NHS
The Leeds
Teaching Hospitals
NHS Trust

CORPORATE RISK REGISTER

May 2021

Summary Corporate Risk Register May 2021

CRR No.	Former 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	CRR Page No.
		Safety and Quality Risk							
CRRS 1	CRR 1	Inadequate nurse staffing levels	May 14	Chief Nurse	16	Feb 21	Aug 21		4-7
CRRS 2	CRR 18	Insufficient Medical Staff to deliver service	May 14	Chief Medical Officer	16	Oct 20	Apr 21		8-9
CRRS 3	CRR 2	Healthcare acquired infection	Mar 19	Chief Nurse	16	Feb 21	Aug 21		10-12
CRRS 4	CRR 33	Violence due to organic, mental health or behavioural reasons	May 15	Chief Nurse	15	Mar 21	Sept 2		13-15
CRRS 6	CRR 42	Risk of a viral pandemic	May 18	Chief Operating Officer	15	Feb 21	Sept 21		16
CRRS 11	CRR 35	Power failure/lack of IPS/UPS resilience due to electrical infrastructure	Aug 15	Director of Estates & Facilities	16	Jan 21	Jul 21		17-19
CRRS 14	-	Inability to provide a cardiac catheter laboratory service - RISK SCORE REDUCED FROM 16 TO 12 AND REMOVED FROM CRR on 01/04/21	Oct 19	Chief Medical Officer	16	Apr 21	-		-
CRRS 16	-	Risk of re-commencing normal activity levels due to reduced capacity (COVID-19)	Jun 20	Chief Operating Officer	20	Apr 21	May 21		20-25
CRRS 17	-	Staff Health, Safety and Wellbeing During the COVID-19 Pandemic	Jun 20	Director of Human Resources	16	Apr 21	May 21		26-38
CRRS 18	-	Failure or complete outage of the Patient Administration System	Aug 20	Chief Digital Information Officer	15	May 21	Nov 21		39
CRRS19	-	Additional staffing capacity (COVID-19) Nightingale Y&H - RISK REMOVED FROM CRR FOLLOWING REVIEW AT RMC ON 06/05/21	Dec 20	Chief Nurse	20	Apr 21	May 21		-
CRRS20	-	Delivery of the Leeds & West Yorkshire Vaccination programme	Dec 20	Chief Medical Officer	16	Apr 21	May 21		40-43
CRRS21	-	Patient harm – falls and hospital acquired pressure ulcers (COVID-19)	Mar 21	Chief Nurse	16	Mar 21	Sept 21		44-45
		Financial Risk							
CRRF 1	CRR 9	Failure to deliver the financial plan 2021/22	May 14	Director of Finance	15	Nov 20	May 21		46-48
CRRF 3	CRR 44	Risk relating to commercial pressures arising from delays in delivering the refurbishment of the Generating Station Complex (GSC) at LGI	Oct 18	Director of Estates & Facilities	15	Jan 21	Jul 21		49
CRRF 4		Risk of failure to deliver the hospital of the future project.	May 20	Director of Finance	16	Nov 20	May 21		50-55
CRRF 5		Risk of failure to deliver the pathology project.	May 20	Director of Finance	16	Nov 20	May 21		56-59
		Performance and Regulation Risk							
CRRP 1	CRR 12	Failure to achieve Emergency Care Standard	May 14	Chief Operating Officer	20	Dec 20	Jun 21	ED LGI	60-61
CRRP 2	CRR 13	18-week RTT target non-compliance	May 14	Chief Operating Officer	20	Dec 20	Jun 21	Ophthalmology/ Cardiac Surgery	62-63
CRRP 3	CRR 15	62-day cancer target	May 14	Chief Operating Officer	16	Oct 20	Apr 21	MDT & Pancreatic Breast Only	64-67
CRRP 4	CRR 23	Failure to achieve 28 day cancelled operations target	May 14	Chief Operating Officer	16	Mar 21	Sept 21	Cardiac	68-71

CRRP 5	CRR 31	Patient flow and capacity for emergency admissions (health economy)	Sept 15	Chief Operating Officer	20	Jan 21	Jul 21	MMPS	72-74
CRRP 6	CRR 32	Unsustainable levels of medical outliers	May 15	Chief Operating Officer	15	Oct 20	Apr 21		75-77
CRRP 7	CRR 45	52-week RTT target non-compliance in spinal injuries and colorectal services	Oct 18	Chief Operating Officer	16	Oct 20	Apr 21	Neurosciences	78-79
CRRP 8	CRR 22	Patients waiting longer than 6 weeks following referral for diagnostics tests	May 14	Chief Operating Officer	16	Dec 20	Jun 21	Breast cancer	80-81

Corporate Risk Register - Key

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

Risk CRRS1: Registered Nurse Staffing levels may not meet safest possible standards	**C = 4**	16	**Very Low Risk**			**Low Risk**			**Medium Risk**		**High Risk**		**Significant Risk**			
	L = 4		1	2	3	4	5	6	8	9	10	12	15	16	20	25
									Target Score					Current Score	Initial Score	

Risk Description:
Inability to recruit to all registered nurse vacancies caused by a national shortage of registered nurses, worsened by the COVID pandemic, resulting in a potential failure to protect patients or staff from serious harm (including death): loss of stakeholder confidence and/or material breach of CQC conditions of registration.

Executive Lead: Chief Nurse

Date Added to CRR: May 2014
Last reviewed: Feb 2021

Committee reviewed at: Resource Management Group

Controls	Gaps in Control	Further Mitigating Actions
Continued focused recruitment of both general and specialist registered nurses.	Inability to reduce vacancy gap due to decrease in supply of qualified registered nurses regionally and nationally.	Recruitment of 287 international nurses through Health Education England (HEE) Global Learning Practitioner programme and international recruitment agencies by June 2021.
	Impact of COVID pandemic in relation to progression through NMC pre-registration Nursing programmes - future waves unknown	NMC Emergency standards reinstated (January 2021) supporting deployment of third year nurses into the workforce.
	Impact of COVID pandemic in relation to flight restrictions delaying arrival of international nurses.	Recovery plans in place, remaining cohorts scheduled to arrive by project completion date. Providing additional Clinical Educator support to CSU's to support transition to practice due to larger cohorts. Progress monitored through the International nurse recruitment task and finish group and the Resource Management Group (RMG).
	Impact of COVID pandemic in relation to the ability to re-book OSCE dates (reduced capacity and increased	NMC temporary register re-opened (January

	demand). International nurses not able to enter the permanent register with the NMC.	2021) in case OSCE capacity reduces.
Roster management and daily Nurse Staffing Status Report (NSSR) to ensure appropriate distribution of resources.	Currently no Trust wide live system for monitoring acuity and dependency to provide more consistent evidence based approach for real time deployment of staff.	SafeCare roll out agreed and implementation commenced. Progress and performance monitored by SafeCare project board chaired by the Director of HR. Daily staffing meetings instigated in relation to COVID Pandemic to ensure appropriate distribution of resources chaired by Director of Nursing (Operations). NSSR to remain during the transition period for all CSU's. See also CRRS6 - Covid Corporate Risk (control 10).
Safer staffing guidance and escalation pathway to ensure operational oversight and appropriate mitigation in safe deployment of staff. This includes the out of hours, assessment, assurance and escalation for safe nurse staffing guidance.	Variance in practice across CSU's in relation to roster governance and management. Impacts on safer staffing returns (Hard Truths) and timely release of vacant shifts to bank and agency.	Safer staffing resources, escalations and safer staffing policy available on the Trust intranet.. All safer staffing documentation reviewed and monitored through the Nursing, Midwifery, AHP Workforce Group (NMAWG). Temporary wards (seasonal and surge capacity) included in external safer staffing return once opened for full roster period of six weeks. Operational staff bank group and non-medical operational roster group re-commenced to address roster and temporary staffing management. Both groups report to the NMAWG group to ensure Trust wide oversight and governance.

	Increased demand for critical care capacity (Level 2/3 beds) in response to Covid-19. Additional workforce required to support critical staff through 'pod' model. Insufficient workforce to maintain Level 3 nurse to patient ratio of 1:1 nursing care as recommended in Guidelines for the Provision of Intensive Care Services (GPICS). National guidance released by NHS E/I December 2020 moving away from Guidelines for the Provision of Intensive Care Services (GPICS) in response to rapidly increasing critical care demand. Level 3 patient to nurse ratio increased to 2:1 (critical care trained nurse) plus additional registered nurse (not critical care trained). Registered nurses released from general wards and theatres to support additional capacity. TFS agency providing additional nursing hours deploying critical care trained staff average 300 hours per week. All patients risked assessed before being cared for in the pod model.	34 Critical Care trained internationally recruited nurses due to arrive in LTHT in March 2021 Investment plans utilising funding from NHSE/I submitted from Critical Care and other surge specialties to provide clinical training and Health and Wellbeing support to the nursing workforce.
Introduction of new registered roles to support workforce	New role with a limited evidence base on patient outcomes.	Adherence to best practice and safer staffing guidance. Nursing Associate deployment reference group commenced to support governance and assurance of new role.

	Impact of COVID pandemic has resulted in one cohort of Nursing Associates delaying qualification by 6 months (February 22)	Future You programme implemented to create workforce plan, recruitment and retention strategy for the Nursing Associate role. Progress reviewed through NMAWG and RMG.
Use of temporary workforce (bank and agency)	Ability to respond to increase in demand as part of operational pressures and winter planning.	Monitoring of staffing requirements through daily staffing meeting. See also CRRS6 - Covid Corporate Risk (control 10)
New bank rates registered nurses, midwives and ODP's	Impact on fill rates and recruitment of bank only workers still to be determined.	Focus on increasing recruitment to the staff bank and promotion of new bank pay rates. To be monitored through the operational staff bank meetings. Compliance and fill rates monitored and reviewed through the quarterly staff bank contract meetings chaired by the Deputy Chief Nurse.
Additional agency registered nursing support provided as part of operational surge plans.	Impact of a sudden reduction in nursing hours with no new supply.	Deployment of additional nursing hours monitored through daily staffing meeting. Focused on CSU's with highest vacancy rates and clinical areas where demand has increased (critical care and emergency departments).

CRRS 2: Insufficient Medical Staff to deliver service	**C = 4**	16	**Very Low Risk**			**Low Risk**			**Medium Risk**		**High Risk**		**Significant Risk**			
	L = 4		1	2	3	4	5	6	8	9	10	12	15	16	20	25
						Target Score								Initial Score Current Score		

Risk Description:	
There is a risk of insufficient medical staff to deliver a timely service to patients and achieve the safest possible levels of care. The main cause of which is gaps in trainee rotas which lead to non-compliant or non-feasible rotas and planned changes to the organisation of Internal Medicine Training from August 2020, worsened by Covid 19. This may result in clinical services under pressure; delays in responding to the deteriorating patient; and/or poor experience in training for junior doctors, which could result in training posts being removed – causing further rota gaps.	**Executive Lead:** Chief Medical Officer **Date added to CRR:** May 2014 **Last reviewed:** April 2021 **Committee reviewed at:** Resource Management Group

Controls	Gaps in Control	Further Mitigating Actions:
The Trust has a clear vision for junior doctors with a programme of engagement e.g. Empowering junior doctors (Junior Doctor Body and Junior Doctor Forum) making LTHT an attractive place to work and train. Funding has been agreed for Trust Doctor posts to fill gaps created by the re-organisation of internal medicine training from August 2020.	Planned new Internal Medicine Training will result in a loss of capacity and additional funding requirement. There is limited ability to influence Health Education England.	The Trust is identifying where the gaps in clinical services will be and CSU's are developing workforce plans to mitigate
Excellent rota design and management. Rotas redesigned to cope with the Covid 19 pandemic		Review of clinical processes using Leeds Improvement Method to reduce inappropriate medical tasks - on-going. Working within BMA and NHS Employers guidance on rota design

Workforce planning - with diversity of workforce appropriate to service needs; Advanced Nurse Practitioners (ANP), Physician Associates (PA)	Recruitment and lead time for ANPs PAs not yet regulated	It has been agreed that the GMC will regulate. Dr James Storey has been appointed as the clinical lead for LTHT PA's
High quality education placements evidenced GMC trainee survey results & Medical Education quality assurance of training programmes	National Workforce plans – provide limited training opportunities	Medical Education team undertakes targeted supportive interventions to improve the training experience (e.g. Orthopaedics)
Guardians of Safe Working, Junior Doctor Forum, Exception Reporting results and subsequent response from specialty.	Reporting processes in the current Covid pandemic have been disrupted	The BMA has provided £30,000 to be spent on improved facilities for junior doctors and in 2019, 13 junior doctors were appointed as Wellbeing Champions.
Use of locum doctors and breach of agency cap	Supply of agency doctors	
Consultant delivered care (consultants in place of trainees)	Proposed changes to pension taxation are resulting in reduction in the Trust's ability to incentivise Consultants to cover junior doctor rotas	The Trust has identified the clinical areas most at risk and EMG is considering options. The Chief Executive is lobbying the national Workforce Strategy Group. National decision to change the planned pension proposals in the 2020 budget
Expanding International Recruitment, including links with the College of Physicians and Surgeons, Pakistan (rolling programme) and a new Gateway Programme, with UK nationals who have studied medicine in Bulgaria,	Impact of Covid 19 pandemic in relation to flight restrictions	
Re-deployment of all doctors in training to support the Covid 19 surge plan	Full assurance not guaranteed due to the competence of re-deployed trainees	HEE sanctioned cessation of training and agreed re-deployment supported by the GMC for doctors working outside normal competencies

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

Risk Description:	
Effective management systems are not in place or sufficient to protect patients from the risk of hospital acquired C difficile, respiratory infections and bloodstream infections caused by multi-resistant organisms caused by insufficient compliance with infection prevention procedures, including hand hygiene, decontamination, environmental cleaning and insufficient training. This may result in serious harm or death to a patient, prolonged LOS, unsatisfactory patient experience, significant financial loss, loss of stakeholder confidence, and/or a material breach of CQC conditions of registration.	**Executive Lead:** Chief Nurse **Date added to CRR:** Mar 19 **Last reviewed:** Feb 2021 **Committee reviewed at:** Infection Prevention and Control Committee

