The Leeds Teaching Hospitals NHS Trust

CORPORATE RISK REGISTER

January 2022

Summary Corporate Risk Register January 2022

New 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	Page No.
Workforce Risk									
		Workforce Supply Risk						*Cautious*	
CRRW1	CRRS1	Inadequate nurse staffing levels	May 14	Chief Nurse	16	Aug 21	Feb 22		5-7
CRRW2	CRRS2	Insufficient Medical Staff to deliver service	May 14	Chief Medical Officer	16	Oct 21	Apr 22		8-9
		Workforce Deployment Risk						*Cautious*	
CRRW3	CRRS20	Delivery of the Leeds & West Yorkshire Vaccination programme	Dec 20	Chief Medical Officer	16	Jan 22	Feb 22		10-14
Operational Risk									
		Business Continuity Risk						*Cautious*	
CRRO1	CRRS6	Risk of a viral pandemic	May 18	Chief Operating Officer	15	Sept 21	Mar 22		15
CRRO2	CRRS11	Power failure/lack of IPS/UPS resilience due to electrical infrastructure	Aug 15	Director of Estates & Facilities	16	Jan 22	Jul 22		16-18
		Health & Safety Risk						*Minimal*	
CRRO3	CRRS4	Harm due to clinically related behaviours that challenge linked to organic, mental health or other reasons	May 15	Chief Nurse	15	Dec 21	Jun 22		19-22
CRRO4	CRRS17	Staff Health, Safety and Wellbeing During the COVID-19 Pandemic	Jun 20	Director of Human Resources	20	Jan 22	Feb 22		23-30
		Information Technology Risk						*Cautious*	
-	-	-	-	-	-	-	-	-	-
		Change Risk						Cautious	
CRRO6	CRRF3	Risk relating to commercial pressures arising from delays in delivering the refurbishment of the Generating Station Complex (GSC) at LGI	Oct 18	Director of Estates & Facilities	16	Jan 22	Jul 22		31
CRRO7	CRRF4	Risk of failure to deliver the hospital of the future project.	May 20	Director of Finance	20	Nov 21	May 22		32-38
CRRO8	CRRF5	Risk of failure to deliver the pathology project.	May 20	Director of Finance	16	Nov 21	May 22		39-43
CRRO9	CRRF6	Risk of failure to deliver the LGI Site Development Project	Nov 21	Director of Finance	16	Nov 21	May 22		44-48
Clinical Risk									
		Infection Prevention & Control Risk						*Minimal*	
CRRC1	CRRS3	Healthcare acquired infection	Mar 19	Chief Nurse	16	Aug 21	Feb 22		49-52
		Patient Safety & Outcomes Risk						*Minimal*	
CRRC2	CRRS16	Risk of re-commencing normal activity levels due to reduced capacity (COVID-19)	Jun 20	Chief Operating Officer	20	Jan 22	Feb 22		53-56
CRRC3	CRRS21	Patient harm – falls and hospital acquired pressure ulcers (COVID-19)	Mar 21	Chief Nurse	16	Sept 21	Mar 22		57-58
CRRC4	CRRP1	Failure to achieve Emergency Care Standard	May 14	Chief Operating Officer	20	Jan 22	Jul 22	ED LGI	59-61

CRRC5	CRRP2	18-week RTT target non-compliance	May 14	Chief Operating Officer	20	Dec 21	Jun 22	Ophthalmology / Cardiac Surgery	62-65
CRRC6	CRRP3	62-day cancer target	May 14	Chief Operating Officer	16	Dec 21	Jun 22	MDT & Pancreatic Breast Only	66-69
CRRC7	CRRP4	Failure to achieve 28 day cancelled operations target	May 14	Chief Operating Officer	16	Sept 21	Mar 22	Cardiac	70-72
CRRC8	CRRP7	52-week RTT target non-compliance in spinal injuries and colorectal services	Oct 18	Chief Operating Officer	16	Dec 21	Jun 22	Neurosciences	73-77
CRRC9	CRRP8	Patients waiting longer than 6 weeks following referral for diagnostics tests	May 14	Chief Operating Officer	16	Jan 22	Jul 22	Breast cancer	78-79
		Capacity Planning Risk						*Cautious*	
CRRC10	CRRP5	Patient flow and capacity for emergency admissions (health economy)	Sept 15	Chief Operating Officer	20	Dec 21	Jun 22	MMPS	80-83
CRRC11	CRRP6	Levels of medical outliers	May 15	Chief Operating Officer	15	Oct 21	Apr 22		84-86
Financial Risk									
		Financial Management & Waste Reduction Risk						*Cautious*	
CRRF 1	CRRF 1	Failure to deliver the financial plan 2021/22	May 14	Director of Finance	15	Nov 22	May 22		87-89
External Risk									

Corporate Risk Register - Key

Risk Type		
Risk Category (*Colour coded for risk appetite level)*		
CRR 1	CRR1	Individual risks

Risk Appetite Scale

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

Risk Score

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

CRRW1: Registered Nurse Staffing levels may not meet safest possible standards	C = 4	16	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
	L = 4								Target Score					Current Score	Initial Score	

Risk Description:
Inability to recruit to 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: Aug 2021

Committee reviewed at:
Workforce Committee

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. Increase in nursing turnover post Covid-19.	Recruitment of 340 international nurses through Health Education England (HEE) Global Learning Practitioner programme and international recruitment agencies by August 2021. All recruitment now completed for this cohort. 75 WTE additional international nurses to be recruited by December 2021 to mitigate increase in turnover.
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. Two systems in place, NSSR turned off for St James site and SafeCare professional judgement in place. LGI and CAH still on NSSR.	SafeCare roll out agreed and implementation commenced. Progress and performance monitored by SafeCare project board chaired by the Director of HR. Daily staffing meetings to ensure appropriate distribution of resources chaired by Director of Nursing (Operations). SafeCare professional judgement and NSSR risk assessments reviewed

		and appropriate mitigations put in place.
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. Increased demand for critical care capacity (Level 2/3 beds) in response to Covid-19 and recovery work. High levels of vacancy across ACC.	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. Roster management master classes for ward leaders and matrons to commence September 2021 to improve roster governance. 28 Critical Care trained internationally recruited nurses arrived in March 2021 and registered with the NMC. Remaining 32 nurses arriving in July/August 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. Impact of COVID pandemic has resulted	Adherence to best practice and safer staffing guidance. Nursing Associate deployment reference group commenced to support governance and assurance of new role. Future You programme implemented to create

	in one cohort of Nursing Associates delaying qualification by 6 months (February 22)	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).

