> <p>Laboratory based ward surveillance process monitored by IPCT. Incident /Outbreak response triggered by surveillance process.</p> | <p>ability to prevent the transmission of infection.</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.</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>Transmission of vancomycin resistant enterococci within Trauma Related Services.</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. This action was paused during outbreak management. LTHT IPC Plan for 2025 to include review of risk mitigations for CPE. First meeting of task and finish group held 3.3.25.</p> <p>Reconfiguration of ICNET, to support surgical site infection surveillance module underway with second phase test occurring end of March, Training April to align with the planned WinPath implementation May 2025.</p> <p>Local outbreak management escalated to a Major Outbreak Control Group (MOCG) following further clinical case in January. Point prevalence screening completed; Ward closure, education campaign, peer daily ward</p> |
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| <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>   | Transmission of CPE in AMS | <p>assurance checks implemented as part of routine control measures.</p> <p>Local outbreak management group convened. Investigation currently underway.</p> |
| <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> |                            |   |
| Environmental Controls: Environmental decontamination programme and standards, segregation and safe disposal of  |                            |   |

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| <p>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. Rapid action tender to scope building work commenced October 2023</p> <p>Formalised cot numbers produced.</p> <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. Outbreak is now closed, and a review is being undertaken to identify ways to support other CSU'S with a proactive HPV resource and incident response service.</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>LGI NNU has experienced new outbreaks of infection related to practice and environment.</p> <p>Rolling programme of whole ward HPV decontamination paused as current decant facility is providing winter bed capacity.</p> | <p>CSU leading a task and finish group to work through the clinical risk and mitigations following receipt of the external report and CQC visit.</p> <p>Trust wide rolling programme of HPV in response to incident management underway.</p> |
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| <p>Hierarchy of controls completed by clinical teams which details controls, risks, and mitigations for Covid-19.</p> <p>All adult haematology ensuite 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>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. 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. Side room Management EForm report being generated to support CSUs to understand utilisation, compliance and improve patient flow.</p> <p>Side room capacity increased in ED, ARCU and Critical Care, with additional 12 side rooms across LGI, SJUH and CAH</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> |
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| <p>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.</p> <p>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>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>Large parts of the estate have natural ventilation only.</p> |  |
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| <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>Antimicrobial Stewardship: Policies and Standards, City Wide Group, Ward Rounds and day 3 IV antimicrobial review.</p> <p>Eolas knowledge management platform implemented Trust wide to support evidence based antimicrobial guideline access.</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 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>A review of Klebsiella sp. Infection reporting has been completed by the IPC administration team demonstrating under reporting of Klebsiella sp. Infection historically.</p> | <p>Infection reporting has now been amended so all Klebsiella species will be reported and investigated, not only Klebsiella oxytoca and Klebsiella pneumoniae as previous from the 1<sup>st</sup> Feb 2025.</p> <p>The review suggests an additional 0-1 cases per month may be reported by LTHT following this change.</p> <p>It is important to note that this under reporting has not impacted on the treatment of infection for individual patients.</p> |
| <p><b>Recovery and lessons Learned:</b> Outbreak Management. Incident investigations. City wide Outbreak response group.</p>   | <p>Feedback of lessons from HCAI incidents to clinicians is variable across LTHT, in some areas learning may not be shared</p>  | <p>HCAI PSIRF process now live across the Trust in bed holding CSU'S.</p>   |

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| <p>CSUs manage individual HCAI case reviews, incidents, and Outbreak Meetings with support from Consultant Microbiologists, IPCT, Antimicrobial Pharmacists and DIPC/DDIPC.</p> <p>Successful recruitment to Microbiologist role. post holder commenced January 24</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. Trust wide participation from January 2025</p> <p>Development of CSU microbiologist role to include reporting of themes and trends from HCAI case reviews 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. The new process for clinical review included in the HCAI PSIRF CSU consultation October 2023</p> | <p>effectively. Not all CSU's have a designated Consultant Microbiologist to support.</p> | <p>The Post Infection Proforma (PIP) remains as paper, current mitigation to upload paper copy of document onto PPM in place. This is impacting on the ability to rapidly review learning and identify themes. Request for work submitted to digitalise the post infection proforma-no progress to date.</p> <p>Trust HCAI MDT review clinics commenced however theses are more established in PSIRF trial areas. Learning event held to share CSU learning.</p> |
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| <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> <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 CSUs are invited to provide an assessment of their position against the programme at the</p> |  |  |