Controls	Gaps in Control	Further Mitigating Actions
Risk Assessment: Patient level assessment of risk on administration/arrival/transfer (filled in patient care record) IPC/Microbiology risk assessment completed electronically in PPM. IPC alert mechanism incorporated into electronic patient record (PPM+).	The risk assessment process is partly electronic and partly manual which means that this is not always 100% successful. The ICNET software is no longer supported by the Company and planned decommissioning will complete during March 2021 which will leave LTHT without an established mechanism for identifying transmissible infections. As part of the IPC pandemic recovery plan the team are currently using a combination of PPM+ results, alerts and the unsupported system to increase the ability to detect infections however subsequent investigation is demonstrating that some individual cases are being missed.	IPCT running two systems to provide quality assurance. LTHT has secured funding and commenced implementation of new ICNET technology including the Surgical Model. In the interim, support has been identified from the Corporate Informatics Team to generate targeted COVID-19 reports from PPM+ data thus allowing IPC to focus on HCAI data reporting. Real time changes made to PPM+ reporting in line with new changes with Covid-19 screening regime to support CSUs with their compliance.
Training Policies and Guidelines: Mandatory infection prevention and control training to all staff, with an overarching Infection Prevention and Control Policy and a	Compliance with policies - Human factors and system issues.	Quality Improvement methodology adopted with a Trust wide HCAI collaborative and LIM utilised in response to lessons learnt from

suite of Guidelines and SOPs.		incidents. Incident command structure in place for COVID-19 related gaps in compliance to ensure a rapid approach to learning and trust wide dissemination.
Environmental Controls: Environmental decontamination programme and standards, segregation and safe disposal of waste process, programme of water safety and IPC design incorporated into refurbishments and new builds.	Limited access to decant facilities to support a rolling programme of deep cleans. No routine HPV conducted during COVID-19 Pandemic. Limited ability to support the IPC design into refurbishments and new builds.	Optimise every available area when a clinical area becomes free. Opportunities have been taken to undertake HPV when a ward has been returned to cold elective activity as part of the recovery plan. A forward plan for deep cleaning is being developed with the CSUs in line with the recovery plan. Close liaising with Head of Estates (Capital) who will escalate higher risk projects to IPC Matrons. Alternative technology being explored.
Antimicrobial Stewardship: Policies and Standards, City Wide Group, Ward Rounds and day 3 IV antimicrobial review	Worldwide shortage of antimicrobials.	Contribution to national planning from MMPs and a robust process for notification and identification of alternatives in place.
Detection through monthly surveillance monitoring and assurance through monthly Perfect Ward meetings and additional hand hygiene audits and ward assurance visits.	Surveillance software to identify new cases of infection ceased to be supported from June 2019 and will be decommissioned by March 2021. LTHT has secured funding and commenced implementation of new ICNET technology.	IPC currently accessing two systems to cross check results. In addition, the IPC Leadership team continued to review the HCAI performance at Trust level and the Consultant Microbiologists provided CSU level review and feedback. HCAI assurance monitoring through the Perfect Ward to be recommenced. LTHT has secured funding and commenced implementation of new ICNET technology including the Surgical Module. Estimated date of full implementation is March 2021.

Recovery and lessons Learned Management of outbreak guidance - ward closures, Outbreak Control Group meetings and city wide response.	CSUs manage the Outbreak Meetings with support from Consultant Microbiologists, IPCT, Antimicrobial Pharmacists and DIPC/DDIPC. During COVID-19 Pandemic, identification of increased incidence of hospital acquired infection has significantly risen. There is limited specific resource to respond to this.	Previous evidence based learning is used to support the actions that need to be taken within CSUs. The Infection Team continues to provide CSU level IPC review and stewardship remotely as part of COVID-19 recovery plans. Mutual aid provided by the Corporate Nursing Team and Quality Team.
HCAI assurance is monitored through the Infection Prevention and Control Committee (IPCC). Covid-19 assurance is monitored through the NHS Level 4 Incident Command Structure and IPC Clinical Governance Structure. Board oversight is provided through the Infection Preventions and Control Board Assurance Framework, published by NHSE in May 2020. **Cross-ref: CRRS17**		
Organism specific route cause analysis investigation adopted for all HCAIs to identify contributory factors and lessons learnt.	Previously, it was unclear what proportion of GNBSIs were avoidable and there were few datasets on the underlying risk factors for preventable GNB infections at LTHT. Continuous CSU-led investigation, Stop the Line STL/RCA documentation and IPC-led collation of results is required to understand which interventions are likely to reduce risk to patients.	Investigation for all GNBSIs underway. A review panel is to be established by the Infection Team to identify the actions that need to be taken to prevent the avoidable cases. Microbiology and IPC have reviewed and updated the STL and RCA documents to make them more user-friendly and to target essential information. These will be piloted in ESM and AMS. Data from these documents will be collated by IPC and consultant microbiologists to report on the proportion of avoidable infections, the underlying reasons, and they will use this information to develop a trust-wide strategy of interventions through liaison with the IPC Faculty Group.

CRRS 4: Violence due to behaviour disturbance caused by organic, mental health or other reasons	**C = 5** **L = 3**	15	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
									Target Score				Current Score		Initial Score	

Risk Description:	
There is a risk of inconsistent responses to patients at risk of disturbed behaviour; leading to aggression/violence resulting in physical harm to patients, visitors and staff. The result is the potential for a fatality, serious harm or litigation against the Trust.	**Executive Lead:** Chief Nurse **Date Added to CRR:** May 2014 **Last reviewed:** Mar 2021 **Committee reviewed at:** Joint LTHT/LYPFT forum

Controls	Gaps in Control	Further Mitigating Actions
Policy for Conflict Resolution (Reducing violence and aggression in the workplace) and establishment of Security Co-ordinators.	Concern that the policy is not being put into operation across patient areas- in particular that the environmental and patient specific risk assessment tools are not being completed and used to inform care planning. Policy due for review December 2020 but review extended until June 2021	Additional Trust wide communication to raise awareness and information on Trust Conflict Resolution Policy to be repeated when the Policy has been reviewed.
Restraint and Restrictive Intervention Policy	Concern that the policy is inconsistently imbedded into care delivery. specific concern: - restraint prevention strategies used infrequently - requirements for reporting restraint are not followed across services	Additional Guidance included regarding prevention and de-escalation as part of the Restraint policy review. Trust wide Communication about the Restraint and Restrictive Intervention Policy will be repeated as part of the launch of the revised Policy and guidance. Completed December 2020
24/7 service provision from Liaison Psychiatry service now		

meeting PLAN standards and Acute Liaison Psychiatry service 1 hour response in ED implemented		
Enhanced Care Procedure and Restraint Care Plan bundle rolled out trust wide. Restraint Care plan bundle added to latest version of Restraint Policy as a mandated staff action	Some evidence that the Restraint Care plan bundle is not yet being used for all patients who meet the criteria- potential risk to safety if proportionate restriction/restraint not being used and monitored; also potential risk of disproportionate restraint/restriction being used without monitoring	Comms to HoN and Matrons and Restraint Quality and Safety briefing sent Trustwide in November 2020 Trustwide Restraint nursing audit planned for Q1 2021
QI collaborative- supporting patients who may present with clinically related challenging behaviours has been re launched post COVID lockdown and will inform these elements. QI collaborative relaunched on 2/10/2020. 7 high volume areas involved in QI with support from expert faculty members	Covid restrictions have limited activity possible across pilot wards	A range of interventions being trialled across pilot areas - e.g. focussed safety huddles, drop in service from experts, trialling of distress tools.
CAMHS referral pathways clarified for patients aged 0-18 A new CAMHS Crisis team has been operational from the beginning of 2020 the service offers - 7 day week 08.00-00.00	CAMHS not co-located in hospital and less robustly embedded into LTHT governance - leading to some variation in accessing timely psychiatric support for patients aged 0-18	Meetings with LCH/LTHT/CCG set up to look at commissioning gaps and improve pathways - all camhs patients admitted for more than 6 days will have a named paediatric consultant and a communication will be sent to connect all relevant services- camhs, LTHT MHA team, children safeguarding etc January 2021
Mental Health and related topics training and education offer being refreshed - lypft/lthth training delivery group developing TNA and working with QI De-escalate collaborative	Currently not mandated across medical and nursing staff or linked to a training needs analysis (TNA)	Tender developed for HHE monies to provide 2 levels of de-escalation training across pilot wards. Separate training commissioned from local survivor led mental health team. LTHT/Camhs signed up for relaunch of WeCanTalk education project to support staff working with camhs patients in hospital.
New clinical guideline " Use of Rapid Sedation/Rapid	Concern that it is not embedded despite	Now Embedded into Restraint/restrictive

Tranquilisation" in place	Comms and that it is incorporated into Mandatory MCA training	intervention policy
MCA/MHA and LD/Autism teams expanded to include additional clinical nurse specialists and now carry liaison case load to support ward staff	Covid risk is currently limiting access to hot wards	
Public facing information campaign regarding Zero tolerance for violence to health care staff	Campaign paused during Covid-19	Campaign was re-launched in October 2020

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

Risk Description:	
There is a risk that the Trust may have to invoke its Emergency Response Arrangements due to a viral pandemic (e.g. influenza or COVID-19) causing the absence of significant numbers of Trust staff and large increase in demand which could overwhelm the Trust's ability to deliver routine care and result in potential fatalities and significant financial loss.	**Executive Lead:** Chief Operating Officer **Date added to CRR:** May 2018 **Last reviewed:** Feb 2021 **Committee reviewed at:** Risk Management Committee

Controls	Gaps in Control	Further Mitigating Actions:
Pandemic Influenza Plan		Plan will be reviewed and considered at the High Consequences Infectious Diseases group in summer 2021
CSU Business Continuity Plans	Not all CSU Business Continuity Plans are up to date	Support CSUs in the completion of Business Continuity Plans. Programme being put in place to update all CSU plans in 2021
Infection Control procedures (including Personal Protective Equipment) Training for 'donning' and 'doffing'		FFP3 fit testing programme has been brought up to date during the COVID-19 pandemic. On-going messaging and monitoring of compliance with PPE usage.
Leeds Outbreak Plan		Organisational action cards
Operational Response Guidance (ORG)		Was reviewed in preparation for Winter 20/21
Priority assessment areas (Pods) at LGI and StJUH		
Arrangements in place to deal with current COVID-19 pandemic		Arrangements constantly reviewed through COVID 19 Tactical Group, CAG, Silver and Gold meetings

CRRS 11: Power Failure due to Electrical Infrastructure/lack of IPS/UPS resilience	**C = 4**	**16**	**Very Low Risk**			**Low Risk**			**Medium Risk**		**High Risk**		**Significant Risk**			
	L = 4		1	2	3	4	5	6	8	9	10	12	15	16	20	25
						Target Score								Current Score	Initial Score	

Risk Description: There is a risk of power failure at a Trust site (ward or clinical area) Due to failure to comply with HTM 06 01 caused by outdated electrical infrastructure and the absence of complete IPS/UPS resilience in Clinical Category 5 areas May result in a poor patient experience; a failure to protect patients or staff from serious harm or fatality; loss of stakeholder confidence; and/or a material breach of CQC conditions of registration or HSE prosecution	**Executive Lead:** Director of Estates & Facilities **Date added to CRR:** Aug 2015 **Last reviewed:** Jan 2021 **Committee reviewed at:** Finance and Performance Committee

Controls	Gaps in Control	Further Mitigating Actions
Emergency generator power provision across all sites. Dual electrical supplies to most clinical areas.	Emergency Generators take on average 20 to 30 seconds to start and supply power, clinical areas without UPS provision **will be without power for this period**. Not all patient bedheads have interleaved electrical supplies which is an HTM requirement. This could result in the loss of electrical supplies to individual bed heads upon a local electrical failure.	When Wards and clinical areas are refurbished in the future interleaved electrical supplies should be installed to each bedhead and all clinical category Grade A areas should have full UPS/IPS support fitted in-line with HTM 06-01.
Medical Physics have fitted independent battery back-up to some life support equipment in clinical areas.	This is not consistent across all areas of the Trust resulting in confusion when power supplies are disrupted	Theatre upgrade programme - limited Capital funding available in 2020/21 and 2021/22 to upgrade theatres
Complete assessment of telephony switchboard resilience in terms of UPS protection and autonomy (up to 4 hours)	Not all Information Technology systems are supported by UPS with the required autonomy to maintain a service upon loss of supplies.	
Estates Handbook updated for emergency plans with detailed processes and regular review.	This handbook provides the Estates on-call team with information of what can be	The handbook is reviewed annually.

	done when power interruptions occur but does not assist with the shortcomings of the installed systems.	
Increased interleaving of circuits in Clarendon Wing i.e. there is now more flexibility as to where power to wards/departments is directed from, increasing resilience.	This interleaving work has improved the resilience in Clarendon at Ward/Department level but not improved the local bedhead interleaving provision.	When Wards/Departments are refurbished in the future local interleaving should be carried out as per HTM 06-01.
Comprehensive review across the Trust with completed documentation detailing precise location of all key electrical infrastructure equipment	The detailed electrical review information is stored in hard copy at both Silver Command positions but would require in-depth electrical knowledge to fully understand.	Reviewed annually and updated as resilience is improved.
HTM's are not retrospective and areas were designed to comply with best guidance at the time of design and construction	Although HTM's are not retrospective HTM 06-01 was introduced in 2007 but work to move the Trust towards full electrical compliance is slow due to shortage of decant facilities and Capital shortages to carry out wholesale Ward/Department/Theatre improvements.	
A UPS/IPS infrastructure was installed to support Geoffrey Giles Theatres 1 to 8 and Recovery in 2017. Theatres 3, 4, 5, 6, 7, & 8 have been connected to the system in 2020	Although the UPS/IPS infrastructure has been installed (£600,000) to support Geoffrey Giles Theatres 1 to 8 and Recovery the final connection and rewiring of Theatres 1, 2 & Recovery is still required. If there is a power failure within these theatres the only system with inbuilt battery back-up are the Operating Light's	Capital investment is required to connect the available IPS/UPS infrastructure to the final 2 Theatres & Recovery in Giles theatres. Maternity Theatres & Recovery in Gledhow are currently being upgraded and fitted with compliant UPS/IPS systems, this work is due to complete by the end of March 2021.
Some areas (e.g. J1) are fitted with the required UPS provision but not fitted with Isolated Power Supplies (IPS).	A number of clinical category 5 areas as required by HTM 06-01 are not fitted with IPS to safeguard the patient from the risk	IPS should be installed to all clinical category A areas in-line with HTM 06-01 when areas are refurbished. Awareness of the electrical

	of electric shock and provide increased local electrical resilience.	shortfalls in UPS and IPS provision in clinical category Grade A areas is required, work is on-going to supply electrical action cards, this will be completed by spring 2021.
UPS/IPS systems have been installed in a number of clinical category A locations in 2020 including those detailed above in Geoffrey Giles e.g. Cath Lab 3 & 4, Jubilee MRI, Theatre 17 Jubilee.	There are still a number of Clinical category A areas without UPS/IPS systems.	A number of refurbishment schemes are underway which include the installation of UPS/IPS: L43 Neonates, Maternity Theatres & Recovery in Gledhow, J10/ARCU, these are all due to complete early in 2021.