CRRW2: 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.
Gaps in training 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.
There are also Consultant vacancies which are very difficult to fill due to a national paucity of trained doctors e.g. paediatric neurology, paediatric palliative care, adult neurology.
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: Oct 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 and these have been recruited to.	Planned new Internal Medicine Training resulted in a loss of capacity and required additional funding to meet the shortfall in workforce as a result. There is limited ability to influence Health Education England. It is unclear how effective future HEE recruitment to the specialty will be which may result in an increased demand on local supplementation of the workforce.	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. Deputy DME overseeing PA undergraduate placement program at LTHT.
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, 23 junior doctors have been appointed since 2019 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	
Discussion with surrounding regional centres to share on call services to provide specialist care e.g. paediatric neurology		
Optimising training exposure for junior doctors whose training has been impacted by the pandemic.	This may impact service provision as affected junior doctors have educational opportunities prioritised in order to meet their training needs.	Use of HEE funded training recovery fund to provide additional resources to support departments deliver this training recovery.

CRRW3: 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, due to

- Staffing
- Infrastructure
- Supply
- Resources to upscale for surge vaccinations

This risk relates currently to one site at the Leeds community vaccination centre at Centenary Pavilion, Elland Road and was then transferred to a new, temporary park and ride site at Elland Road from 29 July 2021

Cross-reference CRRS1 (nurse staffing) and CCRS2 (medical staffing)

Executive Lead: Chief Medical Officer

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

Committee reviewed at:
Quality, Safety and Assurance Group

Controls	Gaps in Control	Further Mitigating Actions
West Yorkshire Vaccination Steering Group in place, overseen by Chief Medical Officer and SRO. A review of governance for the programme was undertaken during August 2021 and it was decided that LTHT will remain as the Lead Provider for the vaccines programme in West Yorkshire.	Available data provision from NHSE/I does not support 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 Leeds community vaccination centre at Centenary Pavilion, Elland Road set out in clinical and operating model (January 2021).	There may not be sufficient HCP staff to meet the demand to consent. Ability to train new staff recruited to the programme could be a constraint if demand returns to a low position following the relaxation of current	Local workforce plan developed, staff recruited to weekly rota from LTHT and partner organisations in health and social care. Staff returned to their parent CSU's and returned could be recalled to support the programme if the city pipeline does not. Training plan implemented for current staff plus new staff coming through the training pod

Nurse Director appointed to oversee programme (December 2020). General Manager and Senior Nurse appointed (secondment) to co-ordinate operational response and delivery (January 2021 At the end of July 2021, the incumbent 8c General Manger left the service and two service managers recruited have been acted up to 8b General Manager roles; one to lead operationally the vaccination programme at Elland Road and associated pop up hub sites and the other to lead operationally the flexible offer in conjunction with LYPFT into phase three of the programme.	measures. Potential impact of insufficient trained staff being available if demand increases in future weeks due to short notice of increases in demand/vaccine supply. Sufficient staff are trained to split the workforce safely this has been reviewed following the phase two plan and having 4 hospital hubs around the city as a local offer. Using Pfizer as the vaccine requires Preparation and assembly of medicinal products requires professional registrant support. A clinical supervisor[1], who must be a registered doctor, nurse or pharmacist trained and competent in all aspects of the protocol, must be present and take overall responsibility for provision of vaccination under the protocol at all times and be identifiable to service users. The final dilution and drawing up of the vaccine has its own supervision requirements in accordance with Part 1 of the HMR 2012 and will need to be done by, or under the supervision of, a registered doctor, nurse or pharmacist. If a vaccination service is being provided at scale, the clinical supervisor should	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 on-going 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. All sites will be led by a minimum band 6 nurse.

	only take on specific supervision requirements in relation to the dilution and drawing up of the vaccine if this can be done safely alongside their overarching role. There is the potential for an oversupply of staffing if-phase three of the vaccination programme results in significant fluctuation in demand. Dependent on the models adopted by PCNs are delivered during phase 3 the main VC and hubs could be left short.	All requests are to be directed to the Workforce lead and discussed at the senior workforce call and the Steering group.
Significant numbers of staff have been recruited either to flexible contracts guaranteeing a minimum number of hours per week or bank contracts to maximise flexibility.	Staff may decline shifts at key periods (school holidays) or if asked to work from less desirable sites	Staffing deployment plan developed by corporate nursing team (December 2020), including volunteer shifts. Daily management by deployment team. Use of flexible / ad-hoc / volunteer (substantive NHS) staff has been reduced as more contracted staff have completed on-boarding.
Staff leaving no-one behind vaccination plan and boosters (Phase 3).	Lack of clarity on scope and timing of Phase 3 presents significant challenges to planning the Booster programme	Staff vaccine and booster plan will be developed, including time allocation to release staff from clinical duties, utilising out of hours/shifts. Staff booster programme due to commence 29/09/21 -

		vaccine to be administered at least six months from second dose will be Pfizer.
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. Plan for clinical and quality responsibilities previously held by Leeds providers to be moved to vaccine programme reporting into LTHT board structures.
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). Pfizer vaccine available (December 2020) 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. Vaccination centres can now hold three Vaccines on site. However, can only use two on site in any one day. School children aged between 12 - 15 years from October half term are now able to access a booked appointment and walk in service at Elland Road. This is part of the evergreen programme ensuring those who missed having their vaccination in school have a	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 All vaccine is allocated at national level and only within the gift of place teams when it arrives.	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. SRO Leeds place currently working with national colleagues to close the shortfall. Moderna is currently being used at Elland Road for adult 1st and 2nd doses with Pfizer administered to 12-18 year olds. • Queue management provided by professional security team • Separate entrances for different vaccines + expected dose.

further opportunity. The vaccine administered is Pfizer. Assurance was provided to SVOV following checklist completion.		• 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.

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

Risk Description:
There is a risk that the Trust may have to invoke its Emergency Response Arrangements due to a viral pandemic (e.g. influenza or COVID-19) causing the absence of significant numbers of Trust staff and large increase in demand which could overwhelm the Trust's ability to deliver routine care and result in potential fatalities and significant financial loss.