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| <p>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. Successful recruitment to Microbiologist role, December 2024.</p> <p>IPCN development plan in place.</p> <p>New JD to include AHP in approved. IPCT Successfully recruited too. Team now at full establishment</p> | <p>Consultant Virologist capacity limited- not all CSU's have a designated Consultant Microbiologist to support the HCAI reduction strategy</p> | <p>Review of virology IPC provision underway. Review of Microbiologist CSU alignment through workplan process.</p> |
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| CRRC4: Emergency Care<br>95% Constitutional<br>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<br>Score   |   |           |    |  |    | Initial<br>Score | Current<br>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<br><b>Last Reviewed:</b> January 2025<br><b>Next Review:</b> August 2025 |    |                  |                  |
|   |       |    |   |   |   |          |   |   |   |   |           |    | <b>Committee reviewed at:</b><br>Finance & Performance Committee   |    |                  |                  |
| Controls  |       |    | Gaps in Control   |   |   |          |   |   | Further Mitigating Actions:   |   |           |    |  |    |                  |                  |
| 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. 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> |
| <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</p>   | <p>All patients awaiting over 24 hours in the ED will be reported on the NHSE KLOE for SCC engagement. 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>  |

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|  | describes necessary clinical monitoring and actions required for maintenance of patient safety including escalation process for patient or staff safety concerns. |  |
| 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). | The estate footprint constraints and adjacency for universal SDEC offer.  | Continued monitoring of ED attendance profile and 95% compliance and breach analysis for patients streamed away from ED.<br>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   |
| Business continuity plans in place for times of high acuity/ attendances to ensure safe patient placement when ED capacity is inadequate for demand.   | The estate footprint constraints within EDs   | 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.<br>Nurse and medical staffing reviewed to ensure patient safety and timeliness of care across a larger footprint.<br>Agreed surge plans for extremis developed as part of a Decision Management Tool to space within or adjacent to the ED's.<br>Minor injury straight to test is routine practice to support rapid test and treat/decision |
| 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.   |



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| 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. |
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| CRRCS: 18-week RTT Constitutional Standard   | 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 |
| <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 combined with referral growth in some areas, and reduced levels of productivity across some specialities in outpatients, diagnostics and theatres.<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<br><b>Date Added to CRR:</b> May 2014<br><b>Last Reviewed:</b> April 2025<br><b>Next Review:</b> September 2025<br><b>Committee reviewed at:</b> Finance & Performance Committee |    |               |               |
| Controls   |       |    |               |   |   | Gaps in Control   |   |   |              | Further Mitigating Actions:   |           |    |   |    |               |               |
| The 2025/26 priorities and operational planning guidance requires NHS providers to achieve 5% improvements in RTT performance, 1 <sup>st</sup> OP waits, and less than 1% of the total waiting list to be over 52 weeks. The expectation is a return to full RTT delivery by the end of the current Parliament in 2029   |       |    |               |   |   | ERF will be capped in 2025/26 with flat funding allocations for ICS.<br><br>Some specialities are experiencing higher referral growth and will require significantly increased activity                         |   |   |              | Theatre, Diagnostic and Outpatient productivity schemes are well established and are increasing levels of productivity across pathways  |           |    |   |    |               |               |
| 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.<br><br>Robotic Process Automation (RPA) supports the administrative validation of the entire RTT waiting list and is further supported by targeted clinical validation  |       |    |               |   |   | Validation does not deliver any additional capacity in areas where backlog continues to grow.<br>Volume of patients means that capacity to undertake reviews is limited and may require cancellation of clinics |   |   |              | CSUs are working through PIFU protocols to support the validation outcomes and embedding wider PIFU options in specialities.<br><br>This is further supported by.<br><br>- the roll out of GIRFT: Further Faster handbooks across 15 specialties.<br>- e-Outcomes<br>- Reduction of low clinical outcome activity<br>- Clinic Utilisation |           |    |   |    |               |               |

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| Implementation of telephone and video conferencing facilities have enabled non-face-to-face appointments to be delivered.                               | <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> |
| Triage of referrals enables identification of some patients at risk of harm if appointments are delayed.  | <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 outpatient's productivity and efficiency PID for 2025/26.</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>Demand variation from winter modelling / Covid modelling will impact elective delivery.</p> <p>Some specialties have larger waiting lists and / or more constrained capacity to deliver planning guidance requirements.</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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| 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) will increase funded capacity for some specialties particularly in imaging and physiological assessments/tests.<br><br>Planned expansion of CDC capacity across 7 days |
| 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.   |
| 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> | Additional Business cases being developed to expand theatre capacity at the LGI within existing estate and into weekend working   |