CRRS16: Risk of re-commencing normal activity levels due to reduced capacity (COVID-19)	C = 5 L = 4	20	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
									Target Score						Initial Score & Current Score	

Risk Description:	
There is a risk of being able to re-commence and increase back to normal activity levels and capacity due to the requirements to follow guidance relating to social distancing, pre-admission isolation and COVID19 testing. This may lead to secondary harms to patients and potential fatalities as a consequence of delayed treatment due to a reduction in inpatient and outpatient capacity. As a result of any increases in admissions, routine non urgent face to face outpatient clinics, routine day case procedures and routine elective overnight activity has been or may be further suspended or reduced in order to release capacity and reallocate staffing to support inpatient areas across the organisation (if required).	**Executive Lead:** Chief Operating Officer **Date added to CRR:** June 2020 **Last reviewed:** May 2021 **Committee reviewed at:** Risk Management Committee

Controls	Gaps in Control	Further Mitigating Actions:
COVID19 Response Review Group now established to proactively prepare for any further surges in COVID19.	Roll-out of vaccine commenced in December 2020. Availability of vaccine will impact on pace of roll out can be undertaken.	Staff lateral flow testing has now commenced with twice weekly staff testing. Leeds COVID19 Vaccination Centre at Elland Road opening from 20/01/2021. All front line staff and Priority 5 and 6 staff (all staff aged 65 and over and staff aged 16-64 with underlying health conditions) have been invited to book for their vaccination now. Roll-out of vaccine continues to all staff in line national guidance. PPE supplies are assessed continuously to identify and escalate any potential risks to PPE supplies.

	Supply of PPE may not be sustained to meet changing demand and will limit the level of activity that can be delivered; supplies will need to be prioritised for high risk areas.	COVID19 modelling undertaken using 7 day forecast model to predict the average expected inpatient admissions and discharges for Covid-19 patients and confidence intervals.
Specialty level plans, including local actions to mitigate most significant risks. Surgical teams across the Trust have reviewed their revised theatre allocations and subsequently prioritised clinically urgent patients (including cancer patients). This continues to be reassessed in line with updated clinical prioritisation. Quality Impact Assessments undertaken by CSUs in June to identify risk to planned services not being provided, overseen by the Corporate Operations team. Framework	The risks of reducing or stopping all routine and planned procedures, including diagnostics and referrals are not uniformly distributed. Increased COVID19 admissions may result in the suspension or reduction of elective activity.	In line with NHSE/I and college national guidance; all CSUs have undertaken clinical prioritisation of the elective, diagnostic and outpatient waiting lists through their sub-speciality clinical teams in order to assess clinical risk and reduce harm to patients - this continues to be reviewed on a regular basis. Further clinical validation of the admitted PTL is now complete. The PAS system has now been updated to include the recording of P status within the patients waiting list entry. This is now available to report. Weekly review is undertaken by Corporate General Manager to assess completeness of P category recordings and any waiting list entries with no P category are followed up. A process has now been established for adding the P category to the patient's record at the time of Decision to Admit.

developed with guidance by Quality Governance team. Reviewed at EMG 24 June 2020, risk scoring 15> reviewed with CMO, Chief Nurse and COO July 2020. QIAs repeated in November 2020 to identify specialties at > risk relating to planned procedures, cancer and clinically urgent.		Any patient safety, quality or governance risks are escalated through CSU Governance Meetings in line with Quality Governance Framework. COVID19 modelling undertaken using 7 day forecast model to predict the average expected inpatient admissions and discharges for Covid-19 patients and confidence intervals.
Outpatient appointments reviewed, converted to telephone consultations where clinically appropriate. Operational Planning Framework outlines delivery on baseline activity levels at 70% for April, 75% for May, 80% for June and 85% for July, August & September.	Outpatient environments may not be suitable to maintain recommended social distancing (2 meters). Reduction in outpatient capacity due to requirements to maintain social distancing (delivering approximately 89% normal baseline outpatient activity). Telephone consultations may lead to missed or delayed diagnosis. Increased COVID19 admissions may result in the suspension or reduction of outpatient activity and staff may need to be reallocated to support inpatient or critical care areas.	Steering group established to work on implementing environmental social distancing measures across all hospital sites to facilitate the safe reintroduction of our services. Outpatient team working with CSUs to expand the volume of remote consultations and prioritised visits. (increased by 45%). To reduce risk and manage potential harm to patients, clinicians have clinically reviewed patients on all outpatient waiting lists to assess clinical priority. Service Delivery Contract's currently being developed at CSU level which will include focussed KPI on reducing longest outpatient waits - this will be monitored on monthly basis. Process for review & clinical validation of patients awaiting a follow up appointment now in place and process establishes for adding the categorisation to PAS system. This will be available to be reported on validation is

		complete. Currently in the process of developing activity plans in line with Operational Planning Guidance to deliver required activity levels. COVID19 modelling undertaken using 7 day forecast model to predict the average expected inpatient admissions and discharges for Covid-19 patients and confidence intervals.
LTHT 2ww referral volumes back to normal levels and flowing into the system as per normal process.	Increased COVID19 admissions may result in the suspension or reduction of elective activity. Increased COVID19 admissions may result in requirement to clinically triage and prioritise referrals. Patients requiring investigation and/or treatment for cancer may choose not to attend hospital due to concerns and heightened publicity about impact on the NHS of COVID-19.	Clinical triage process established should any further surges result in requiring the suspension of activity. Cancer diagnosis, treatment and care continued in line with most recent NHSE/I guidance. COVID19 modelling undertaken using 7 day forecast model to predict the average expected inpatient admissions and discharges for Covid-19 patients and confidence intervals.
All emergency treatments and interventions conducted taking into account the latest NHSE/I, Royal Colleges, national societies COVID19 guidance.	Patients may choose not to attend hospital when they require treatment due to concerns and heightened publicity about impact on the NHS of COVID19, including those requiring clinically urgent treatment.	Partnership working with health and social care, media communications to encourage people to attend hospital if treatment is required. Access Policy updated in line with NHSE/I national guidance. Approved at Execs on 08/02/2021 and live as of 22/02/2021.

		Roll out of vaccine nationally continues to the general public in line with national guidance.
Specialty cancer MDTs undertaken risk assessments and established process for tracking patients that have been deferred. In line with most recent NHSE/I advice, clinical guidance for the management of essential cancer surgery for adults during the COVID-19 pandemic is being followed.		Pre-op COVID testing/preparation guidelines in place and regularly updated in line with emerging guidance. Guidance around pre-operative self-isolation periods are currently being reviewed with a view to potentially decreases pre-op self-isolation period. LTHT referral volumes now back up to 100% and flowing in to the system as normal. Normal cancer tracking processes have now resumed to manage patient pathways. Planned Care Programme established - reporting progress and oversight. New IS contract now in place from 1 April with activity being IPT to IS where appropriate.
Laboratory testing capacity increased, operating hours increased, turnaround times standard 12 hours following installation of Panther platform (June 2020). Staff testing commenced from March 2020 in line with national guidance from PHE. Testing extended to all non-elective admissions (April 2020) and planned/elective admissions (May 2020). Care home testing in place (April 2020). Asymptomatic staff testing and antibody testing (May	Capacity of labs to achieve national expectation on staff testing Availability of reagent Staff sustainability in pathology Resilience of telepath	Pathology team working with national procurement and supplies team to achieve testing targets.

2020). Lateral Flow Staff Testing commenced in December 2020. Public Health Laboratory requirement for LTHT to undertake Genomic sequencing. This requires use of same staff and equipment as routine COVID19 testing utilises at present.	Logistics of cohorting patients (infection prevention and control) to comply with guidance to extend testing to non-elective and planned/electives admissions. Prevalence rate of asymptomatic tested patients. Any surges in routine COVID19 testing will need ongoing service provision.	Operational plan in place in line with national guidance for testing of non-elective and planned/electives admissions. Review of nosocomial rates in order to reduce volumes of routine testing being monitored via weekly testing group and will be stepped down at earliest opportunity.
Clinical Advisory Group (CAG) established 24 March 2020 to review concerns raised by clinical teams, including clinical concerns re planned and elective treatments. Daily operational oversight group established February 2021, following discussion at CAG, to support and document rationale for clinical-decision making re planned surgery and access to critical care beds.		
Weekly quality review meeting led by the Chief Medical Officer and Chief Nurse, including serious incidents, complaints related to potential harm as a consequence of delays in treatment due to the ongoing operational response to the coronavirus pandemic.		

Risk CRRS17: Staff Health, Safety and Wellbeing During the COVID-19 Pandemic	**C = 4** / **L = 4**	16	**Very Low Risk**			**Low Risk**			**Medium Risk**		**High Risk**		**Significant Risk**			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
									Target score					Current Score	Initial Score	

Risk Description:	
There is a risk that the Trust fails in its duty of care to staff health and wellbeing during the COVID Pandemic due to the failure to comply with Government Guidelines (Working Safely during COVID-19), resulting in potentially fatal harm and a further depleted and dispirited workforce.	**Executive Lead:** Director of Human Resources **Date added to CRR:** June 2020 **Last reviewed:** May2021 **Committee reviewed at:** Workforce Committee and Infection Control Committee

Controls **Note the controls listed are based on the sections of the Working Safely during COVID 19 guidance.**	**Gaps in Control**	**Further Mitigating Actions**
Thinking about Risk and Managing Risk (Lead - Chris Carvey)		
The Trust Board has direct oversight in relation to managing this risk with assurance provided by the Risk Committee, the Workforce Committee and Infection Control Committee.		
The Trust's short and medium-term People Priorities have been reviewed in light of the COVID-19 pandemic recognising the new working environment and risks.		
The Workforce Committee has been re-established to oversee progress against the updated People Priorities and associated risks.		
National guidance is available in relation to managing risk during the pandemic. This guidance is regularly updated, and mechanisms are in place via the Incident Command Structure to ensure the latest guidance is being followed.		
Specific COVID Workplace Risk Assessments developed to be completed by all areas with assurance to be provided by the		

Health & Safety Annual Assurance Process. Managers asked to display posters (as recommended in the Working Safely during COVID 19 document) to display workplace assessment has been undertaken. The annual health and safety assurance process included COVID workplace risk assessments. The results of this process have been reported to the Health & Safety Committee and no concerns were raised.		
Specific PPE risk assessments undertaken for all clinical areas.		
Occupational health guidance and risk assessment template for staff with underlying health conditions and pregnancy is in place and is regularly updated.		
Programme of positive action completed to provide assurance that all precautionary measures required at the time have been taken for BME colleagues.		
Organisational assurance framework for individual employee risk assessments agreed by CAG and Executive Team. This covers all currently identified vulnerable groups and is reviewed regularly in light of emerging evidence.		
A personal communication sent to all employees from the Director of HR & OD to ensure they are aware of the vulnerable groups and actions required in in relation to risk assessment. 99.4% completed. Additional communication sent to all males aged over 50 requiring them to complete an updated Risk Assessment. Risk Assessments now built into the Corporate Induction process.	Assurance that individual risk assessments are updated in accordance with changing guidance (for example the changed guidance re Extremely Clinically Vulnerable individuals) or changing personal circumstances.	

Assurance process, to ensure all Villa Care staff have had a risk assessment, discussed and agreed with Director of Nursing. Health and Wellbeing Conversations Launched Trustwide which include the need to review risk assessments		
Ongoing programme of corporate communications, through the COVID bulletin and other channels, to ensure all staff are aware of the latest guidance and encourage them to adhere to all guidance. Weekly Coffee Mornings now in place with all Clinically Extremely Vulnerable staff		
Who Should go to Work (Lead – Jo Buck/Chris Carvey)		
Staff are encouraged to work from home wherever practicable - communicated via COVID Bulletin. This is supported by Working from Home Guidance and the roll out technology to support home working, for example Microsoft Teams. Workstream established with Executive Leads. Teams encouraged to work together to agree an approach which allows all staff to support service delivery whilst minimising unnecessary on-site attendance and protecting vulnerable employees. Latest staff survey results shows remote/home workers scored most highly across the majority of themes, including support from team and line manager.	Availability of IT such as laptops or mobile devices with VPN access is a limiting factor for homeworking.	Home and agile working workstream to continue to develop arrangements to facilitate new ways of working, including increasing the technological support.
Blended working with staff combining home working and attendance at the workplace is encouraged to reduce the number of staff in the workplace at any time to enable social distancing for staff in the workplace.		