Executive Lead: Chief Operating Officer

Date added to CRR: May 2018
Last reviewed: Sept 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.
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. New BC strategy was approved by the Emergency Preparedness Coordinating Group in May 2021 and is being implemented. An audit of CSU BCPs will be undertaken in November 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

CRRO2: Power Failure due to Electrical Infrastructure/lack of IPS/UPS resilience	C = 4	16	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
	L = 4		1	2	3	4	5	6	8	9	10	12	15	16	20	25
						Target Score								Current Score	Initial Score	

Risk Description: There is a risk of power failure at a Trust site (ward or clinical area)

Due to failure to comply with HTM 06 01 caused by outdated electrical infrastructure and the absence of complete IPS/UPS resilience in Clinical Category 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 2022

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 done when power interruptions occur but	The handbook is reviewed annually.

	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 1-8 have been connected to the system in 2020/21. Theatre 9 has UPS but is not connected to the central system and is scheduled to be connected before it is due for lifecycle replacement.	Although the UPS/IPS infrastructure has been installed (£600,000) to support Geoffrey Giles Theatres 1 to 8 and Recovery the final connection and rewiring of Theatre 9 & Recovery is still required. If there is a power failure within these theatres the only system with inbuilt battery back-up are the Operating Lights.	Capital investment is required to connect the available IPS/UPS infrastructure Theatre 9 & Recovery in Geoffrey Giles Theatres~~,~~ was planned for 2021/22 due to access restrictions now looks to be delayed into 22/23.
Some areas (e.g. J54) 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 of electric shock and provide increased	IPS should be installed to all clinical category A areas in-line with HTM 06-01 when areas are refurbished. Awareness of the electrical shortfalls in UPS and IPS provision in clinical

	local electrical resilience.	category Grade A areas is required, electrical action cards have been provided by Estates to Clinical, this will be reviewed 6 monthly.
UPS/IPS systems have been installed in a number of clinical category A locations including those detailed above in Geoffrey Giles (theatres 1-8); Cath Labs 3 & 4; Jubilee Wing MRI; 2no. Clarendon Wing B Floor NHS MRIs; Theatre 17 Jubilee Wing; Theatres 1 & 2 CAH. L43 Neonates (Clarendon Wing); Maternity Theatres & Recovery (Gledhow Wing) and ARCU (Gledhow Wing) have being upgraded and fitted with compliant UPS/IPS systems in 2021. IPS has been installed in J1 (Neonates SJUH) in 21/22.	There are still a number of Clinical category A areas without UPS/IPS systems.	£200K in programme for UPS/IPS installs in years 22/23, 23/24 and 24/25, the priority order for which is under review between Estates and Clinical teams. Intending to order IPS for J54 in Dec 2021 for installation when access is available.

CRRO3: Harm due to clinically related behaviours that challenge linked to organic, mental health or other reasons	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 of inconsistent responses to patients at risk of clinically related challenging behaviour; leading to agitation/aggression/violence resulting in physical harm to patients, visitors and staff. The result is the potential for a fatality, serious harm or litigation against the Trust.

Executive Lead:
Chief Nurse

Date Added to CRR: July 2019
Last reviewed: December 2021

Committee reviewed at:
LTHT MHLSG

Controls	Gaps in Control	Further Mitigating Actions
Policy for Conflict Resolution (Reducing violence and aggression in the workplace) and establishment of Security Co-ordinators.	Concern that the policy is not being put into operation across all patient areas- in particular that the environmental and patient specific risk assessment tools are not being completed and used to inform risk reduction plans. Policy currently under review- extended until Jan 2021	Conflict resolution policy currently being reviewed by newly formed Challenging Behaviours/V&A Prevention and Reduction Steering Group . Planned for approval Jan 2021 Additional Trust wide communication to raise awareness and information on updated Trust Conflict Resolution Policy
Restraint and Restrictive Intervention Policy includes detailed practical guidance on prevention strategies and de-escalation strategies Restraint Care Plan bundle rolled out trust wide. Restraint Care plan bundle added to latest version of Restraint Policy as a mandated staff action	2021/22 Q1 restraint audit identified gaps in staff knowledge in relation to the guidance on prevention and de-escalation strategies Some evidence that the Restraint Care plan bundle is not yet being used for all patients who meet the criteria-	October 21 - Restraint Audit reported to CEOG meeting in October with action plan and recommendations - Restraint Quality & Safety Matters produced Signposting/Comms to front line staff regarding guidance available cascaded again following the

	potential risk to safety if proportionate restriction/restraint not being used and monitored; also potential risk of disproportionate restraint/restriction being used without monitoring	Audit RFC request for developing E-form version of Restraint Care plan in response to audit feedback
Enhanced Care Procedure in place	Wards report that they struggle to fill 1:1 enhanced care shifts frequently. Gaps identified in the skill mix for enhanced care provision	Awaiting Trust Board approval for increase in funded establishments for additional clinical support workers. Croma service have faced significant recruitment problems during Q3 but a specific recruitment drive is in place during Q4 to address this issue Mental health trained Clinical support worker agency commissioned to provide 1:1 enhanced care in SJUH ED and acute medical admissions wards.
24/7 service provision from Liaison Psychiatry service now meeting PLAN standards and Acute Liaison Psychiatry service 1 hour response in ED implemented	ALPS service currently only partially co-located on hospital site	Consultant Psychiatrist now whole time equivalent in ALPS service
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. 12 high volume areas involved in QI with support from expert faculty members	Covid and capacity issues 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. A variety of local interventions, initiatives and metrics continue to be tested across pilot areas and are having a clear positive impact on staff knowledge/skills and are beginning to contribute to a reduction in incidents recorded across pilot areas 6 month trial of dedicated RMN support to acute medical admissions wards from December 2021