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|  | Delay of the BTLW programme reduces planned expansion of theatre capacity at the LGI   |   |
| 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. The ICB has increased capacity for the IPT of additional non-admitted and admitted activity in Orthopaedics, General Surgery,            |

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|  | There is currently <del>no</del> minimal capacity for paediatric elective activity at tariff in the Independent Sector  | Ophthalmology, Plastics, Urology, Gastroenterology, ENT and Gynae.  |
| 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.   | 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 / Average Case per session / DNA/WNB rate / cancellation (patient and hospital) rates / first to follow up rate / advice and guidance provision | Impact of unplanned pressures on elective bed base<br><br>Willingness of clinicians to do extra work due to pension / tax issues.<br><br>Capacity to focus on improvement work alongside operational pressures. | Recognising the pressures on teams, and the pressures on the organisation, the improvement work through theatres has focussed on those areas less impacted by loss of elective beds.<br><br>A specific Theatre productivity and efficiency PID for 2024/25 developed to deliver an increase in list utilisation and cases per session by individual specialities and theatre suite. |

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|  |   | <p>A specific Outpatients productivity and Transformation PID for 2024/25 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>Each project will reassess productivity expectations in line with required activity targets for delivery of RTT improvement requirements in 2025/26</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> |   |

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| CRRC6: 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> July 2025<br><b>Next Review:</b> January 2026<br><br><b>Committee reviewed at:</b><br>Finance and Performance Committee |    |               |               |
| <b>Controls</b>   |       |    | <b>Gaps in Control</b>                              |   |   |          |   |   | <b>Further Actions Planned:</b>   |              |           |    |   |    |               |               |
| Operational plans to meet the waiting time standards set out in the NHS Constitution (2012), monitoring against the following standards: <ul style="list-style-type: none"><li>28 day Faster Diagnosis Standard measures 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><li>A maximum 2-month (62-day) wait from receipt of an urgent GP (or other referrer) referral for urgent suspected cancer or breast symptomatic referral, or urgent screening referral, or consultant upgrade, to first definitive treatment of cancer</li></ul> |       |    | Variation in capacity requirement<br>Demand control |   |   |          |   |   | Monthly accountability meetings with the COO and Deputy COO by Cancer Pathway.<br>Task and finish groups looking at LIM work to streamline pathways.<br>Reviewed PTL process implemented<br>Pathology PTL in place, Radiology PTL to be introduced in June 2025 |              |           |    |   |    |               |               |



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| The 2025/26 Cancer National Priorities and operational planning guidance to improve the 62 day position sets out a recovery of 75% by March '26 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<br>Monthly accountability meetings with the COO and Deputy CoO to review all cancer pathways.<br><br>Appointment of a MDOP for Cancer   |
| 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>CSU ownership through the 7 commitments and Gap analysis completed for Years 1 and 2 of the strategy – actions for gaps to be agreed at the Cancer Transformation Group   |
| <p>Radiotherapy Task and Finish group established to review Capacity and Demand.</p> <p>Radiotherapy are now delivering within standard waiting times.</p> <p>Cat A referrals are currently being booked to start around 22-24 days from referral.</p> <p>Cat B referrals are being booked to start around 23-25 days from referral</p> <p>Cat C patients are currently starting 25-28 days from referral</p> <p>Cat D patients are currently being booked to start at day 26-29</p> | <p>-</p> <p>Business Case on Staffing review for phase of growth in service to maintain service delivery within turnaround times.</p> | <p>Radiotherapy continue to review their workforce and on going recruitment need for growth in service. Ensuring that there is a clear strategy.</p> <p>However, through on going review of pathways and recruitment success into the team the Linac utilisation is on average over 100% with additional sessions being delivered across weekends and is now within target.</p> |