Where it is only practicable for a proportion of a team to work from home at any one time, cohorting and rostering of home working has been encouraged. In these circumstances, staff who are required to stay away from the workplace due to shielding or isolation are prioritised for home working.		
Occupational health guidance and risk assessments in place to identify vulnerable staff who are required to work from home or who should be prioritised for home working.		
Workers in roles that are critical for business and operational continuity, safe facility management or regulatory requirements and which cannot be performed remotely have been identified		
Planning for minimum number of people on site to operate safely and effectively has taken place via Tactical Meetings		
The wellbeing of people working from home is undertaken by Line Managers and health & Wellbeing Leads - advice issued via COVID Bulletin, weekly email, Trust Internet and closed Facebook Group		
Advice and guidance issued to managers and employees in relation to shielders and engagement events undertaken for both managers and returning employees. Review workshop held with shielders on 3rd September 2020. An additional 1.7m people nationally were advised to shield from February 2021. No significant impacts on service delivery were escalated due to this change. From 1 April 2021, shielding advice will be paused nationally. CEV staff should continue to work from home		

where possible and if ithis is not possible a risk assessment (RA) must be undertaken. The Trust has issued updated guidance and weekly workshops are in place for both shieders and managers to assist with the review of RA		
Clinically extremely vulnerable staff advised to work from home.		
Social Distancing at Work (Lead - Jo Buck)		
A social distancing workstream has been established with several work streams that cover the areas outlined in the national guidance.		
The requirements for social distancing have been proactively communicated to all staff and managers Advice available to managers who are completing the Workplace Assessment Enhanced Risk Assessment now available for non-clinical workplaces for teams to resolve workplace social distancing issues. Enhanced risk assessments identified the need for more space in some CSUs and space has been made available following utilisation of THQ. Processes for auditing and recording compliance issued to all departments. Staff cohorting guidance has been developed and implemented	Continuing evidence that staff not fully complying with social distancing requirements in non-clinical areas leading to increased risk of transmission and or requirement for staff to isolate. None of the national guidance has been relaxed and risk of reduced compliance with social distancing due to increasing numbers of staff and patients on site as a result of re-starting a variety of clinical services.	Ongoing and proactive programme to communication to reinforce the need for staff to undertake all necessary precautions in all settings/environments.
Social Distancing group is installing physical prompts		

including signage and screens/barriers. No requests for social distancing prompts (e.g. signage, screens / barriers) are being delayed due to lack of funding.		
Gym continues to be closed due to increasing prevalence rates in Leeds. This decision was taken at CAG. A rolling programme of lateral flow testing is now in place which will help to identify Asymptomatic staff Covid Vaccination centres established and staff vaccines have commenced in accordance with national priorities. As at 28th April 2021, Trust data shows 74% of frontline workers have had first vaccination (60.9% for BME frontline workers). National restrictions on vaccine supply are not impacting vaccination rates for frontline staff. Live Q&A session for all frontline staff on 31st March 2021, designed in partnership with BME Staff Network	Continuing indications of lower take up from some types of staff, for example BME colleagues. Data gaps in relation LTHT staff vaccinated in other locations	Working with BME staff network and others to ensure communications are appropriate and reach all staff. Continuing to proactively telephone staff in areas where vaccination rates are low and working closely with E&F Management Team. Asking staff to update their records, via a secure website, if they have received vaccinations elsewhere. Still a large numer of staff to update records and continuing programme of communication.
Managing your customers, visitors and contractors (Lead - Helen Christodoulides & Jon Craven)		
Restriction of Visitors to Patients is in place including wearing of face coverings/face masks Visiting guidance is being reviewed every 4 weeks or sooner		.

if national or local restrictions are applied by Director of Nursing (Operations). Screening checklist for visitors completed prior to visit.		
Operational plan for the placement of patients in relation to COVID 19. Signage in place for all clinical areas to ensure staff are aware COVID status of patients.		
Restriction on Visitors to other areas e.g. Sales Reps are in place.		
Estates, Facilities, Capital, PFI Providers and Supplies contractors carrying out work on Trust premises have own risk assessments in place. CSUs advised to review the Safe Management of Contractors Procedure and ensure suitable risk assessments are in place prior to any CSU commissioned work commencing on site.		
Cleaning the workplace (Lead – Chris Ayres)		
Staff are encouraged regarding regular hand washing and surface cleaning - Communicated via COVID Bulletin and in local areas. Further advice disseminated from IPC requiring all areas to undertake a cleaning audit.		.
Hand gel and cleaning wipes provided and available in all areas.		
Staff are encouraged to opening windows and doors frequently to encourage ventilation.		
Switched routine cleaning to the use of Chlor-clean for all		

cleaning with disposable cloths.		
From March 2020 additional staff were deployed to carry out touch point cleaning, concentrating on areas of highest activity. The frequency of cleaning of both the environment and equipment in patient areas has been increased to at least twice daily, in particular, frequency of touched sites/points. Cleaning practices switched to chlorine based products and disposable cloths as standard "Touch Point Clean" documents introduced with effect from 30 November 2020 in line with latest national guidance. Each CSU covid secure risk assessment includes the need for additional touch point cleaning. Additional cleaning staff where required to .clean patient toilets after each use, undertake cleaning of high frequency touch points and cubicle curtain changes for each patient (suspected Covid) across around 25 areas in order to reduced nosocomial infection. Started a process of assurance training for the existing 100 Ward Environment Porters regarding patient shared equipment	.	
In some areas signage is displayed regarding Social distancing for toilet areas.		
Housekeeping staff have ensured enhanced cleaning in Public areas.		
Good Mechanical ventilation is in place in some areas to	Despite programme of improvement, the	Plan to pilot 5 portable air purifiers in side

ensure air flow is changed every hour. New air handing unit installed in Acute Respiratory Care Unit. Working with UoL to trial ventilation in J10 and plan to extend this to ED. Initial results indicate Social Distancing continues to be of utmost importance. Informatics have now developed a safe control document for the control of contractors	design and construction of some buildings means recommended levels of ventilation are not practicable.	rooms. Trial commenced on 12th April for 2 weeks in ED.
PPE and face Coverings (Lead - Gillian Hodgson)		
Risk assessments are in place and national guidance is being followed.	National guidance can change at short notice.	Application of the published IPC guidance continues, this is reviewed through the newly formed Trust COVID-19 Operational IPC group and disseminated through tactical. Update of IPC guidance expected to accompany the lifting of lockdown restrictions.
Identification and use of Latex products is recorded on each General H&S Risk Assessment for every and ward and dept and Latex products. Usually gloves, are restricted for use in certain areas e.g., Theatres. Robust escalation process in place if supply problems occur resulting in the need to look at latex alternatives.		
Employees are requested to declare any known sensitivity/allergy to Latex upon commencement of employment via Occupational Health processes and are subject to annual health surveillance measures. LTHT adopts a latex free environment where there are		

alternatives available.		
CSUs have taken responsibility for providing FFP3 mask fit testing locally. Escalation of any gap in the process is raised through the Incident Co-ordination Centre. All CSUs submit a weekly return detailing the staff that have been FFP3 fit tested and the masks that they can use. A centralised database is held.		
Incident Command Structure used to ensure adequate on-going provision of PPE and robust escalation process is in place if supply declines. Areas are supplied with fluid resistant face masks(FRFM) that secure in different ways and mask adjusters, to prevent the frequency of slippage/dislodgement..		
Workforce Management and Staff Resilience (Lead - Jo Buck)		
Health and wellbeing Leads in all CSUs to keep in contact with those self-isolating/shielding etc and re-purposed staff.		
Mental Health and wellbeing advice available via Intranet, Staff Connect and Facebook Group. Additional link psychologists recruited to provide support to staff. Working with partner organisations in the city and ICS to ensure consistent levels of support are available. Adequate treatment is now available for identified individuals and additional senior psychologist started to further enhance service provision.	Increased risk of staff anxiety and 'burn out', including potential PTSD, due to sustained nature of pandemic, increasing patient numbers, increasing staff absence, staff being repurposed into unfamiliar areas, on-going social isolation due to long term home working and other demands on the workforce (for example, staffing Y&H Nightingale and supporting vaccination/immunisation programmes). Risk to employee HWB linked to resetting the provision of clinical services	Continuing work to balance integration of service delivery, workforce, financial and quality priorites. Support from Occupational Health and referral to best available treatment.

Health and wellbeing conversations template now available for all staff to complete. HWB principles agreed and 1 of 4 priorities for HR&OD. HWB principles incorporated into tactical response and HR&OD representation on tactical group.	Adequate treatment availability for employees with serious and/or ongoing mental health concerns due to known long waits for access to NHS treatment. Risk that staff will suffer from long Covid. In addition to the risk to the individual worker, this could also adversely impact workforce availability	
Advice has been given for staff to be split into teams or groups where practicable.		
Maintain consistent pairing where 2-person deliveries are required		
Shops within the Trust are using Electronic payment methods.		
Communication/Training materials developed for workers prior to returning to site.		
Advice developed and issued in relation to cohorting of staff in clinical areas.		
Testing in place for symptomatic staff and/or household members. Enough capacity and home testing available. Good levels of performance against turnaround time. This is actively monitored through the Incident Command Structure. CEV staff working remotely		
Staff testing in place for test and trace and comprehensive guidance in place to support Managers Senior Leaders session on 02.09.20 used case studies to reinforce lessons learned for staff test and trace		
A variety of staff Health and Wellbeing offers are available	Take up of Health and Wellbeing Offer	Work continues across organsation to

and a dashboard has been developed to monitor staff utilisation. New exit interview arrangements launched to understand impact of Covid on turnover. Turnover is monitored by Resource Management Group as there is a risk it may increase due to the pandemic	unclear and dependent individuals coming forward.	develop a screening tool and Director of HR&OD convened a task and finish group with individuals from across the ICS.
Inbound and Outbound Goods (Lead - Chris Slater)		
Measures to minimise person to person contact for deliveries in place. There are on-going discussions with suppliers about on-site requirements. Guidance for suppliers has been developed Methods to reduce frequencies of deliveries for example by ordering larger quantities have been undertaken. The Trust has now opened an offsite consolidation centre for inbound deliveries of PPE. This ensures suppliers deliver to one single site and adhere to social distancing measures. Pick up and drop off collection points, procedures, signage and marking have been devised. Pick pack and dispatch of PPE is now from the consolidation centre and the local stores within the hospital have been closed. No staff are able to drop in for PPE which limits the risk of exposure.	There is less control over 3rd party goods deliveries for retail	

PPE is now in plentiful supply and stocked at Dolly Lane, this means the inbound deliveries are now kept to a minimum. The Trust now holds a minimum of 30 days stock Dolly Lane signage is now in place with one-way systems in operation. Single working at Dolly Lane is not permitted. All staff have had training and induction on lifting and handling. Where possible single workers unload/load vehicles		

Risk CRRS 18: Failure or complete outage of the Patient Administration System	**C = 5**	15	**Very Low Risk**			**Low Risk**			**Medium Risk**		**High Risk**		**Significant Risk**			
	L = 3		1	2	3	4	5	6	8	9	10	12	15	16	20	25
							Target Score						Current Score		Initial Score	

Risk Description:	
There is a risk of failure or complete outage of the Patient Administration System which is running on legacy hardware which is outside of live support and is running on an unsupported version of the software (Patient Centre) The operational and financial risk to the Trust would be significant in the event of a hardware failure or PAS malfunction which left the Trust unable to recover the PAS and running on Business Continuity Plans indefinitely	**Executive Lead:** Chief Digital Information Officer **Date Added to CRR:** Aug 2020 **Last reviewed:** Feb 2021 **Committee reviewed at:** Digital Hospitals Programme Board

Controls	Gaps in Control	Further Actions Planned:
DXC three month rolling contract with third party supplier (SCC) for hardware support. Change freeze for any upgrades to or affecting the PAS system to mitigate risks of platform destabilisation.	The supplier's (DXC) contract with SCC is on a reasonable endeavours basis, and carries no guarantees in the event of hardware failure.	• Business case approved for bringing the PAS onto a fully supported platform • New Hardware procured • Deployment plans being firmed up with DXC resource commitments for the hardware stabilisation, with draft plans in place for the PAS 8.1 upgrade
CSU BC Plans for planned or unplanned PAS outages.	Incomplete CSU Business Continuity Plans for a PAS outage, and the affected 50+ down-stream clinical systems not recognised.	• External BCP consultant appointed to lead on a standardised approach for all CSUs. • BCP working group established • BCP approach options drafted - Craig Brigg engaged regarding approach to option risk assessment, management of risks and sign-off • Lead CSU (Oncology) engaged to deliver a standard CSU BC Plan template (for all CSUs to utilise) • Investigate options for using another Trust's PAS as part of BCP planning

CRRS20: Delivery of the Leeds & West Yorkshire Vaccination programme	C = 4	16	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
	L = 4								Target Score					Initial/Current Score		

Risk Description: The Trust may not be able to meet the requirements relating to its role as lead provider for the West Yorkshire ICS and the accountable organisation for the Leeds place vaccination programme, including sustaining the infrastructure, procurement and supply, and the number of staff required to meet the demand of the vaccine programme, in addition to supporting the continued operational response to the coronavirus pandemic. This includes the 1st phase of the Leeds vaccination programme at the St James's location and establishment of the Leeds community vaccination centre at Centenary Pavilion, Elland Road. This may have an impact on the Trust's staffing capacity to care for patients in its hospitals, resulting in harm to patients.
Cross-reference CRRS1 (nurse staffing) and CCRS2 (medical staffing)

Executive Lead: Chief Medical Officer

Date added to CRR: December 2020
Last reviewed: May 2021

Committee reviewed at: Quality Management Group

Controls	Gaps in Control	Further Mitigating Actions
West Yorkshire Vaccination Steering Group in place, overseen by Chief Medical Officer and SRO.	Available data provision from NHSE/I is insufficient to allow localised planning and delivery at place, including Leeds	Access to Foundry dataset supplemented by local place-based and organisational data
Staffing plan developed by Director of Workforce in conjunction with partners in Health & Social Care, overseen by Vaccine Steering Group. Staffing and operational requirements for Thackray building set out in clinical and operating model (December 2020). Staffing and operational requirements for Leeds community vaccination centre at Centenary Pavilion, Elland Road set out in clinical and operating model (January 2021). Nurse Director appointed to oversee programme	There may not be sufficient staff to meet the demand to administer vaccines that are made available. Ability to train new staff recruited to the programme is constrained by current low demand. Potential impact of insufficient trained staff being available if demand increases in future weeks due to short notice of increases in demand/vaccine supply.	Local workforce plan developed, staff recruited to weekly rota from LTHT and partner organisations in health and social care. Staff released from CSUs and corporate teams to support programme delivery through Thackray building. Training plan implemented for current staff plus new staff coming through the training pod