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.	Camhs in-reach referral pathway redesigned / camhs Crisis team resource increased and now includes section 12 approved Doctor with responsibility for MHA assessments on LTHT wards. CAMHS representatives now identified for strategic / operational governance meetings. Medical and Consultant Psychiatry enhanced support agreed for camhs patients who remain inpatient for more than 6 days.
	CAMHS Crisis team do not have write access to PPM+ in order to ensure timely visibility of their assessments	Head of mental health legislation for LTHT has contacted CAMHS Crisis Team manager and is supporting them to complete the relevant access request forms and process - expected completion Dec 2021
	Nationally and regionally, there has been a surge in demand for specialist Tier 4 mental health inpatient beds for children and young people (CYP). We are currently seeing an increase in demand of up to 1/3 compared to pre Covid times.	Model for care of children and young people in crisis who are inpatients in acute trusts issued October 2021 including NHSEI escalation process
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 De-escalate training commissioned for 2 levels of training: E learning (Linus) and face-to-face de-escalation and safe	Currently not mandated across medical and nursing staff or linked to a training needs analysis (TNA) Current restrictions in place regarding face-to-face training	Face-to-face De-escalation training commissioned from GoodSense. Sessions delivered across acute admissions wards. CAG Agreement now in place to open up sessions to all De-escalate QI pilot areas over

restraint (GoodSense)		next few months starting from Nov 2021
	E-learning De-escalate package from Linus not yet delivered	Amendments made to draft Linus e-package and expected to be available through ESR/OL from December 2021
	Front line nursing staff not currently trained to use safe holding or physical restraint with patients who may need these techniques in order to deliver care safely.	Corporate Nursing Team have now developed Nursing TNA that includes core skill re mental health
	Specific face to face training has been commissioned to begin to address this gap but this has been postponed following decision by CAG regarding the infection risks related to Covid.	Leeds Survivor Led Crisis Service have now delivered 12 sessions on managing self-harm /suicidal ideation - next phase to evaluate/review and roll out another block of sessions from January 2022
Clinical guideline - Use of Rapid Sedation/Rapid Tranquilisation in place and linked to appropriate Polices/procedures	Current guideline only covers adult patients	Development of similar guidance for children/young person's in development to complete Q4 2021/22
LD and Autism Team has been temporarily expanded. The temporary structure allows for all flagged patients to receive a face to face review within two working days (previously 5%). The temporary structure also allows for the development of reasonably adjusted pathways and increased training of the LTHT workforce	The current structure has only been agreed until May 2021, at which point the LD and Autism service will return from 8.5 clinicians to 3 unless further funding is identified.	The benefits of the current LD and Autism Team structure, and the risks if this cannot continue, will be considered by the Associate Director of Nursing in December 2021.

CRRO4: Staff Health, Safety and Wellbeing During the COVID-19 Pandemic	C = 4 L = 5	20	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
									Target score						Initial & Current 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 stop staff contracting COVID at work and to support staff while under extreme pressure, 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:** Jan 2022 **Committee reviewed at:** Workforce Committee and Infection Control Committee

Controls **Note the controls listed are based on the sections of the "Leading health and safety at work Actions for directors, board members, business owners and organisations of all sizes" (hse.gov.uk)**			**Gaps in Control**	**Further Mitigating Actions**
Preventing the spread of covid in work	Strong and active leadership from the top	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.		
		A deep dive into this risk took place in Nov '21, using HSE guidance as a framework Leading health and safety at work. Actions for directors, board members, business owners and organisations of all sizes (hse.gov.uk)		
	Worker involvement	Individual COVID Risk Assessments are in place for staff in at risk groups,	The controls in the risk assessments require regularly	They were reviewed by CAG in Nov '21.

		including BME, CEV and pregnant staff which are undertaken by staff in partnership with their line manager.	updating to respond to any changes in national or local guidance. The Individual COVID Risk Assessments require updating when there are any changes to a staff member's health or working conditions.	Coffee mornings for CEV staff are held monthly to update them on any changes to current guidance. They are also reminded to regularly review their risk assessments. Support and guidance is available from OH and HWB teams. Staffing Assurance Framework for winter 2021 preparedness has been reviewed – all controls are in place with one gap. Updated LTHT COVID individual risk assessment guidance to add need to complete before a member of staff is redeployed. Change to be communicated.
		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. Regular consultation with staff representatives.		
		Covid vaccination - LTHT is implementing the Vaccine as a Condition of Deployment regulations, which come into force on 1st April 2022.	Process for managing staff who are medically exempt from vaccination Some staff have not yet had their vaccine.	Develop a Medical Exemption Risk Assessment for medically exempt staff by Feb 22 to manage the risks to patients and colleagues. Weekly communications encouraging uptake and providing information on how to get the vaccine. Weekly pop ups on site to facilitate staff to their vaccine. From January 21, data from NIMs will be used to identify staff who have not had the vaccine, to manage those who decide not to have it using the Leeds Way.
		Flu vaccination – all staff are supported to have their flu vaccine.	Some staff may not yet have had their vaccine.	Weekly communications encouraging uptake and providing information on how to get the vaccine.

				Weekly pop ups on site to facilitate staff to their vaccine.
		Staff testing is available to ensure staff who are COVID positive do not attend work.	Staff may not be able to access community testing services due to demand.	Staff testing reinstated in December ’21 to increase availability for frontline staff.
	Assessment and review	Covid Workplace Assessments are in place for clinical and non-clinical areas.	The assessments need regular review to ensure all controls are being followed.	Regular reissue of the workplace assessments, last reissue in Nov ‘21
		Covid Workplace Assessments are included in the annual Health and Safety Controls Assurance process to ensure they are completed.	There is no interim assurance outside the annual process to reflect changes to workforce, guidance or working practices.	Identify the assurance mechanism by January ’22
		CSU Infection Prevention and Control Board Assurance Framework undertaken in 2021 and reviewed in December 2021 to ensure all IPC and clinical guidance, including travel advice (added in Dec 21), is followed in clinical areas. Review in Dec ’21 included assessment of new Covid variants and changes were made to controls as a result.	Needs regular review to reflect national guidance.	Review quarterly and when national guidance changes.
		The Board Assurance Framework is reviewed within CSUs by Each Head of Nursing with the Deputy Director of Infection Prevention (DDIPC) and the Director of Nursing for Operations to review and where gaps are identified,		

		mitigations registered. The overview of this is through Operational Infection Prevention Committee (OIPC).		
		An internal audit was undertaken into the effectiveness and impact of the Individual Risk Assessment process during Aug ’21.		Final report complete. Outcomes to be reviewed by Audit Committee in Dec ’21. Implementation of recommendations to be assured by Workforce Committee.
		Day 5 negative PCR release from isolation for household contacts implemented November 1st 2021. Risk assessment panel providing quality assurance process for negative staff returned.		Regular review undertaken by CAG in light of changing national context including COVID numbers and guidance.
Keeping staff well at work whilst under extreme pressure	Strong and active leadership from the top	Commitment from the Board to deliver the health and wellbeing strategy, which is focused on three key areas of support, engagement and recovery.	Same commitment may not be happening at CSU level.	HWB team are supporting CSUs with clear expectations and programme of activity. All CSUs should have a HWB plan by the end of March ‘22
		Trust commitment to ensuring health and wellbeing is considered as part of reset and recovery planning through the LTHT principles.	Operational pressures, particularly to deliver elective recovery may negatively impact on staff health and wellbeing.	Continuing work to balance integration of service delivery, workforce, financial and quality. We have circa 450 nurses due to be onboarded from September to February ‘22 – we anticipate this will ease