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| Pathology turn around times across cancer pathways   | Turn around of samples within 7 days<br>(Trust standard) is currently not achieving | <p>A Task and Finish Group has been established with a full review of workforce within the Lab. A LIMS review has been completed looking at the perfect week.</p> <p>A Business case for staffing has been approved and recruitment has started attracting 40 applicants for 4 posts.</p> <p>Benchmarking is being completed and the team have made contact with a number of pathology labs including Nottingham.</p> <p>The Alliance and Trust has supported funding for home stations to enable Pathologist to report from home, these are currently on order. Any new job adverts will include the provision of Home stations.</p> <p>Production board introduced into the Lab and weekly trajectory monitoring produced.</p> <p>Trajectories based on impact of appointment of new starters is being completed.</p> <p>Meetings with Clinical leads to review capacity and demand and develop ongoing solutions, alongside reviewing need to outsource.</p> <p>Visit to Cambridge is planned in June/July</p> |
| Recovery plan in place for the skin backlog position |   | <p>Skin backlog maintained at acceptable level currently although oversight maintained weekly at the PTL meeting</p>  |

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| 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 completed, action plans in place for all pathways<br>The RCAs are completed by the Corporate Cancer team but where there is suspicion of harm this is devolved to CSUs for review/assessment for greater learning and implementation of change.<br>Process for harm assessment below 104 days to be agreed and implemented in the CSU's (led by Kelly Cohen) |
| 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 25/26 agreement and are reflected within the Service Delivery Meetings and Integrated Accountability Meetings                     |  | 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,  | Cancer Escalation and Service delivery oversee the delivery of cancer waiting times, with   |

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|   | causing increased activity and delivery challenges particularly in Breast (2 spikes), Skin, Colorectal and Head and Neck<br>Late referrals from other organisations.   | escalation as required to DOP's and GM's via email and Cancer Board  |
| Weekly surgical/ HDU prioritisation processes continue to be in place, with additional operating accessed in the Independent sector where possible/ appropriate.<br>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 referring trusts work programmes to improve timely transfers. |
| 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.<br><br>No episodes of downtime exceeding 24 hours have occurred                                    | 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. | A solution is in testing stage to reduce this risk further, awaiting final result.   |

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| CRR7: Failure to achieve 28 days cancelled operations Constitutional Standard  | C = 4 | 16 | Very Low Risk   |   |   | Low Risk |   |   | Medium Risk   |   | High Risk |    | Significant Risk   |                         |    |    |
|  |       |    | 1   | 2 | 3 | 4        | 5 | 6 | 8   | 9 | 10        | 12 | 15   | 16                      | 20 | 25 |
|  | L = 4 |    |   |   |   |          |   |   | Target Score  |   |           |    |  | Initial & Current Score |    |    |
| <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> April 2025                                   |                         |    |    |
|  |       |    |   |   |   |          |   |   |   |   |           |    | <b>Next Review:</b> September 2025                                 |                         |    |    |
|  |       |    |   |   |   |          |   |   |   |   |           |    | <b>Committee reviewed at:</b><br>Finance and Performance Committee |                         |    |    |
| <b>Controls</b>  |       |    | <b>Gaps in Control</b>  |   |   |          |   |   | <b>Further Mitigating Actions:</b>  |   |           |    |  |                         |    |    |
| To support elective recovery a programme of work led by the Medical Director of Operations and supported by the ADOPs for Planned and Cancer care was established in October 2020 to focus on increasing Critical Care, inpatient and day case capacity, and improving efficiency and patient experience within the elective pathway (Pre-op, Peri-op, and Post op), which will develop and strengthen the controls for CRRP 4. The projects include.<br>British Association of Day case Project<br><br>Enhanced Care Areas<br><br>Theatre Productivity & Efficiency<br><br>Pre-optimisation<br><br>Development of elective hubs<br>The programme reports monthly to the Tactical Sponsorship group chaired by the COO |       |    | Focussed on transformation programmes and long-term developments.<br>Impact of unplanned pressures on elective bed base |   |   |          |   |   | Service Delivery Framework and Integrated Accountability Meetings used to support the daily management of CSU KPIs and delivery of the 28-day constitutional target for CSUs. |   |           |    |  |                         |    |    |