(December 2020). General Manager and Senior Nurse appointed (secondment) to co-ordinate operational response and delivery (January 2021).	sufficient staff are trained to split the workforce safely There is the potential for an oversupply of staffing if vaccination continues to be delivered predominantly in the community.	Recruitment plan agreed that will deliver maximum flexibility in the workforce by recruiting to limited hours contracts. Enables on-boarding to be completed and training to commence. This mitigates the risk of training of staff and over-supply. Planning for ongoing delivery of vaccination service has commenced to develop more certainty about how vaccination programme will be delivered in Leeds, to inform staffing model required in the medium to long term.
Recruitment plan developed by individual Leeds Trusts, primary care and social care organisations to provide capacity to meet the demand for Thackray Museum at St James's location and Leeds community vaccination centre.	Staff deployment from local organisations to Leeds vaccination site may impact on the Trusts ability to meet demand re caring for patients with COVID-19 and other conditions.	Staffing deployment plan developed by corporate nursing team (December 2020), including volunteer shifts. Staffing requirements have been lower than anticipated in the early weeks of operation at the Leeds Community Vaccination Centre. Medical and nursing staff have been released back to substantive roles early where possible. Use of flexible / ad-hoc / volunteer (substantive NHS) staff has been reduced as more contracted staff have completed on-boarding.
Staff vaccination plan.	Releasing staff for vaccine may have an adverse impact on local ward staffing.	Staff vaccine plan developed, including time allocation to release staff from clinical duties, utilising out of hours/shifts. Staff prioritisation for vaccination agreed, communicated to CSUs, including booking arrangements (December 2020). By Feb 2021 over 80% of frontline staff have received vaccination – reducing risk of adverse impact from

		staff needing release for vaccination.
Lead provider contractual arrangements with NHSE and subcontracting arrangements with place-based lead provider in place.	Contractual arrangements between LTHT and place-based lead providers not fully in place.	Full reporting of financial actions at place reported to LTHT; clinical and quality responsibilities held by place-based lead providers
Location of vaccination site to facilitate release of staff to receive vaccination agreed January 2021 – Centenary Pavilion, Elland Road, operational from February 2020.	Lease for Elland Road location – timescale to be agreed.	
Vaccine procurement, delivery and storage arrangements set out in clinical and operating model (December 2020). Statement of Purpose (LTHT) updated and submitted to CQC to meet Regulatory requirements (January 2021). AstraZeneca vaccine available (January 2021). Moderna vaccine available April 2021. Monthly report to Quality and Safety Assurance Group, setting out progress, reported patient safety incidents, risks and mitigation.	Regulations re vaccine storage limiting options (Pfizer BioNTech), including local peer vaccination. Vaccine supply to WY ICS controlled centrally and subject to short-term change. Handling two vaccines in one site requires careful segregation of storage and administration and consenting processes Media coverage related to AstraZeneca vaccine may impact on uptake at Elland Road vaccination centre People could inadvertently join the wrong queue and receive the wrong vaccine	AstraZeneca vaccine in use at, at Centenary Pavilion, Elland Road. All relevant procedures in place and approved Place-based flexibility of delivery capacity in place. National SOP describes segregation arrangements when handling more than one vaccine per site. Training and handling arrangements under development (March 2021) Advice provided to people attending for vaccination Booking, access and administration processes to be implemented in April 2021 to reduce risk and enhance control of the distribution of multiple vaccines. 1st dose Moderna and 1st doses on separate days alongside 2nd dose AZ • Queue management provided by professional security team • Pods 1 to 5 for 1st doses with separate

		lanes • Pods 6 to 10 for 2nd dose with separate lanes • Separate entrances for different vaccines + expected dose. • Update training for all staff • Briefings at the start of every shift • Dedicated pods for different vaccines with clear signage Where it is unclear which vaccine a patient has received as a first dose, administration staff check on NIVS history page.

<table>
<tr><td rowspan="3">CRRS 21: Patient harm – falls and hospital acquired pressure ulcers (COVID-19)</td><td rowspan="2">C = 4</td><td rowspan="3">16</td><td colspan="3">Very Low Risk</td><td colspan="3">Low Risk</td><td colspan="2">Medium Risk</td><td colspan="2">High Risk</td><td colspan="4">Significant Risk</td></tr>
<tr><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>8</td><td>9</td><td>10</td><td>12</td><td>15</td><td>16</td><td>20</td><td>25</td></tr>
<tr><td>L = 4</td><td></td><td></td><td></td><td></td><td></td><td></td><td>Target Score</td><td></td><td></td><td></td><td></td><td>Initial/Current Score</td><td></td><td></td></tr>
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<table>
<tr><td rowspan="3">Risk Description: There is a risk of hospital-acquired harm to patients related to pressure ulcers and falls due to repurposing of staff, reconfiguration of clinical services and restrictions re hospital visitors and volunteer support, as a result of the on-going coronavirus (COVID-19) pandemic.
Cross-reference CRRS16: risk of re-commencing normal activity levels due to reduced capacity (COVID-19)</td><td>Executive Lead: Chief Nurse</td></tr>
<tr><td>Date added to CRR: March 2021
Last reviewed: March 2021</td></tr>
<tr><td>Committee reviewed at:
Safety and Outcomes Assurance Group</td></tr>
</table>

Controls	Gaps in Control	Further Mitigating Actions
Risk assessment framework and clinical guidelines/care plans for staff in practice	Variable compliance with completion of documentation. Mixed models of paper and digital risk assessment documentation.	Procedure update and documentation review due for completion 2020/21 Q4 Joint Strategic clinical nursing documentation group provides strategic oversight for transfer of paper records to digital format.
Ward metrics/audit process – ward assurance visits	Change from peer assessment to self-assessment, potential impact on validity of results. Capacity of Professional Practice Safety Standards team to respond to increased assurance visits due to team vacancies.	Falls external review commissioned January 2021. Recruiting to vacancies within the team, target completion April 2021.
Governance framework – Perfect Ward review meeting, specialty and CSU Quality Assurance (governance) meetings.		
Root Cause Analysis (RCA) investigation process – review panel.	Consistency/variability in standard of completion of RCAs.	Oversight/sign off by Head of Nursing. QA review process in place via pressure ulcer/falls panel.

Quality Improvement Faculty falls/pressure ulcers		
Safety huddles/enhanced care	280 WTE and 11.7 % Clinical Support Worker vacancies in CSUs (Jan 21)	Rapid increase in recruitment activity to close vacancy shortfall by April 2021.
Specialist support – Tissue Viability team	Capacity to provide support to all clinical areas.	External review – tissue viability service completed September 2020. Recommendations re staffing additional 3.0 WTE, target completion April 2021
NHSE guidance on hospital visiting (COVID-19), including exceptions for patients with specific care needs.	Reduced footfall in hospital wards, including visitors and volunteers	

<table>
<tr><td rowspan="3">Risk CRRF 1: Failure to deliver the financial plan for 2021/22</td><td>C = 5</td><td rowspan="3">20</td><td colspan="3">Very Low Risk</td><td colspan="3">Low Risk</td><td colspan="2">Medium Risk</td><td colspan="2">High Risk</td><td colspan="4">Significant Risk</td></tr>
<tr><td rowspan="2">L = 4</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>8</td><td>9</td><td>10</td><td>12</td><td>15</td><td>16</td><td>20</td><td>25</td></tr>
<tr><td></td><td></td><td></td><td></td><td>Target Score</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>Current Score</td><td>Initial Score</td></tr>
</table>

Risk Description:
There is a risk that the Trust does not achieve its planned control total in 2021/22. This would have the following impacts:

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

Executive Lead: Director of Finance

Date added to CRR: Nov 20
Last reviewed: May 2021

Committee reviewed at:
To be reviewed at the next Finance & Performance Committee on 19-05-21

Controls	Gaps in Control	Further Mitigating Actions
Yearly Board approved five year plan. The Board agree the Five Year plan, including Income and Expenditure position and Five Year Capital Plan. The Board are sighted on risks to delivery of the plan through a risk range and executive agreed mitigation plans	• Requirement for additional capital expenditure due to Covid-19 may restrict non- Covid capital expenditure in 2021/22. • Unexpected expenditure on COVID and backlog clearance • Failure to achieve Elective Recovery Framework thresholds	• 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 • Executive review of Backlog work and COVID expenditure. Weekly Activity reporting
Annual Financial Plan signed off by the Board. The Income and Expenditure Plan and the Capital Plan are signed off by the Board. In addition to this the Finance and Performance Committee are sighted on the progress of the Waste Reduction identification and CSU forecasts for the following	Changing financial regime and as yet unknown income level for Q3 and Q4 2021/22	• Regular updates to the Executive Team and Finance and Performance Committee including Exec lead financial mitigations • Regular communication with NHSE/I to identify and adapt to changes

year		
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	Changing financial regime and as yet unknown income level for Q3 and Q4 2021/22	Regular updates to the Executive Team and Finance and Performance Committee including Exec lead financial mitigations
Weekly reporting of the Waste Reduction position CSU to the Director and Deputy Director of Finance which in turn feed into Finance Performance Framework CSU meetings	None	Regular meetings with the PMO to assess risks to the programme
CSU ownership of realistic control targets and run rate based forecasts linked to the Integrated Accountability Framework.	Changing financial regime and as yet unknown income level for Q3 and Q4 2021/22	Regular updates to the Executive Team and Finance and Performance Committee including Exec lead financial mitigations
Operation of the financial performance framework with: • Monthly Clinical Director signed off forecasts and a RAG rating against CSU agreed Control Totals • Escalation meetings with Director of Finance for RED rated CSUs and with the Deputy Director of Finance for AMBER CSUs • Financial sustainability board, including the Chief Executive and other Executive Directors, for those CSUs on Amber and Red for multiple months	Changing financial regime and as yet unknown income level for Q3 and Q4 2021/22	Regular updates to the Executive Team and Finance and Performance Committee including Exec lead financial mitigations
Fixed Income allocations through the negotiation of Aligned incentive contracts with Leeds CCG and NHSE	Changing financial regime and as yet unknown income level for Q3 and Q4 2021/22	• Regular meetings with commissioners and attendance at all ICS finance forums • Regular communication with NHSE/I to identify and adapt to changes
Implementation of Finance the Leeds Way Improvement Plan	None	None
Emergency cash funding available to meet payment obligations or unforeseen capital emergencies through NHSE/I bidding process	This is a bidding process and not all requests will be supported	Estates and Facilities Risk Review Group required to prioritise schemes for any funding that is made available
Progress against the five year capital plan is overseen by the Capital Planning Group including specific prioritisation for the MSE, BME and DIT programmes.	Requirement for additional capital expenditure due to Covid-19/activity recovery may restrict spend in 2021/22	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).	There is no contingency in the Capital plan for 2021/22 for any emergency failures.	Any unforeseen equipment failure would lead to immediate re-assessment of current year spending priorities with a view to substitution

<table>
<tr><td rowspan="3">Risk CRRF 3: Risk of further delays in delivering the refurbishment of the Generating Station Complex (GSC) at LGI</td><td>C =</td><td rowspan="3">15</td><td colspan="3">Very Low Risk</td><td colspan="3">Low Risk</td><td colspan="2">Medium Risk</td><td colspan="2">High Risk</td><td colspan="4">Significant Risk</td></tr>
<tr><td rowspan="2">L =</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>8</td><td>9</td><td>10</td><td>12</td><td>15</td><td>16</td><td>20</td><td>25</td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="15" rowspan="3">Risk Description:
The management of this risk is commercially sensitive information which has been removed from the public version of the Corporate Risk Register</td><td colspan="4">Executive Lead: Director of Estates & Facilities</td></tr>
<tr><td colspan="4">Date added to CRR: Oct 2018
Last reviewed: Jan 2021</td></tr>
<tr><td colspan="4">Committee reviewed at:
Finance and Performance Committee</td></tr>
</table>

Controls	Gaps in Control	Further Mitigating Actions

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

Risk Description:

There is a risk that the Hospitals of the Future Project fails to meet its objectives as a result of: ineffective assurance; insufficient capital and revenue funding for key elements (including digital by design, equipment, net zero carbon, car park); uncertainty around potential increases in costs related to the COVID pandemic and Brexit; delays in the programme (including from DHSC and NHS-E&I's New Hospitals Programme); issues around specification, design and quality; digital infrastructure; and/or inadequate stakeholder engagement.

If the project is not delivered, LTHT will: have insufficient capacity to meet service demand; retain high levels of backlog maintenance and resultant service challenges; not be able to improve efficiency in a number of areas including estates utilisation; continue to have maternity services on two sites and not be able to centralise in line with commissioner requirements; and have limited opportunities to further transform clinical services.

Executive Lead:
Simon Worthington

Date Added to CRR: May 2020
Last reviewed date: May 2021

Committee reviewed at:
Building Development Committee

Controls	Gaps in Control	Further Mitigating Actions
Assurance The Trust has implemented a robust programme assurance framework for the delivery of the BtLW Programme and specifically the Hospitals of the Future Project with internal management controls and management assurance supported through independent assurance provided by the Building Development Committee (and other Committees, Boards and Groups in the governance structure) and a programme of assurance activities undertaken by PwC as the Trust's auditors. The Programme Team has regular discussions with NHS regulators, legal advisors and partners on procurement strategies and the development of	Implement local assurance controls, measures and processes through the BtLW PMO. Undertake a review of Supplier assurance processes and procedures/quality plans in connection with the delivery of contracts.	▪ Review and respond to PwC audits and assurance recommendations (on-going). ▪ Monitor services delivered by specialist/professional advisers in terms of the quality of deliverables through PMG (monthly) and BtLW PMO. ▪ Introduce DHSC Gateway Review process following issue of central DHSC guidance (on-going).