			National discussions are taking place reviewing the principle of no financial detriment for any staff who are absent form work for covid related reasons including self isolation, sickness and covid related anxiety. If removed this may impact on both sickness rates and nosocomial transmissions. The national decision to mandate covid vaccinations for healthcare workers may result in individuals leaving the organisation.	some of the staff pressures. Continue to monitor the national discussions and develop the personalised people management approach to ensure managers can deliver any changes in a positive way, with minimal impact. An implementation steering group has been established to manage the implementation with the least amount of disruption
		Organisational programme of health and wellbeing support including staff clinical psychologists, counselling, train and EAP offer.	Services may not meet staff need.	Peer review into services by March ’22.
		Organisational absence rates are reviewed at Workforce Committee, to ensure that suitable actions are taken to address any increases in absence rates.	Same commitment may not be happening at CSU level. The anticipated increased unavailability of staff as a result of the Omricon variant at the end of December and into	HRBPs review absence rates at JAAF meetings to agree actions at local level. Process agreed where staff will be bought in from annual leave on a voluntary basis.

			January 22.	If necessary we will cancel annual leave and allow staff to carry over additional leave on top of existing policy. Mobilisation of all available resource across the city, including military and retire and return. Mobilisation of resource across the city reviewed daily. Will implement national changes to workforce mobilisation as they come into force e.g. changes to the registrants register. Daily management of safe staffing levels with a risk based approach
	Worker involvement	All staff are supported to work from home wherever possible	Small number of staff who are unable to return to pre-covid workplace due to health issues. Availability on IT equipment can be a limiting factor to remote	The HR team are supporting managers to resolve any issues on a case by case basis however, there are ongoing issues that are exacerbated by the length of the

			working.	pandemic and the impact on service delivery on increased staff unavailability. We are therefore using both personalised people management and MDT approaches to support managers where cases are particularly challenging.
		Programme of health and wellbeing activity to embed support in teams including Mental Health First Aid and HWB Champions.	External issues have slowed the roll out of both programmes.	Agreement to run a train the trainer model as well as programme delivered by Leeds One Workforce for HWB champions so internal capacity can be rapidly built.
	Assessment and review	The new Flexible Working guidance encourages to review approaches to flexible and off site working as a team, to encourage and enable solutions that work for the individual, team and service.	Some managers may struggle to undertake these discussions.	Roll out of the Leading the Leeds Way training, to support managers to build capability to use PPM approaches.
		Social Distancing Group established which now meets in response to organisational need.		

CRRO6: Risk of further delays in delivering the refurbishment of the Generating Station Complex (GSC) at LGI	C =	16	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
	L =		1	2	3	4	5	6	8	9	10	12	15	16	20	25

Risk Description:
The management of this risk is commercially sensitive information which has been removed from the public version of the Corporate Risk Register

Executive Lead: Director of Estates & Facilities

Date added to CRR: Oct 2018
Last reviewed: Jan 2022

Committee reviewed at: Finance and Performance Committee (by exception)

Controls	Gaps in Control	Further Mitigating Actions

CRRO7: Risk of failure to deliver the hospital of the future project.	C = 5	20	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
	L =4										Target Score			Initial Score	Current Score	

Risk Description:

There is a risk that the Hospitals of the Future Project fails to meet its objectives as a result of: delays to the programme due to the New Hospital Programme; increases in costs related to the NHP delays, market conditions, COVID-19 and Brexit; insufficient capital funding for agreed scope and for key additional elements (including digital by design, equipment, net zero carbon, car park); Trust requested and/or NHP Programme imposed changes to specification, design and quality; problems associated with inter-connectivity to existing digital infrastructure; ineffective assurance; inadequate/ineffective stakeholder engagement; and/or delays to the Enabling Works sub-project.

If the project is not delivered, LTHT will: have insufficient capacity to meet service demand and education and training requirements; 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 will not be able to centralise in line with Commissioner requirements; and a lack opportunities to further transform clinical services.

Executive Lead:
Simon Worthington

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

Committee reviewed at:
Building Development Committee

Controls	Gaps in Control	Further Mitigating Actions
Programme Delays New Hospital Programme has assessed the HofF Project and BtLW is responding to its recommendations, for example in relation to OBC scope. Regular liaison between SRO/Programme Director and NHP to understand progress on programme phasing, design standards and procurement strategy. NHP forms a standing agenda item for the Building Development Committee and matters are escalated	Lack of influence over implications and pace of NHP work.	SRO and Programme Director to continue to undertake on-going liaison with key members of the New Hospital Programme on need for clarity on phasing, design standards and procurement strategy.

to the Trust Board as necessary for Chair and Chief Executive action. Programme Director involved in networking with other Pathfinder trusts on a regular monthly basis to understand shared/common and individual issues/ scheme implications. BtLW business cases follow standard regulatory review process for approval of capital projects.		
Funding and Cost Increases New Hospital Programme has assessed the HofF Project and BtLW is responding to its recommendations, for example in relation to OBC scope and cost allowances. Regular liaison between SRO/Programme Director and NHP to understand progress on programme phasing, design standards and procurement strategy. NHP forms a standing agenda item for the Building Development Committee and matters are escalated to the Trust Board as necessary for Chair and Chief Executive action. A Finance Workstream ensures that the financial implications of BtLW's projects are identified and that integrated financial plans are in place. The Workstream monitors performance against the LTFP and Government guidance and reviews financial risks. The BtLW Programme Team undertook a cost review of the Hospitals of the Future scheme in Spring 2021	Through the Finance Workstream, the LTFM is 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.	SRO and Programme Director to continue to undertake on-going liaison with key members of the New Hospital Programme on the financial implications of its review, phasing, design standards, procurement strategy and the suggested need for LTHT to resubmit the HofF OBC with digital and net zero carbon requirements included which will significantly affect affordability. SRO to undertake further discussions with NHS-E&I regarding approach to funding the £8 million shortfall for the Pathology scheme which was suggested to be funded from the HofF contingency provision. External advisers to provide regular updates on known and forecast key policy/design standard changes. Finance Workstream to review and update LTFM twice yearly to capture any financial changes (and identify risks) in costs/income/inflation. Equipment Design Team to refine equipment requirements in consultation with LTHT leads and update the associated forecast costs The MEPH Design Team to develop a more detailed Net