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| <p>Prompt starts for all elective theatre lists to automatically send for patients requiring inpatient or day case capacity.</p> <p>All ACC SJUH patients are automatically sent to theatre and Priority 1-4 patients at LGI are automatically sent to theatre</p>  | <p>Co-ordination of theatre/ ward and critical care capacity does not always align leading to greater risk of cancellations.</p> <p>Not all Critical Care patients can be automatically sent for</p>                           | <p>Daily circulation of planned TCIs and previous cancellation status the day prior to surgery</p>  |
| <p>All CSUs have weekly access meetings to identify available theatre capacity for additional sessions, manage risks and review cancellations and discharge and theatres KPI's using the LTHT scheduling tool.</p> <p>Collaborative CSU process to 'book' patients into an admission area by appointment and lock down of list order to improve patient flow and reduce risk of late starts and subsequent on day patient cancellations.</p> <p>Daily email prompt to CSUs highlighting their 28-day breach risks.</p> <p>Weekly collaborative critical care clinical prioritisation review by LGI and SJUH CSUs to support listing of clinically urgent patients and to match listed activity to anticipated capacity.</p> <p>LTHT scheduling tool has been updated with the 'Monte Carlo' simulation to improve scheduling accuracy and theatre efficiency.</p> | <p>Critical Care capacity can change overnight due to staffing absence or high numbers of unplanned admissions and result in on day cancellations</p>  |   |
| <p>Multidisciplinary BADs Day case project identifying CSUs and individual procedures through PLICS and Model Hospital that could be treated as day case to reduce need for IP beds and risk of cancellation.</p> <p>Use of Independent sector to increase available capacity and treatment options for patients.</p>   | <p>Theatre staff and surgeons are not always available to undertake additional activity in response to peaks in demand.</p> <p>Independent sector contract restricts type of patient able to be transferred for treatment.</p> | <p>Planned Care Dashboard developed to highlight BADs / Day case opportunity by procedure.</p> <p>WDH theatre expansion completed and now operational.</p> <p>GIRFT project embedded in Theatre efficiency project to ensure appropriate patient pathway is followed.</p> |

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| Monthly focus on 6-4-2 process and Specialty level performance within Theatre Board. |  |  |
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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  |    |                         |    |
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|  |       |    | 1   | 2 | 3 | 4        | 5 | 6 | 8   | 9 | 10        | 12 | 15  | 16 | 20                      | 25 |
|  | L = 4 |    |   |   |   |          |   |   | Target Score  |   |           |    |   |    | Initial & 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> August 2025<br><b>Committee reviewed at:</b><br>Finance & Performance Committee |    |                         |    |
| Controls   |       |    | Gaps in Control   |   |   |          |   |   | Further Mitigating Actions:   |   |           |    |   |    |                         |    |
| 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><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 patient's 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 2025/26 activity growth from CSU requiring use of diagnostics. | Early review of trust wide 2025/26 activity plans to enable capacity and demand planning for diagnostics completed in Q4 2024/25.   |
| Equipment replacement programmes agreed for MRI, CT and Cath Laboratories. | Loss of MRI Scanner at Seacroft, no further funding secured through the national CDC programme.                                      | MRI capacity and demand reviews underway to mitigate the loss of the mobile scanner.<br><br>CT scanner at Seacroft now operational,<br><br>Continued review of Insourcing and outsourcing opportunities across Radiology. |

| 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 |    |               |    |
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|   | 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 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. Patient harms in A&E for patients waiting for long periods for inpatient placement is specifically referenced in risk CRRC4. There is also a risk to the delivery of constitutional standards, impacting on the Trust’s delivery and efficiency ratings and reputation. |       |    |  |   |   |          |   |   |  |   |           | <b>Executive Lead:</b> Chief Operating Officer                   |                  |    |               |    |
| Cross-referenced to Corporate risks <b>CRRC4, CRRC5, CRRC6, CRRC7, CRRC8, CRRC9, CRRC11.</b>  |       |    |  |   |   |          |   |   |  |   |           | <b>Date Added to CRR:</b> September 2015                         |                  |    |               |    |
|   |       |    |  |   |   |          |   |   |  |   |           | <b>Last Reviewed:</b> March 2025                                 |                  |    |               |    |
|   |       |    |  |   |   |          |   |   |  |   |           | <b>Next Review:</b> September 2025                               |                  |    |               |    |
|   |       |    |  |   |   |          |   |   |  |   |           | <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.   |       |    | 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 in progress. |   |   |          |   |   | Review of Live bed state development in progress<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. Roles and responsibilities outlined to improve consistency in working practice.<br>Discharge lead nurse appointed to work with and provide support to discharge coordinators.<br>Tracking of DMT actions taken at times of pressure and recorded for theming.<br>Weekly report to weekly Quality meeting to understand the frequency of use of TES and safety |   |           |  |                  |    |               |    |