OBCs/FBCs for the Project and subsets of the Project (on-going). Reviews are undertaken by NHS-E&I, DHSC, and HMT at each key business case stage to ensure compliance with guidance and to provide further on-going assurance (next formal assurance at FBC stage).		
Funding and Costs A Finance Workstream has been established to ensure that the financial implications of the BtLW's constituent projects are identified and appropriate and that integrated financial plans are in place. The Workstream monitors performance against the LTFP and will retain financial risks under review on a monthly basis. The Workstream will monitor guidance from NHS-E&I, DHSC and HMT to ensure compliance of financial plans with appropriate guidance and liaise as necessary with regulators. Regular monthly updates are provided to the BtLW Programme Management Group, BtLW Programme Board and Building Development Committee on affordability issues. CSR submission in August 2020 incorporated the scheme's key capital requirements relating to digital and innovation, net zero carbon, MSCP, and programme acceleration. The BtLW Programme Team established a risk/contingency allowance based upon a quantified	LTFM to be reported to the BtLW Programme Board so that any actions required, including integration with other services in LTHT, are monitored and escalated as appropriate. Key market updates on economic factors to be reported to the BtLW Programme Board and financial due diligence reports to be completed on key market contractors/suppliers. An £8 million funding shortfall identified in the Pathology scheme's OBC has been allocated against the HofF contingency provision following discussions with NHSI/E and DHSC (GMP target date for Pathology is August 2021). Undertake scheme cost review February to April 2021 – capital costs; VAT; scope review. Complete further market engagement surrounding delivery options to deliver	▪ External advisers to provide regular updates on key policy changes. ▪ LTFM to be reviewed and updated twice yearly to capture any financial changes (and identify risks) in costs/income/inflation. LTFM currently being reviewed following up-date to Demand and Capacity Plan (updated October 2020). ▪ Monitor delivery through stakeholder engagement and review other developments to ensure plans are progressed to timescales and provide sufficient capacity (monthly). ▪ Network with other schemes to identify any early warning issues that may have funding and cost implications for HofF.

risk assessment at the Outline Business Case Stage. This is supported by a robust change control process managed by the Project Board with further assurance undertaken by the Programme Board and Building Development Committee. Business Cases: reviews are undertaken by NHS-E&I, DHSC, and HMT at each key business case stage to ensure compliance with guidance and to provide further on-going assurance (next formal assurance at FBC stage). New Hospitals Programme: BtLW is collaborating with DHSC and NHS-E&I to support work to implement a programme-wide approach to the DHSC/NHS-E&I Hospital Programme. Leeds Hospitals Charity: BtLW has established a Charities Workstream to support the delivery of the minimum charitable funding target of £30m. Digital by design: an outline Digital Design Brief has been prepared with a focus on what essentials are needed which can be supplemented as funding permits. A CSR application for additional funding has been submitted. Robust change management/control processes implemented to monitor for design variance against the approved scheduled of accommodation. Net Zero Carbon Funding: a cost assessment has been completed relating to the Net Zero Carbon and	the new MSCP.	

Sustainability Brief. Lessons from the implementation of the Pathology Project will be fed-in to the new hospitals design development process. Once appointed, the MEPH Engineer will develop a more detailed strategy with the input of the Trust and their advisers. Car parking: the Trust is actively progressing options for the provision of a new multi-storey car park in light of Government guidance on the use of private finance.		
Programme Delays Regulatory review process for all capital developments within NHS and public sector before approval of scheme and contract close to ensure scheme within Trust/ regulator affordability envelope and approvals/authorisations. DHSC guidance limits on changes to key assumptions without further approval to ensure plans are delivered with realistic assumptions. BtLW is collaborating with DHSC and NHS-E&I on the New Hospitals Programme to support the implementation of a Programme wider delivery approach to the New Hospitals Programme without causing unnecessary delays to the progress of this programme (on-going).	Risk of change and variations to be reported to Programme Board to assess the impact on business cases Changes/delays to be reviewed by Finance Sub-Group to ensure financial implications are fully considered. Update NHS-E&I at monthly meetings on any significant programme delays.	External advisers to provide regular updates on the risk of potential delays. Network with all other schemes to ensure any issues identified elsewhere are considered for implications.
Specification, design and quality	Monitor progress of the detailed design against the Design Briefing	Full assessment of the RIBA Stage 2 Design Response and design recommendations against the Project design

Design Brief/design requirements are working to deliver a robust, flexible and agile design solution and also build on lessons from COVID-19 experience. The Programme has undertaken significant clinical engagement completed on design briefing documentation. Project Board, Programme Board, Building Development Committee and CSU Strategic leads have signed-off clinical design briefing documentation. Robust change management process established and implemented at a Project level.	Documentation.	briefing documentation.
Digital infrastructure The Programme is actively engaged with DIT to develop a design solution taking account of current standards and known future standards/policy changes. DIT is working to identify core infrastructure requirements and align with available funding/ funding strategy. A Business Case is being developed in collaboration with DIT to inform discussions with national bodies.	Additional funding needs to be identified by the Trust to support basic digital delivery.	Development of Business Cases to support future funding opportunities.
Stakeholder Engagement The Programme has established a programme-level Communications and Stakeholder Engagement Plan,	Stakeholder feedback process to be further refined and developed. Stakeholder Engagement Reporting	

supported by a specific stakeholder communications engagement plan for the Hospitals of the Future project which are aligned to delivery plans and reviewed monthly at Building Development Committee, Programme Board and Project Board. A public consultation process was completed (Maternity & Neonates) on 6 April. Leeds CCG Board approved the outcome of the maternity consultation in July 2020. No further formal/ statutory consultation is required. The Programme maintains a regularly updated section on the Trust's website with the latest information on developments.	process to Project Boards to be established. Process to be implemented to monitor the on-going impact and success of engagement.	

<table>
<tr><td rowspan="3">Risk CRRF 5: Risk of failure to deliver the pathology project.</td><td rowspan="2">C = 4</td><td rowspan="3">16</td><td colspan="3">Very Low Risk</td><td colspan="3">Low Risk</td><td colspan="2">Medium Risk</td><td colspan="2">High Risk</td><td colspan="4">Significant Risk</td></tr>
<tr><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>8</td><td>9</td><td>10</td><td>12</td><td>15</td><td>16</td><td>20</td><td>25</td></tr>
<tr><td>L = 4</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>Target Score</td><td></td><td></td><td>Current/Initial Score</td><td></td><td></td></tr>
</table>

Risk Description:

There is a risk that the Pathology Project fails to meet its objectives as a result of: ineffective assurance; a failure by the Principal Contractor to deliver within the Guaranteed Maximum Price/Affordability; COVID-related delays in developing and implementing workforce planning and associated change management plans as well as the delivery of the proposals; and the impact of any delays to the reprocurement of the Pathology Managed Services Contract (MSC).

If the Pathology Project does not meet its objectives, LTHT will: not be able to make the improvements in efficiency in line with the Naylor Report; find it more challenging to attract high quality workforce with the right skills; not be able to reduce backlog maintenance; have limited opportunities to contribute to the implementation of the WYAAT Network Pathology Strategy and will not be able to centralise and transform services for patients with reduced testing times.

Executive Lead:
Simon Worthington

Date Added to CRR: May 2020
Last reviewed date: May 2021

Committee reviewed at:
Building Development Committee

Controls

Assurance

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

The Programme Team has regular discussions with NHS regulators, legal advisors and partners on procurement strategies and the development of OBCs/FBCs for the Project and subsets of the Project (on-going).

Gaps in Control

Implement local assurance controls, measures and processes through the BtLW PMO.

Undertake a review of Supplier assurance processes and procedures/quality plans in connection with the delivery of contracts.

Further Mitigating Actions

- Review and respond to PwC audits and assurance recommendations (on-going).
- Monitor services delivered by specialist/professional advisers in terms of the quality of deliverables through PMG (monthly) and BtLW PMO.
- Introduce DHSC Gateway Review process following issue of central DHSC guidance (on-going).

Reviews are undertaken by NHS-E&I, DHSC, and HMT at each key business case stage to ensure compliance with guidance and to provide further on-going assurance (next formal assurance at FBC stage).		
Guaranteed Maximum Price/Affordability A Finance Workstream has been established to ensure that the financial implications of the BtLW's constituent projects are identified and appropriate and that integrated financial plans are in place. The Workstream monitors performance against the LTFP and will retain financial risks under review on a monthly basis. The Workstream will monitor guidance from NHS-E&I, DHSC and HMT to ensure compliance of financial plans with appropriate guidance and liaise as necessary with regulators. Regular monthly updates are provided to the BtLW Programme Management Group, BtLW Programme Board and Building Development Committee on affordability issues. Business Cases: reviews are undertaken by NHS-E&I, DHSC, and HMT at each key business case stage to ensure compliance with guidance and to provide further on-going assurance (next formal assurance at FBC stage). Robust change management/control processes implemented to monitor for design variance against the approved scheduled of accommodation. Robust OBC capital cost plan allowances.	LTFM to be reported to the BtLW Programme Board so that any actions required, including integration with other services in LTHT, are monitored and escalated as appropriate. Key market updates on economic factors to be reported to the BtLW Programme Board and financial due diligence reports to be completed on key market contractors/suppliers. The £8 million funding shortfall identified in the Pathology scheme's OBC has been provisionally allocated against the HofF contingency provision following discussions with NHSI/E and DHSC (GMP target date for Pathology is August 2021). Undertake scheme cost review February to April 2021 – capital costs; VAT; scope review. Value-engineering options register established.	▪ External advisers to provide regular updates on key policy changes. ▪ LTFM to be reviewed and updated twice yearly to capture any financial changes (and identify risks) in costs/income/inflation. LTFM currently being reviewed following up-date to Demand and Capacity Plan (updated October 2020). ▪ Monitor delivery through stakeholder engagement and review other developments to ensure plans are progressed to timescales and provide sufficient capacity (monthly). ▪ Complete pre-RIBA Stage 3 submission review of value engineering and cost reduction proposals.

The BtLW Programme Team established a risk/contingency allowance based upon a quantified risk assessment at the Outline Business Case Stage. This is supported by an effective design development robust change control process managed by the Project Board with further assurance undertaken by the Programme Board and Building Development Committee. Robust cost plan monitoring and monthly cost plan up-dates/reporting. Regular monthly cost monitoring of scheme capital costs.		
COVID-Related Delays on Workforce Planning & Change Management Funding identified for additional Pathology CSU Management posts including a Project Manager role to support capacity agreed and recruitment to commence (in recruitment). Funding for additional HR role specifically supporting Pathology Projects agreed.	On-going review and monitoring processes.	▪ Establish on-going review and monitoring process via the Pathology CSU surrounding resourcing the implementation of the change management plans.
Managed Services Contract (parallel Equipment procurement) Delays* Programme Plan for MSC Reprocurement established and mapped to New Pathology Facility. Statements included in the HLIP (for the P22 Contractors) outlining the proposed summary process and requirement for managing equipment. Confirmation received from NHS-E&I that full Green	Review MSC Re-procurement Programme following finalisation of the OBC to review and revise an integrated programme following to support effective management of inter-dependencies.	▪ NEC PM to advise PSCP of equipment procurement timescales. ▪ Lifecycle to ensure PSCP briefing allows for flexibility around equipment installation. ▪ Review of inter-dependencies of programmes as part of MSC approvals process.

Book business case is not required. Progress monitoring of the New Lab Project and the MSC Project reported and managed through the BtLW Pathology Project Board – separate governance arrangements for MSC Project linked with WYAAT.		

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

Risk Description:	
Failure to achieve the 95% compliance threshold against the 4-hour Emergency Care Standard, caused by sustained adult main department attendances and insufficient patient flow. This can lead to a congested department impacting on patient outcomes, patient experience, increased infection risk, staff morale, non-compliance with required national standards and financial penalties. Risk has increased In light of increased COVID19 admissions through wave 2 response. Challenges with flow continue due to the required changes in patient placement pathways both within and out with the hospital. Hospital occupancy levels have risen reflecting change in patient demand during the wave 2 of COVID19.	**Executive Lead:** Chief Operating Officer **Date Added to CRR** May 2014 **Last reviewed:** Dec 2020 **Committee reviewed at:** Finance & Performance Committee

Controls	Gaps in Control	Further Mitigating Actions:
CSM status reports, daily silver meeting and operational response guidance in place - Bronze, Silver and command escalation process both within LTHT and across city system.	Community / partner provider new process requires embedding and capacity e.g. Package of Care, delays in accessing Community Care Beds which is being affected by COVID19.	Early identification of patients MOFD and referral to SPUR for community placement CCB/ discharge to assess community beds.
Daily monitoring and reporting of 4 hour performance	Timeliness of bed allocation by CSUs to ED Absence of real time electronic bed state and real time beds overview.	Revised focus through the 4 times per week tactical meetings with COO oversight and governance regarding non elective flow and discharge. CSU operational response is focused on improvement in Non-admitted performance SJUH and LGI site. Centralised operational model currently being tested and forms part of a PDSA to be reviewed post COVID.
Patient streaming in place to most appropriate route e.g. GP, Minors, Frailty, JAMAA SAU.	Estate footprint constraints	Continued monitoring of 95% compliance and breach analysis for patients streamed away from ED. Model currently being developed which identifies

		other estates options for LGI & SJUH. Forms part of the overall estates strategy.
Creation of space to support social distancing requirements and internal A&E flows.	Estate footprint constraints	St James's A&E footprint will increase into eye casualty and ultra sound following re-provision of those services to enable asymptomatic A&E internal flow. LGI A&E will have a modular build in January 2021 to support internal A&E flow.
System Gold action plan being implemented and monitored through SROG / STaR.	Community capacity to support timely transfer of patients from acute bed base. Complexity of discharge pathways. Impact of Long COVID.	Implement work plan and monitor against the key objectives through twice weekly SROG which acts as city bronze and reports into STaR. "Cracking Discharge" working group to support timely care chaired by COO
System level mutual aid actions (system wide agreed tactical options to be considered during periods of escalating pressures)	Ability of system partners to respond in a timely fashion	Monitoring of Mutual Aid actions through System Resilience Operational Group and STaR
Winter and COVID planning with CSU's for 2020/21	Unpredictable activity levels	Operational response guidance developed and monitored through daily operational processes developed and refined in time for winter 20/21 CSU owned winter schemes monitored for implementation and impact
COVID19 modelling in place for wave 2 response in order to proactively manage and support flow and admissions across LTHT.	Novel modelling with a 14 day forward view only.	Further modelling in progress to enable responsive configuration of red/amber/green beds by site.