to identify savings and efficiencies which highlighted potential savings of £13.5m. Robust change management/control processes implemented to monitor for design variance against the approved scheduled of accommodation. Regular monthly updates are provided to the HofF Project Board, BtLW Programme Board and Building Development Committee on funding and affordability issues. 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 a robust change control process managed by the Project Board with further assurance undertaken by the Programme Board and Building Development Committee. Following the refresh of the Project risk register with the newly appointed design team, the BtLW Programme Team will complete a financial capital appraisal of the risk register. Key market updates on economic factors are reported to the Project Board, BtLW Programme Board and BDC on a quarterly basis. Financial due diligence reports are completed on key market contractors/suppliers. 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 of		Zero Carbon strategy informed by emerging NHP guidance and complete a detailed options/economic appraisal to inform the decision-making process. BtLW Programme Team to continue to develop the MSCP strategy on options for MSCP delivery drawing upon good practice at other hospitals.

the Business Case will be prior to the FBC submission and, if necessary, the resubmission of the OBC).. Equipment: the Charities Workstream supports work to deliver the charitable funding target of £30m with monthly reporting presented by the Programme Director to the Capital Appeal Board about progress to deliver the Project. A workshop is planned with the Leeds Hospitals Charity and other charity partners to identify fundraising opportunities. 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. An indicative cost assessment was completed as part of the process to prepare the Digital Design Brief. This is being refined and developed with the newly appointed design team. A business case is being developed of funding to support the implementation of the digital hospital. Net Zero Carbon: an indicative cost assessment was completed as part of the process to prepare the Net Zero Carbon and Sustainability Brief. This is being developed and refined with the newly appointed design team and design strategies and options shall be presented for review in accordance with the BtLW governance processes. Multi-Storey Car Park: 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.		

Robust change management/control processes implemented to monitor for design variance against the approved scheduled of accommodation.		
Specification, design and quality The Design Brief/design requirements are seeking, within the constraints of affordability, to deliver a robust, flexible and agile design solution and also build on lessons from COVID-19 experience. Significant clinical engagement completed by the BtLW Programme Team in the development of design briefing documentation. Project Board, Programme Board, Building Development Committee and CSU Strategic leads have signed-off the clinical design briefing documentation. Robust change management processes established and implemented at a project-level. Comprehensive new governance structure implemented for Design Team to oversee and manage the co-ordination of the design development process. Regular dialogue between SRO and Programme Director and key members of the New Hospital Programme around the need for clarity and guidance on standards regarding single rooms, room sizes, structural grids, net zero and digital requirements. A number of key consultants working for BtLW Programme Team are also working on the New	Through the newly establish delivery governance arrangements for the FBC stage, monitor progress around development of the detailed design against the Design Briefing Documentation.	BtLW Programme Team to undertake full assessment of the RIBA Stage 2 Design Response and design recommendations against the Project design briefing documentation. Design Workstreams to continue to assess the design brief, but develop the solution within the communicated affordability constraints. Design Workstreams to identify key design related decision-making milestones and develop and present options/economic appraisals to inform key design decisions, e.g. in relation to net zero carbon, digital, etc. SRO and Programme Director to continue liaison with key members of the New Hospital Programme on need for clarity and guidance on standards.

Hospital Programme, thereby providing a good insight in to the development of various matters.		
Digital infrastructure The BtLW Programme Team 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 identify and align with available funding/ funding strategy.	Additional funding needs to be identified by the Trust to support basic digital delivery.	DIT to develop Business Cases to support future funding opportunities.
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 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	Implement local assurance controls, measures and processes through the BtLW PMO. Following the signing of contracts, undertake a review of supplier assurance processes and procedures/quality plans in connection with the delivery of contracts.	BtLW Programme Team to review and respond to PwC assurance reviews and recommendations (on-going). BtLW Programme Team to monitor services delivered by specialist/professional advisers in terms of the quality of deliverables through Design Team Project Team meeting (monthly), PMG (monthly) and BtLW PMO. Quality Plans have been requested from all newly appointed Design Team Suppliers.

with guidance and to provide further on-going assurance (next formal assurance at FBC stage and/or OBC re-submission/refresh point).		
Stakeholder Engagement The Programme has established a programme-level Communications and Stakeholder Engagement Plan, supported by a specific stakeholder communications engagement plan for the Hospitals of the Future Project, which are aligned to delivery plans. Monthly Communications activities are presented at the Hospitals of the Future Project Board and the Programme 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.	Stakeholder feedback process to be further refined and developed. Stakeholder Engagement Reporting process to Project Boards to be established. Process to be implemented to monitor the on-going impact and success of engagement.	BtLW PMO to develop a Stakeholder Management Database to capture key stakeholder information and support more effective reporting to decision-making bodies. Quarterly Stakeholder Report to be presented to the Project Board.

CRRO8: Risk of failure to deliver the pathology project.	C = 4	16	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
	L = 4		1	2	3	4	5	6	8	9	10	12	15	16	20	25
											Target Score			Current/Initial Score		

Risk Description:

There is a risk that the Pathology Project fails to meet its objectives as a result of: a failure by the Principal Contractor to deliver within the Guaranteed Maximum Price/Affordability; COVID-related delays on progress development of scheme; delays in developing and implementing workforce planning and associated change management plans as well as the delivery of the new Pathology Lab and AHL proposals; tender cost prices increasing more than expected and the impact of any delays to the re-procurement of the Pathology **Managed Services Contract (MSC); ineffective assurance; and/or delays to the Enabling Works sub-project.**

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

Executive Lead:
Simon Worthington

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

Committee reviewed at:
Building Development Committee

Controls	Gaps in Control	Further Mitigating Actions
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	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 31 August 2021).	▪ External advisers to provide regular updates on key policy changes. ▪ Finance Workstream to review and update LTFM twice yearly to capture any financial changes (and identify risks) in costs/income/inflation. ▪ Finance Workstream Lead to report on the LTFM to the BtLW Programme Board so that any actions required, including integration with other services in LTHT, are monitored and escalated as appropriate. ▪ Programme Director/Finance and Commercial Lead to report key market updates on economic

Programme Management Group, BtLW Programme Board and Building Development Committee on affordability issues and also reviewed within workstreams at a project delivery level. 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 of the Business Case will be prior to the FBC submission. Robust change management/control processes implemented to monitor for design variance against the approved scheduled of accommodation. Regular monthly cost monitoring of scheme capital costs. Robust OBC capital cost plan allowances were established as part of the OBC process. A VE register has been established for the new lab scheme with items risk assessed for their impact. Robust cost plan monitoring and monthly cost plan up-dates/reporting. 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		factors to the BtLW Programme Board and financial due diligence reports to be completed on key market contractors/suppliers. ▪ BtLW Programme Team has established a Value-engineering options register.