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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 Temporary Escalation Spaces (TES) 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>Management of long length of stay patients.</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- trajectory not met.</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 and potential for patient harm impacted by use of TES beds.</p> <p>Bed modelling for this winter was not based on prevalence as accurately as previous years due to reduction in COVID testing. Flu came earlier than nationally predicted and overlapped with the children's RSV surge requiring some winter responses to be brought forward.</p> | <p>checks. Monthly report provided to the Quality &amp; Safety Assurance Group (QSAG).</p> <p>Review of TES areas undertaken by Chief Nurse team in October 2024 and minor amendments to spaces allocated made. TES spaces in ED identified and reported daily. SOP for the management of patients in TES in place.</p> <p>Datix reviewed weekly to monitor harm incidents and reported through weekly quality meeting. Full Capacity Plan and exclusion criteria updated to mitigate the risk of harm to patients placed in TES.</p> <p>Length of stay<br/>Additional 3 wards currently open in LTHT to meet the need of patients no longer requiring hospital in patient care. With seasonal plans to meet additional demand</p> <p>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> |
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| <p>Protected elective capacity at SJUH, CAH and Wharfedale Hospitals to support elective (planned patient) capacity.</p> <p>All patients on an active elective waiting list receive regular correspondence from the Trust advising them that they are still on a waiting list, and what to do / who to contact if their condition has changed etc</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>Dr Foster data set identifies further opportunity for length of stay reduction</p> | <p>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> |
| <p><b>Tactical:</b><br/>Alternatives to admission-</p> <p>Established Same Day Emergency Care unit 7 days per week.</p> <p>Primary Care Access Line receives calls for primary care colleagues, GPs and ambulance services to navigate as clinically appropriate away from ED and admissions to a series of rapid access clinics, specialist advice of a</p> | <p>SDEC's across the organisation will host overnight inpatients when the organisation is under significant pressure and demand outstrips capacity.</p>   | <p>Medical and elderly SDEC established alongside the SJUH Emergency Department with a focus on increasing admission avoidance and early senior decision making for patients is established 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. LGI multi- speciality SDEC and enhancement of MSSA unity change from September 2024 continues to be embedded.</p> <p>Review of a Single Point of Access across the city continues to explore a consistent approach for YAS to route to alternatives to admission and patient in right place, right speciality first time.</p>   |

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| <p>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>City funding to be established to continue this service.</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 from 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 rolled 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 2025/26   | 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 2025/26. 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, 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> May 2025                                     |    |    |    |               |
|  |       |    |  |   |   |          |              |             |  |           |    | <b>Next Review:</b> August 2025                                    |    |    |    |               |
|  |       |    |  |   |   |          |              |             |  |           |    | <b>Committee reviewed at:</b><br>Finance and Performance Committee |    |    |    |               |
| <b>Controls</b>  |       |    | <b>Gaps in Control</b>   |   |   |          |              |             | <b>Further Mitigating Actions</b>  |           |    |  |    |    |    |               |
| 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>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><li>Regular communication with ICS to assess and mitigate risks</li></ul> |           |    |  |    |    |    |               |

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| 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 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  | 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> <li>Regular communication with NHSE to identify and adapt to changes.</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> <p>Impact of organisational change at NHS E and ICB.</p> | <ul style="list-style-type: none"> <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>• 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 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 | 20 | Very Low Risk |  |   | Low Risk     |   |   | Medium Risk |   | High Risk |    | Significant Risk |    |  |                         |
|---|-------|----|---------------|--|---|--------------|---|---|-------------|---|-----------|----|------------------|----|--|-------------------------|
|   | L = 5 |    | 1             | 2  | 3 | 4            | 5 | 6 | 8           | 9   | 10        | 12 | 15               | 16 | 20   | 25                      |
|   |       |    |               |  |   | Target score |   |   |             |   |           |    |                  |    |  | Initial & current score |
| <b>Risk Description:</b><br>Operational capital allocations to address the Trust’s capital risks are insufficient to meet expected programme plans for 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 across all areas, resulting in the Trust’s risk appetite not being met</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> March 2025                                   |                         |
|   |       |    |               |  |   |              |   |   |             |   |           |    |                  |    | <b>Next Review:</b> August 2025                                    |                         |
|   |       |    |               |  |   |              |   |   |             |   |           |    |                  |    | <b>Committee reviewed at:</b><br>Finance and Performance Committee |                         |
| Controls  |       |    |               | Gaps in Control  |   |              |   |   |             | Further Mitigating Actions  |           |    |                  |    |  |                         |
| Monthly ICB Capital Working Group and ICB Director of Finance meetings to review risks and opportunities at an ICB level as well as discussing priorities and impact on individual Trusts of decision making.   |       |    |               | <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><li>Reduction in CDEL allocation to ICB – 2025/26 allocation has reduced by c25%.</li></ul> |   |              |   |   |             | <ul style="list-style-type: none"><li>Regular updates provided to Director of Finance 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   |       |    |               | <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.</li></ul>  |           |    |                  |    |  |                         |