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

Risk Description:
There is a risk that the Trust will not recover 18-week RTT performance as a result of reduced levels of activity during periods of COVID19 admissions. Increased COVID-19 activity has resulted in a reduction in non-urgent face to face outpatient clinic activity to allow staff to be released to support additional inpatient capacity. This is required to support increased COVID19 admissions. In addition, all routine non urgent daycase and routine elective procedures may be cancelled in order to release capacity and staffing to support inpatient areas. As a result of suspending this activity, the number of patients waiting over 18 weeks is expected to increase.

28/04/21 - Current specialities non-compliant with 18 week RTT performance are; General Surgery, Urology, Cardiac Surgery, Trauma and Orthopaedics, ENT, Ophthalmology, Oral Surgery, Neurosurgery, Plastic Surgery, Cardiothoracic Surgery, Gastroenterology, Dermatology, Thoracic Medicine, Rheumatology, Gynaecology and All other specialties.

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

Executive Lead: Chief Operating Officer

Date Added to CRR: May 2014
Last reviewed date: Dec 2020

Committee reviewed at: Finance & Performance Committee

Controls	Gaps in Control	Further Actions Planned:
Implementation of telephone and video conferencing facilities have enabled non-face-to-face appointments to be delivered. Opportunities are being explored to maximise the use of this method of engaging with patients.	Not suitable for patients where investigation or examination is required	Use of Patient Knows Best system to enable patients to upload care information for review by clinical teams.
Triage of referrals enables identification of some patients at risk of harm if appointments are delayed.	Quality of referrals from GPs can vary.	Delivering easier access to consultant opinion for GPs ahead of referral through enhanced advice and guidance systems
Delivery contracts with CSUs will enable improved management of recovery trajectories - these will be developed as soon as possible to support recovery.	Prolonged social distancing restrictions may limit activity and result in continuing growth in waiting lists.	

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.	
Work with commissioners to control growth in referral rates where appropriate alternate pathways exist.		
Recovery plans to allocate available theatre, critical care, ward and staff capacity to areas of greatest clinical risk will be required during the recovery phase.	Prioritises clinically more urgent patients and so does not improve RTT position.	
Use of Royal College guidance to prioritise elective activity to improve planning for capacity allocation to patients with greatest clinical need.	Prioritises clinically more urgent patients and so does not improve RTT position.	
Established arrangements are in place to allow additional outpatient and inpatient activity to be scheduled outside normal working hours - will be required during recovery phase	Pension taxes had reduced number of additional sessions provided by consultant staff	
Independent sector capacity likely to be available to support during recovery phase.	Capacity available for higher volume outpatient activity is limited.	
Work is underway to develop a greater Advice & Guidance model in order to reduce unnecessary referrals.	Trial is in a limited number of specialties and PCNs.	Roll-out to all GP practices during w/c 23 Nov 2020
During the process of standing down any outpatient clinics or theatre lists in order to release staffing; only activity will be cancelled that provides benefit to the organisation. Therefore some activity may remain.		
In order to reduce follow-up demand, work towards patient initiated follow-ups has commenced.		

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

Risk Description:	
There is a risk that the Trust will not treat 85% of patients in line with the 62 day referral to treatment standard. This is due to the risk of late referral from other providers, an imbalance between capacity and demand, for key pathways/ at key pathway points, variable waiting list management, insufficient control over pathways of care or higher than expected demand (for acute and urgent care). This may result in poor timeliness of care, unsatisfactory patient experience, and unacceptable delays for patients, deterioration in stage of cancer at the point of treatment with worsened clinical outcomes and/or deterioration in LTHT's governance rating.	**Executive Lead:** Chief Operating Officer **Date added to CRR:** May 2014 **Last reviewed:** April 2021 **Committee reviewed at:** Finance and Performance Committee

Controls	Gaps in Control	Further Actions Planned:
The Trust Board has a named Executive Director responsible for delivering the national cancer waiting time standards.	None	None
The Board receives 62 day cancer wait performance reports for each individual cancer tumour pathway, not an all pathway average and will scrutinise actions to improve performance.	None	None
The Trust has a cancer operational policy in place which has been approved by the Trust Board.	None	Annual review in line with required updates
The Trust maintains and publishes timed pathways, agreed with the local commissioners and any other Providers involved in the pathway, taking advice from the Cancer Alliance for the following cancer sites: lung, colorectal, prostate and breast	Referrals from other providers do not always occur in a timely manner to support delivery of 62 performance LTHT capacity does not match the demand to deliver treatment within 62 days	Optimal pathway gap analysis completed and key actions are underway MDT level. Across all pathways the focus is on more timely access to diagnostics (particularly MRI) with additional MRI capacity available from May 2021. There should also be better access to theatres as we reset and renew throughout the year.

		Breast value stream work continues as part of LIM.
The Trust maintains a valid cancer specific PTL and carries out a weekly review for all cancer tumour pathways to track patients and review data for accuracy and performance.	Awareness of 62 day Breach risks are not always visible to CSU management teams	Focus on reinstating production boards from Q1 onwards to ensure oversight and visibility. Corporate Cancer Team weekly 2WW and 62 day risks oversight with CSUs has continued with focus on achievable actions during COVID surges. 2ww referral volumes now back up to 95-100% and flowing in to the system as normal. Normal cancer tracking processes have now resumed to manage patient pathways.
Root cause breach analysis is carried out for each pathway not meeting current standard.	Root cause analysis is not always carried out for the 10 previous breaches across all non performing pathways	Due to volume of current breaches, a weekly cancer team review of all 2ww, 31 and 62 day 10 longest waiters has been introduced with challenge by the Associate Medical Director of Cancer where required. Check what monthly RCA being done RCA/ optimal pathway review has been undertaken, with results being quantified to inform CSU recovery plans to be developed in Q1 2021/22. Routine root cause analysis processes will be re-introduced during 2021/22 as recovery is more established
Capacity and demand analysis for key elements of some	Capacity & demand modelling is not	Optimal pathway gap analysis completed and

but not all of the pathways not meeting the standard (1st outpatient appointment; treatment by modality) is carried out systematically and routinely.	routinely completed for all elements of every pathway	key actions are underway MDT level. Across all pathways the focus is on more timely access to diagnostics (particularly MRI) with additional MRI capacity available from May 2021. There should also be better access to theatres as we reset and renew throughout the year.
The national guidance on reporting methodology being consistently applied.	None	None
A clinical review of 104 day patients undertaken.	None	Weekly review of longest (over 104 day) waiters in place with escalation to Associate Medical Director for Cancer/ Treating Clinician or Lead Clinician/Clinical Director where required.
COVID 19 In response to the Trust enacting it's Emergency Response Arrangements due to a viral pandemic (COVID-19) LTHT introduced a number of actions to mitigate risk in relation to the diagnosis and treatment of cancer. Cancer MDTS undertook risk assessments to establish which patients could be safely deferred or offered treatments that may vary from standard treatment protocols. CNS teams continue to support patients by telephone, augmented by a patient support line that operated 7 days a week including bank holidays (Maggie's and Cancer team staffed). Weekly surgical prioritisation process in place, with additional operating accessed in the Independent sector where possible/ appropriate.	Additional pressure emerge as patients start to come off holding treatment patterns and still require time sensitive surgical intervention	This is fed into surgical capacity allocation process. Exploring the offer from Northern Cancer Alliance for additional operating capacity. Oversight will be through the Planned Care recovery programme of work.

Focus on bringing theatre/ ward bed capacity back as aligned to clinical priorities as possible as COVID pressures ease/ recovery can begin.	Bed, theatre, theatre staffing and patient priorities not neatly aligned to date.	Teams to continue to access Independent Sector capacity and work on surgical prioritisation to support allocation of theatre capacity as opportunities to restore arise as COVID case levels fall. Further work need to be undertaken as part of new Planned Care. Programme board to review routine theatre allocations.

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

Risk Description	Details
Risk Description: There is a risk that the Trust does not achieve the 28 day cancelled operations target due to acute activity pressures, critical care capacity, availability of theatre time, patient flow and the impact on elective bed availability, resulting in delays to patient treatment and possible harm and financial penalties COVID 19 The Trust has invoked its Emergency Response Arrangements due to a viral pandemic (COVID-19) causing the absence of significant numbers of Trust staff and large increase in demand which could overwhelm the Trust's ability to deliver routine care and result in potential fatalities and significant financial loss. This has led to an increased risk of patients having their planned procedure cancelled.	**Executive Lead:** Chief Operating Officer **Date added to CRR:** May 2014 **Last reviewed:** Aug 20 **Committee reviewed at:** Finance and Performance Committee

Controls	Gaps in Control	Further Actions Planned:
Daily management Daily 8am capacity planning meeting to prioritise admissions, including patients who have had operations cancelled and to allocate demand for critical care capacity.	Co-ordination of theatre/ ward and critical care capacity does not always align leading to greater risk of cancellations	Roll out the systematic use of the Electronic theatre scheduling tool, coupled with an increased emphasis on improving step downs from Critical Care in 4 hours to ensure all available capacity is utilised to ensure as many patients are treated as is possible Introduction of prompt starts for all theatre lists at SJUH (excluding Critical care) following the visit to Sheffield except when in Silver Command from 1/10/2019 Introduction of prompt starts for all theatre lists at SJUH (including the first 3 Critical care cases) following the visit to Sheffield except when in Silver Command from 1/11/19

		Introduction of prompt starts for all Neuro and Spinal theatre lists at LGI following the visit to Sheffield from 15/11/19
Daily/weekly CSU review 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 PA consultant scheduling tool	Awareness of the cancellation and 28 day rebooking risks are not always visible to CSU management teams	Introduction of a daily review of Production Boards by CSUs containing cancellation data and forward booking profile to manage risks coupled with the introduction of Service delivery contracts with CSUs to include cancelled ops and 28 day re-booking data - embedded process as part of delivery contract since 1/4/19 Introduction of daily email prompt to CSUs highlighting their 28 day breach risks for the following day from 1/9/19
Monthly planning CSUs to systematically engage in process to identify procedures and patients who could have their procedure as day case to reduce risk of cancellation Proactive reduction in normal operating levels during Jan, Feb and March which should reduce the cancellation numbers	Theatre staff and surgeons are not always available to undertake additional activity in response to peaks in demand	Review current Demand & Capacity tools and processes employed within LTHT to improve planning and flow in this area. This will involve visits to review best practice in other centres who perform well in this area **Sept 2019 -** - learning from visit to Sheffield incorporated into new actions on prompt starts/ daily and weekly process improvements and oversight Visit other Acute Trusts who have lower numbers of LMCO's and 28 day breaches to understand their processes and incorporate any learning into LTHT processes - learning from visit to Sheffield incorporated into new actions on prompt starts/ daily and weekly process improvements and oversight Work closely with Informatics to create a new G Drive report to replace the current Portal reports - on-going but not complete

Oversight Monthly meetings with CSU's who experience the highest numbers of 28 day breaches to understand the reasons for cancellations and why they are unable to rebook patients within 28 days		Creation of a "user friendly" guidance document of the standard & update the Elective Treatment Access Policy Introduction of weekly review of breach risks, including an oversight email to CSUs highlighting their breach risks for the month
COVID 19 In response to the Trust enacting it's Emergency Response Arrangements due to a viral pandemic (COVID-19) LTHT suspended routine and planned procedures including diagnostics and referrals, in line with NHSE/I/PHE guidance issued 17 March 2020, to provide capacity to meet the admission demand, including critical care and respiratory. In response LTHT is planning it's recovery response as outlined below • Proposals for a phased recovery are being developed internally, mindful of local issues & national policy decisions. • LTHT cancer leads are working with WY&H Alliance and partner organisations to develop robust recovery plans which ensure priority is given to the timely treatment of cancer patients. Cancer Board convening weekly to commence planning and review of cancer recovery Update 22/7/20 (score to remain at 16) From 25th May 2020 more operating capacity has been created to support the delivery of service.	Capacity may not be sufficient to meet likely demand	Options appraisal is being developed which will aim to maximise the capacity available whilst minimising the risk to staff and patients of COVID 19, including all LTHT sites, the Independent sector and partner organisations

All CSUs have undertaken 2 rounds of PTL validation based on national guidance and a further round is due at the end of July. From this work Theatre allocations are made for each specialty to reflect the volume of the most urgent patients they have. CSUs continue to work with IS providers to provide additional capacity based on clinical priority. Spire (Leeds) also working up a plan to deliver Level 2 CC capacity which will support additional activity.		
	Disruption to patients lives caused by cancellation may be heightened during the COVID pandemic due to the 14 day self isolation rules	All patients listed for elective surgery self-isolate for 2 weeks and have a COVID swab within 72hrs of surgery, therefore the implications and disruption to patients lives of a cancellation are significant. To reduce the likelihood of cancellation • CSUs are listing patients up to 3 weeks in advance which allows for all prep work to be completed and reduce on day problems • CSUs are utilising the Theatre scheduling tool to reduce the likelihood of overbooked lists • CSUs are working in close collaboration with Critical Care to even out demand • Some CSUs are holding a reserve list of patients who can be scheduled at the last minute if a cancellation does occur to ensure the theatre time is utilised

<table>
<tr><td rowspan="3">CRRP 5: Insufficient capacity and patient flow across the health care system for emergency admissions</td><td>C = 5</td><td rowspan="3">20</td><td colspan="3">Very Low Risk</td><td colspan="3">Low Risk</td><td colspan="2">Medium Risk</td><td colspan="2">High Risk</td><td colspan="4">Significant Risk</td></tr>
<tr><td rowspan="2">L = 4</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>8</td><td>9</td><td>10</td><td>12</td><td>15</td><td>16</td><td>20</td><td>25</td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>Target Score</td><td></td><td></td><td></td><td>Current Score</td><td>Initial Score</td></tr>
</table>

<table>
<tr><td rowspan="3">Risk Description:
Failure to maintain adequate capacity to meet the needs of patients requiring emergency admissions, caused by increasing demand and insufficient patient flow. This can lead to high bed occupancy levels impacting on our ability to maintain elective operating, non-compliance with national standards, poor patient outcomes and patient experience.</td><td>Executive Lead: Chief Operating Officer</td></tr>
<tr><td>Date Added to CRR: Sept 2015
Last reviewed date: Jan 2021</td></tr>
<tr><td>Committee reviewed at:
Finance & Performance Committee</td></tr>
</table>

Controls	Gaps in Control	Further Mitigating Actions:
Continued focus on ambulatory models of care to ensure admission avoidance wherever safe and possible to do so Daily consultant ward rounds across all CSUs.	Continue with high numbers of long length of stay and MOFD patients within hospital bed base	Systems level trajectories agreed and actions agreed to deliver reduction in long length of stay and MOFD numbers. Adult Social Care attendance at weekly review meeting from January 2020 to help assist in progressing discharge for patients. March 2020 level achieved. LIM work on SAU to further enhance ambulatory models of care in place and commenced. RPIWs held allowing improved communication with patients (patient leaflets), PGDs in place for nurses to be able to issue pain relief. Funding agreed for 6 additional General Surgical consultants to enhance senior decision making at front door. **December 2020**
Escalation process and full capacity plans by CSU - bronze, silver and gold command in place.		