Programme Board and Building Development Committee.		
Impact of COVID-Related Delays on Progressive Development of Scheme Funding identified for additional Pathology CSU Management posts including a Project Manager role to support capacity.. Funding for additional HR role specifically supporting Pathology Projects agreed to support service managers and operational leads with change management that has an impact on the workforce.	On-going review and monitoring processes.	▪ Workforce Lead/CSU Project Manager to 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 re-procurement established and mapped to New Pathology/AHL facilities. Statements included in the HLIP (for the P22 Contractor) outlining the proposed Equipment responsibilities relating to the management of equipment. Progress monitoring of the New Lab Project and AHL Project and the MSC Project reported and managed through the BtLW Pathology Project Board/Programme Board and BDC – separate governance arrangements for MSC Project linked with WYAAT.	Review MSC Re-procurement Programme following finalisation of the OBC and commencement of procurement to review and revise an integrated programme to support effective management of inter-dependencies.	▪ NEC PM to advise PSCP of equipment procurement timescales and requirements. ▪ Lifecycle to ensure PSCP briefing allows for flexibility around equipment installation. ▪ Review of inter-dependencies of programmes as part of MSC approvals process.

Tender Cost Price Inflation Early market testing (during pre-construction) to be carried out with Contractor to ascertain likely out-turn cost of key components and packages. Baseline reasonable market assumptions have been included within the baseline OBC Cost Plan. Some allowances for inflation have been included in the baseline OBC Cost Plan, although current reports significantly exceed budgeted allowances. Continue to retain market inflation under review - prepare quarterly inflation updates. Tendering of work packages and affordability checks currently being completed ahead of the return of the GMP proposed for 31 August 2021. Development and implementation of VE and cost mitigation register.		▪ Whilst DHSC has permitted some allocated funding from the Hospitals of the Future Project to support the DHSC underfunding for the Pathology Project, the projects are being effectively de-coupled to minimise any risk to programme – funding continues to remain supported.
Assurance The Trust has implemented a robust programme assurance framework for the delivery of the BtLW Programme and specifically 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	Implement local assurance controls, measures and processes through the BtLW PMO. Following the signing of contracts, undertake a review of supplier assurance processes and procedures/quality plans in connection with the delivery of contracts.	▪ BtLW Programme Team to review and respond to PwC assurance reviews and recommendations (on-going). ▪ BtLW Programme Team to monitor services delivered by specialist/professional advisers in terms of the quality of deliverables through Design Team Project Team meeting (monthly), PMG (monthly) and BtLW PMO. Quality Plans have been requested from all newly appointed

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). 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 and/or OBC re-submission/refresh point).		Design Team Suppliers.

CRRO9: Risk of failure to deliver the LGI Site Development Project	C = 4	16	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
	L = 4		1	2	3	4	5	6	8	9	10	12	15	16	20	25
											Target Score			Initial & Current score		

Risk Description:

There is a risk that the LGI Development Site Project fails to meet its objectives as a result of: delays to the delivery of the HofF Project; failure to reach decision on the approach to addressing the future actions associated with the tunnel/ A58 ring road and failure to resolve the allocation of tunnel obligations between parties; site constraints reducing the level of developer interest; failure to secure a contractor to develop the site on offer; a strategic misalignment with other research and innovation initiatives in the Leeds City region; a failure to instil a culture of innovation within the Trust; failure to receive, or delays in, external approvals if required; Covid-19 precipitating a fall in property values; uncertainty associated with the NHP requirement for E&T to be addressed in the updated HofF OBC (potential reinstatement of need for sale value to cover cost of E&T); potential misalignment of Family Accommodation with site viability and potential need for cross-subsidisation, E&T funding and location and NHP's expectations).

If the LGI Development Site Project does not meet its objectives, LTHT will be unable**:** to contribute as expected to the Leeds Innovation District; support the city's economic regeneration; be unable to dispose of surplus buildings. The Trust would continue to incur on-going maintenance costs.

Executive Lead:
Simon Worthington

Date Added to CRR: May 2020
(Removed from CRR Nov 2020)
Re-added back to CRR: Nov 2021
Last Reviewed: Dec 2021

Committee reviewed at:
Innovation District Committee

Controls	Gaps in Control	Further Mitigating Actions
Assurance A robust programme and project delivery governance and controls framework is in place to support the delivery of the LGI Development Site Project objectives involving key stakeholders within the Trust. A new committee has been formed (Innovation District Committee) focused on the delivery of the LDS Project. An annual audit of governance arrangements was		LDS Project Team to review and respond to PwC assurance reviews and recommendations (on-going).

completed in January 2021, linked to an update to the PEP, and approved by BDC in February 2021 with a mid-year review of PEP in August 2021 and annual review to be undertaken in Dec 2021.		
Finance 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 NHSEI, DHSC and HMT to ensure compliance of financial plans with appropriate guidance and liaise as necessary with regulators.		
Business Case Business cases are being developed aligned to the HMT 5 Case Model. The SOC was completed outlining key benefits, objectives, risk, finance requirements, and economic options. SOC has been submitted to, and reviewed by, NHSEI. Specialist advisors have carried out a review of possible options for the site and reviewed market assessment options/potential. The Project Team will develop a robust OBC stating a clear case for the approach to the regeneration of the	Identification of NHS regulatory requirements for scheme completion. NHSEI Joint Investment Committee has indicated that it will not receive the SOC at this stage. DHSC has not reviewed the SOC due to link with NHP.	SRO and Programme Director to continue liaison with key members of the NHP on the business case progress and the treatment of proceeds from surplus land.