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| including specific prioritisation for the MSE, BME and DIT programmes.   |  | Confidence levels and risks are specifically addressed.   |
| Development of in-house mitigation plan allows for the Trust to respond to changes in funding allocations or utilise slippage in other Trusts. | <ul style="list-style-type: none"> <li>• Restrictions on capital allocation due to funding formula – 25/26 CDEL limit for ICB has reduced by c25%</li> <li>• Restrictions on capital allocation due to decision on New Hospitals Programme funding with delay until 2031.</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> |
| External funding opportunities monitored closely with bids and applications submitted wherever possible  | <ul style="list-style-type: none"> <li>• Constrained by available opportunities.</li> <li>• Bids and applications not always successful</li> <li>• Trust not always able to identify appropriate schemes quickly</li> </ul>  | <ul style="list-style-type: none"> <li>• Capital Planning Group regularly discuss opportunities to maximise external funding opportunities.</li> <li>• Capital Planning Group to develop a pipeline of proposals to maximise external funding opportunities.</li> <li>• Strengthening of operational input to capital equipment programme.</li> </ul>   |

|   |       |    |   |   |   |          |   |   |  |   |           |               |  |               |    |    |
|---|-------|----|---|---|---|----------|---|---|--|---|-----------|---------------|--|---------------|----|----|
| CRRF3: Cash Availability  | C = 4 | 16 | Very Low Risk   |   |   | Low Risk |   |   | Medium Risk  |   | High Risk |               | Significant Risk   |               |    |    |
|   |       |    | 1   | 2 | 3 | 4        | 5 | 6 | 8  | 9 | 10        | 12            | 15   | 16            | 20 | 25 |
|   | L = 4 |    |   |   |   |          |   |   | Target Score   |   |           | Initial Score |  | Current Score |    |    |
| <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                         |               |    |    |
|   |       |    |   |   |   |          |   |   |  |   |           |               | <b>Date added to CRR:</b> Nov 2024                                 |               |    |    |
|   |       |    |   |   |   |          |   |   |  |   |           |               | <b>Last reviewed:</b> April 2025                                   |               |    |    |
|   |       |    |   |   |   |          |   |   |  |   |           |               | <b>Next Review:</b> October 2025                                   |               |    |    |
|   |       |    |   |   |   |          |   |   |  |   |           |               | <b>Committee reviewed at:</b><br>Finance and Performance Committee |               |    |    |
| Controls  |       |    | Gaps in Control   |   |   |          |   |   | Further Mitigating Actions   |   |           |               |  |               |    |    |
| 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.<br><br>The cash availability is unclear for 2025/26 based on timing of decision making across the ICS for capital specifically. |   |   |          |   |   | Additional meetings will be held to improve the understanding of others of the information needed to ensure the accuracy of the cashflow forecast.<br><br>The cashflow forecast risk will be reviewed monthly.           |   |           |               |  |               |    |    |
| 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. Th ability to apply for it is uncertain at this point in time. |   |           |               |  |               |    |    |
| The cash position and forecast are reported to the Finance & Performance Committee  |       |    |   |   |   |          |   |   | Cash support is available for capital and revenue. The ability to apply for it is uncertain at this point in time.   |   |           |               |  |               |    |    |
| 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   |   |           |               |  |               |    |    |