DOP / CSM out of hours support and co-ordination.		
Robust bed modelling analysis to identify known activity surges Operational Response Guidance in place from November 2019. Winter planning sessions to be undertaken and operational guidance in place from Nov 2019. Detailed inpatient bed modelling has been undertaken in conjunction with the University of Leeds, which incorporates the city COVID19 prevalence rate. Internal bed modelling has also been used at LTHT on a daily basis to assess current demand against current capacity.	Physical capacity	Opel 4 actions to be further developed and incorporated into the operational Guidance - Feb 2020. Internal bed modelling has also been used at LTHT on a daily basis to assess current demand against current capacity. We endeavour to have 15-20 beds available on hot wards at any one time. Where anticipated demand is likely to exceed capacity; further wards are designated as hot capacity. The modelling forecasts inpatient numbers one week ahead in advance in order for LTHT to plan and manage capacity to the expected requirement for inpatient beds throughout the surge in COVID19 admissions. LTHT inpatient bed modelling has been combined with SAGE models for COVID prevalence to forecast COVID admission numbers.
Management of Long Length of Stay patients (Stranded patients)	Ageing population with complex comorbidities leading to increased demand on health and social care services without the required community infrastructure to keep people in their own home (particular at time of crisis) Multiple ward moves in patient pathway leads to increase length of stay.	Complete (system level) all actions outlined within Newton Europe recommendations. **Monthly monitoring through SROG** Roll out of ARC programme across LTHT wards from **Oct 2019.** Roll out commenced across cohorts 1&2. Full rollout expected within 18 months of go-live date - rollout currently on suspended due to COVID. Patient pathway review in Medicine and Elderly to review non-clinical ward moves in progress.

City wide OPEL escalation and mutual aid actions.	Discharge to assess process of not fully established	Feed into System level Winter Review meeting
Maximum utilisation of community care beds and Early Supported Discharge models.	Patients under 60 years old are unable to access current CCB and D2A community beds.	Decision making workstream to continue to implement work plan and wider actions/recommendations to be monitored through Systems Resilience Assurance Board. Hospital discharge service policy and operating model issued on 21st August 2020, clear “must do’s” for all providers in a Health & Social Care system. Streamlined electronic referral mechanism was implemented on 2nd November 2020 for patients requiring Community services on discharge . New Discharge to Assess bed capacity has been introduced to support patients requiring rehabilitation or convalescence following a hospital admission.
Additional capacity in partnership with Villa care to provide a ward capacity on Beckett Wing in times of extreme demand	Ability of private providers to deliver the required care packages to enable early transfer for patients from a hospital setting.	Escalate patient flow concerns through weekly ODG / Operational Winter Group. **Weekly**

CRRP 6: Unsustainable levels of medical outliers and patients waiting in non-designated areas	C = 5 L = 3	15	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
							Target Score						Current Score		Initial Score	

Risk Description:	
Risk of patients being cared for in non-designated areas, high number of outliers in wards and overnight admissions to Surgical Assessment Unit (SAU), caused by demand outstripping available capacity and reduced outflow from the acute bed base. This can lead to poor patient outcomes, poor patient experience increased out of hours transfers and a failure to comply with national performance standards (e.g. ECS compliance and Last Minute Cancelled Operations).	**Executive Lead:** Chief Operating Officer **Date added to CRR:** May 2015 **Last reviewed:** April 2021 **Committee reviewed at:** Finance & Performance Committee

Controls	Gaps in Control	Further Mitigating Actions:
CSM status reports and operational response guidance in place - Bronze, Silver and command escalation process.	Community / partner provider access and capacity e.g. Social Worker Assessment, Package of Care, delays in accessing Community Beds.	Early identification of patient's no longer requiring inpatient care and implementation of a central community point (SPUR) where patients are clinically triaged to care environment to support their care needs.
Demand prediction model established and winter plan matched against key pressure points in line with PHE information on Covid predictions. Decision Management Tool in place including options for extremis, subject to silver command decisions.	Estate capacity/ workforce availability	Unplanned care Board established with associated Winter and discharge tactical group established with 2021/22 actions and updates raised and agreed through this forum. Operational Response Guidance Decision management tool for Adults and Children's services updated October 2020 and will be re-reviewed in October 2021.
Operational Response Guidance developed and early escalation of risk of patients being care for in NDAs through to the on-call teams.	High numbers of MOFD / Super stranded patients within LTHT.	Decision Management Tool forms part of operational response guidance to be updated reflecting learning from previous winter and Covid surge - October 2021
Continued focus on ambulatory models and Same Day Emergency Care offer to ensure admission avoidance	Continue with high numbers of Super stranded / MOFD patients within hospital	Systems level trajectories agreed and actions agreed to deliver reduction in super stranded

wherever safe and possible to do so. Daily consultant ward rounds across all CSUs.	bed base. (Currently achieving required trajectory as a result of COVID response - monitor sustainability through recovery period)	numbers. LIM work on SAU to further enhance ambulatory models of care. Enhanced surgical cover in place.
CSU surge plans in place.		
Dedicated medical ward team to provide consistency of cover to patients being cared for outside of the traditional ESM bed base. Redesign of outlier process and model to concentrate medical patients outside ESM traditional bed base in agreed hubs across site.	Winter pressures / Nurse staffing/infection outbreak pressures resulting in loss of bed capacity and high bed occupancy rate.	Winter Gannt Chart initiatives as per Operational Response Guidance in place. Risk Assessment Decision Management Tool developed for ‘in extremis’ decision support. Operational response guidance to be refined to reflect learning from previous winters and Covid first surge. Refreshed Operational Response by October 2021
Additional bed capacity in place with private provider.	Ability of private provider to sufficiently staff capacity.	System level super stranded patient reduction required in order to reduce reliance upon bed capacity within acute trust. Improvement trajectory in place. Work with system partners to ensure sustainability during and post Covid.
Continued system level work to strengthen community models and allow maximum utilisation of Community services including Virtual ward for Frailty and Discharge to Assess Community Care Beds.	Younger adults are unable to access all community discharge pathways.	Implementation of new National Discharge guidance. System partners to maintain Discharge to Assess bed capacity beyond government funding which ends on 31st March 2021. Criteria for the Virtual Frailty ward to be reviewed.
NHS England/Improvement - Alliance 16 programme being launched in March 2021 with a focus on reducing length of stay for patients through focusing on Reasons to Reside implementation, Criteria Led Discharge and expected date of discharge.	Development work will be required to implement an electronic form for Criteria Led Discharge.	Quality Improvement Programme and faculty has been established to implement the Reasons to Reside Project Trust wide, with expected launch in April 2021.

Model for delivering patient flow to be reviewed, with centralised models initially being trialled at the LGI and then consideration being made for the SJUH patient flow model.	Nurse staffing pressures can result in Patient Flow Co-ordinators being required to cover wards, particularly out of hours.	Operations Centre fundamental review to take place in April 2021 to define the roles and responsibilities for the function. Review of Leeds Adult Clinical Pathways document to be completed to ensure direct admission rights from the ED and between specialty bed-bases.

Risk CRRP7: Patients waiting over 52 weeks for treatment across a range of services.	C = 4 / L = 4	16	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
									Target Score					Current Score	Initial Score	

Risk Description:
There is a risk that patients may have excessive waits for treatment as a result of constraints on activity imposed as part of the response to COVID-19. In some specialties waiting times are likely to exceed 52 weeks for outpatient pathways in addition to those on admitted waiting lists.

This may result in a poor experience for patients, significant external scrutiny and reputational harm through media coverage. There has previously been the risk that fines would be imposed or payments required to release additional capacity internally or from other providers.

Executive Lead: Chief Operating Officer

Date Added to CRR May 2015
Last reviewed date: April 2021

Committee reviewed at: Finance and Performance

Controls	Gaps in Control	Further Actions Planned:
Prioritisation of waiting lists in line with Royal College guidance identifies patients at most risk of harm from long waits enabling prioritisation of priority.	None	Previously undertaken in October 2020 and December 2020, further clinical validation of the admitted PTL is underway to assess categorise patients into priority groups, and now documenting this within the PAS system. This can be used to assess the services who require further capacity to treat clinically urgent/priority patients in a more timely manner. Clinical validation is due for completion by 16 March 2021.
Recovery planning recognises the need to deliver capacity for long waiting patients.	None Due to priority being given to P1 and P2 patients, we have not been able to treat our longest waiting P3 and P4 due to constraints in capacity.	Development of flexible phased plans to deliver additional capacity. Service Delivery Contract's currently being developed at CSU level which will include focussed KPI on reducing longest outpatient waits - this will be monitored on monthly basis.

Additional theatre and inpatient bed capacity may be provided by re-allocation of theatre sessions and bed capacity to those with longest waits	Existing surgeons must be allocated to cover additional sessions, which can stretch teams if more sites need cover. Reallocation of capacity may result in growing waits in other services.	Potential use of IS capacity to deliver additional theatre and bed capacity - As of 1st April, under the new national Independent Sector contract, the IS is accepting LTHT patients to be treated within their own capacity. These patients are Priority 3 and Priority 4 long waiting patients.
Additional outpatient sessions are relatively easy to schedule and outpatient waiting lists can reduce quickly if clinicians are available	Social distancing rule may result in less efficient use of outpatient capacity	Roll out of new working models (eg virtual reviews) can deliver additional capacity. Service Delivery Contract's currently being developed at CSU level which will include focussed KPI on reducing longest outpatient waits - this will be monitored on monthly basis
Established arrangements in place to allow additional outpatient and inpatient activity to be scheduled outside normal working hours.	Relies on staffing throughout overtime and additional hours.	
Independent sector capacity used to deliver activity where possible	Providers in Leeds deliver activity using LTHT surgeons increasing risk of burnout. Capacity outside Leeds has failed to deliver significant capacity with high rejection rate and may be required by local Trusts.	As of 1st April, under the new national Independent Sector contract, the IS is accepting LTHT patients to be treated within their own capacity. These patients are Priority 3 and Priority 4 long waiting patients.

<table>
<tr><td rowspan="3">Risk CRRP8: Patients waiting longer than 6 weeks following referral for diagnostics tests</td><td>C = 4</td><td rowspan="3">16</td><td colspan="3">Very Low Risk</td><td colspan="3">Low Risk</td><td colspan="2">Medium Risk</td><td colspan="2">High Risk</td><td colspan="4">Significant Risk</td></tr>
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<tr><td></td><td></td><td></td><td></td><td></td><td></td><td>Target Score</td><td></td><td></td><td></td><td></td><td>Initial Score & Current Score</td><td></td><td></td></tr>
</table>

Risk Description:
There is a risk that the Trust has more than 1% of patients waiting more than 6 weeks at month end following referral for the defined basket of 15 tests against this standard.
During wave 1 of COVID-19, there was a significant growth is diagnostic backlog as all routine work, other than urgent, was suspended. This backlog has been significantly reduced since the recovery restart in June 2020, however capacity remains at approximately 85% of normal levels and is expected to remain at this level throughout the remainder of 2021/21.
Performance will therefore remain challenging due to reduced levels of activity and increased levels of COVID-19 admissions requiring higher levels of IP diagnostic provision than previously seen.

Executive Lead: Chief Operating Officer

Date Added to CRR: May 2014
Last reviewed: Dec 2020

Committee reviewed at:
Finance & Performance

Controls	Gaps in Control	Further Actions Planned:
Weekly review of current diagnostic operational pressures alongside daily COVID19 status - providing the ability to review current position and inform decision making processes on levels of activity that continue to be delivered.	Unexpected levels of demand (resulting in cancellations of diagnostic activity)	Continuation of weekly review of operational status - staff will be reallocated as necessary.
To support operational pressures across the organisation, diagnostic inpatient activity will be prioritised.	Unexpected levels of demand . Outpatient activity may be reduced or cancelled if required which may impact on diagnostic backlog position	Weekly review of operational status will be continued.
Weekly Tactical meetings now moved to monthly as position is stable -to manage process during lockdown and recovery in place, chaired by ADOP with clinical input from all CSUs.	Data available to all diagnostics teams is not the same, with limitations in data from some clinical systems (e.g. CRIS and Cardiobase) to support management and recovery planning. Support from IT is constrained to support better data production.	Will review options available as part of Endoscopy and PAS system upgrades.
Weekly Diagnostic month end breach prediction	Unexpected levels of demand may result in	Weekly monitoring of position and supporting

process continues to be in place.	activity being reduced or cancelled to support increased in COVID-19 admissions and reallocate resource.	actions re- instated.
Diagnostic Improvement Board in place with key workstreams for all 4 major diagnostics services agreed.	Diagnostics Improvement Board has been suspended during wave 1+ 2 of COVID-19 response.	Diagnostics Improvement board has been replaced with Diagnostic Recovery Board Opportunities identified as part of previous Diagnostics Improvement Board work will be fed into recovery action planning where appropriate.
Equipment replacement programmes agreed for MRI, CT and Cath Laboratories during 2020/21. 1st phase commenced for MRI and CT. Radiology PACs system upgrade planned for November 2020	Impact of plans being progressed on Diagnostic recovery if mitigating action plans do not align. Lack of any capacity may impact on any 2nd surge COVID -19 recovery actions required.	Cath Laboratory and MRI replacement plans progressing during 2020/21. Mitigation plans for capacity lost in place with other providers/ extended hours. PACS update completed successfully in early November giving increased system robustness.