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| 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 will be developed for 2025/26 as necessary.                             |
| 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.  |  |   |

| CRRE1: CQC<br>Registration – breaches<br>of Regulation(s)<br>Maternity and Neonatal<br>Services  | 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<br>Score   |   |           | Initial<br>Score |   | Current<br>Score |    |    |
| <b>Risk Description:</b><br>There is a risk to the Trust’s conditions of registration with the Care Quality Commission (CQC) due to Warning Notice under Section 29A of the Health and Social Care Act 2008 (maternity staffing), breaches of Regulations and failure to meet the fundamental standards under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) (as amended):<br>Regulation 12 Safe care and Treatment<br>Regulation 15 Premises and Equipment<br>Regulation 17 Good Governance<br>Regulation 18 Staffing<br>This may impact on the provision of safe care to patients in maternity and neonatal SERVICES, confidence and experience of people who use these services, reputation, and capacity to respond to the regulatory requirements and scrutiny. |       |    |  |   |   |          |   |   |   |   |           |                  | <b>Executive Lead:</b> Chief Nurse  |                  |    |    |
|  |       |    |  |   |   |          |   |   |   |   |           |                  | <b>Date added to CRR:</b> July 2025<br><b>Last reviewed:</b> July 2025<br><b>Next Review:</b> August 2025 |                  |    |    |
|  |       |    |  |   |   |          |   |   |   |   |           |                  | <b>Committee reviewed at:</b><br>Quality Assurance Committee  |                  |    |    |
| Controls   |       |    | Gaps in Control  |   |   |          |   |   | Further Mitigating Actions  |   |           |                  |   |                  |    |    |
| Resources to support CSUs and corporate teams in preparation for CQC inspection, including quality statements, key questions and self-assessment: <u>CQC – Quality Statement and Preparing for Inspection – Leeds Teaching Hospitals NHS Trust</u>   |       |    |  |   |   |          |   |   |   |   |           |                  |   |                  |    |    |
| Inspection report from CQC (maternity and neonatal services) published 20 June 2025. Letter setting out breaches of Regulation and how the Regulations were not being met.<br>Trust response setting out improvement actions implemented and how these will be measured and monitored, for assurance.  |       |    | Capacity to manage regulatory requests alongside improvement work. |   |   |          |   |   | Additional leadership capacity and support provided to the maternity and neonatal teams, including Medical Director Operations, Director of Operations, Improvement Lead, Corporate Nursing, focusing on oversight of improvement plan. |   |           |                  |   |                  |    |    |

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| Perinatal report to Quality Assurance Committee, report to Trust Board.  | Flow of assurance to Board (perinatal risks).   | Review of assurance flow to Board, including KPIs to be undertaken and completed by 30 September 2025.   |
| Maternity and neonatal services improvement plan.  | Oversight of different workstreams and improvement plans (MSSP, CQC) – Trusted listed in national maternity programme.              | Integrated improvement plan developed with separate tabs, to be incorporated into single plan, for oversight and assurance.  |
| Maternity Safety Support Programme (MSSP) – monthly MSSP Quality Improvement Group (QIG), to provide oversight of improvement plan and assurance.  | Capacity to deliver improvements.   | Support provided by MSSP – 2 members of MSSP commissioned to provide direct support to improvement programme.  |
| Programme of engagement with people and families who use maternity and neonatal services.  | Staff not experienced in managing trauma informed conversations with people and families who use maternity and neonatal services.   | Trauma informed workshop provided for 40 clinical staff (maternity services). Further support and training plan to be provided by MSSP.  |
| Programme of listening events with staff, including staff surveys.   |   |  |
| Complaints and PALS process with oversight provided by Director Midwifery, Head of Midwifery, Clinical Director, General Manager.  | Capacity to manage all enquiries following publication of CQC inspection reports (maternity and neonatal services) On 20 June 2025. | PALS helpline established to support CSU in the handling of enquiring for people who use maternity and neonatal services.<br>Process for monitoring the number of enquiries and escalation to clinical team where this is requested. |
| Patient safety incident reporting process, weekly review of incidents by CSU. Process for reviewing all patient safety incidents that are categorised as moderate harm, or above by Risk Management leads, including PMRT reviews graded C or D, and MNSI referrals for investigation. |   |  |
| Communications plan, including the management of media enquiries and Freedom of Information (FOI) requests.  |   |  |

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| Response to letters under Section 29A and Section 31 of the Health and Social Care Act 2008.<br>Weekly assurance reports on maternity staffing and neonatal designation at the St James's location, including breaches of the 24-hour standard. |  |  |
| Standard Operating Procedure – neonatal designation and escalation.   |  |  |
| Monthly reports (by exception) to Risk Management Committee, focusing on key risks and mitigating actions, reporting to Board.  |  |  |