Leeds Development Site. The OBC outlining key benefits, objectives, risk, finance requirements, and economic options is planned for completion by January 2022 or an internal Trust business case will be produced to the same timescale. Members of project team/workstream leads to continue work to develop the OBC. Workstreams have undertaken workshops to define the project scope and investment objectives. Adjustments made to the options as a result of the E&T facility being incorporated in the HofF revised OBC. Quantified appraisal will consider full costs over life. Further project documentation developed regarding the procurement strategy (OMS, clusters vs site, planning/ tunnel, commercial delivery strategy). Appraisal will consider full costs over life. Reflects robust governance arrangements that are in place. SRO and Programme Director are undertaking regular liaison with NHP leads to understand their progress on the business case process and the treatment of proceeds from surplus land. BtLW Project Team has monthly liaison meetings with the NHSEI/ DHSC team to discuss project and approvals. In addition, the LDS Project Team is in discussions with the NHSEI Estates Team regarding support and approval requirements.		
Stakeholder Engagement A specific LGI Development Site Project		LDS Comms and Engagement lead to continue to review the Comms plan and implement actions

Communications and Stakeholder Engagement plan has been developed which complements the BTLW Programme-level Communications and Engagement Plan. Internal Trust Stakeholder reporting process has been developed and implemented. Engagement with Trust staff as well as a range of strategic and supplier-based stakeholders has been undertaken to gain support and will be on-going.		identified.
Programme Delays SRO and Programme Director are undertaking regular liaison with NHP leads to understand their progress on the issues associated with the HofF business case process. NHP update is a standing agenda item for the Building Development Committee and matters are escalated to the Trust Board as necessary for Chair and Chief Executive action.		SRO and Programme Director to continue to undertake on-going liaison with key members of the NHP on timing and process.
Market interest and Site Usage (including Research & Innovation) The Trust will develop a decisive and clear strategy in terms of how the site will be marketed to maximise opportunities for regeneration and to deliver the stated requirements of the Local Planning Authority as included within the Site Allocations Plan. The assessment of options for the LDS recognise the opportunity costs associated with alternative uses of the clusters. The Trust is progressing with the Innovation pop-up and has held initial discussions		The LDS Project Team will ensure it is clear what the LDS can offer potential Innovation partners and will foster an environment where organisations who want to work with the NHS can do so without impediments. The Director of Strategy and Planning will ensure close working between the HofF and LDS project teams, particularly as the design solution of the new healthcare facilities and the new MSCP are developed in detail. The LDS Project Team will seek master-planning

with providers of children's family accommodation to understand commercial parameters. The Trust will involve key individuals in the decision-making process for developing the site as well as take a proactive role in other innovation initiatives within the Leeds City area to ensure alignment of objectives. The Trust will develop an Innovation Business Plan that will describe the planned growth of innovation services on the LDS. The Trust will consider establishing an Industry Advisory group to support LTHT on the development, operation and success of the Leeds Innovation District.		advice as well as undertake soft market testing with a range of developers to solidify ideas for future usage of the site prior to marketing the opportunity. A review of the property market position at key milestones will be undertaken and identify actions to address the risks of (changes in) the development market/ commercial property market.
The LDS Property Workstream is developing a plan for engagement with the public sector partners in Leeds regarding the plans for, and obligations associated with, the tunnel and the A58.		

CRRC1: Risk of exposure to HCAI	C = 4	16	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
	L = 4					Target Score								Current Score	Initial Score	

Risk Description:
Effective management systems are not in place or sufficient to protect patients from the risk of hospital acquired Clostridium difficile infection, Methicillin Sensitive *staphylococcus aureus* (MSSA)bloodstream infection(BSI), 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: Aug 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 Module. Implementation of phase 1 -lab package to be completed by October 2021 Phase 2 -surgical model implementation due to commence October 2021. Existing HCAI reports continue to be used to monitor trust wide performance, on-going. Any new reporting requirements will need to be risk assessed and provided through PPM +. COVID 19 reports are being generated directly from PPM. On-going
Training Policies and Guidelines: Mandatory infection	Compliance with policies - Human factors	Quality Improvement methodology adopted

prevention and control training to all staff, with an overarching Infection Prevention and Control Policy and a suite of Guidelines and SOPs.	and system issues.	with a Trust wide HCAI collaborative and LIM utilised in response to lessons learnt from 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. Multi-resistant Pseudomonas likely to be caused by environmental factors in water supply and water drainage within the haematology and BMTU specialty. Outbreak meetings have identified on-going issues with the design of the environment including sinks showers and drains in the near patient environment which may provide the point source Limited side room capacity	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. Temporary cessation of patient showering whilst a focused review of all water outlets and design is completed by the trust water safety committee and the trust Authorised person for water. July and August 2021. Weekly screening of inpatients. Commenced May 2021 until environmental factors has been addressed. Water filters applied to all water outlets. May 2021 Daily monitoring of water outlets, June 2021 until all estates remedial work has been completed. Twice weekly decontamination of drains June

	Large parts of the estate have natural ventilation only. An options appraisal for understanding where further mechanical ventilation is required and can be delivered.	2021 on-going. Planned re design and removal of problem outlets. Corporate planning are undertaking a review of side room capacity and an options appraisal to deliver further side room capacity is being developed by end of July 2021. Estates have undertaken a review of the ventilation Trust wide and Mechanical ventilation installed in Respiratory Speciality Unit. Trust wide Ventilation Safety Group being established September 2021. Estates and IPC to develop a Trust wide ventilation group.
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: 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. Implementation ICNET phase 1 -lab package to be completed by October 2021 Phase 2 - surgical model implementation due to commence October 2021

Recovery and lessons Learned: Outbreak Management. Incident investigations. City wide Outbreak response group.	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 Governance Structure. Covid-19 assurance is monitored through the Trust tactical response and IPC 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 root 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. IPN attendance at all GNBSI RCA and STL Weekly RCA tracker issued to all CSU's - including line list of outstanding incident review documents to assist with identifying lessons learnt in a timely manner.

CRRC2: Risk to re-commencing normal activity levels due to reduced capacity (COVID-19)	C = 4 L = 5	20	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
									Target Score						Initial Score & Current Score	

Risk Description:
There is a risk of not 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, COVID19 surges 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, COVID19 surge, routine non-urgent face to face outpatient clinics, OP Diagnostics, 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).
Ref: Patient Safety and Outcomes Risk: CRRP1 (ECS); CRRC5 (18-week RTT); CRRC6 (62-day cancer); CRRC8 (52/104 weeks); CRRC9 (6 weeks diagnostic tests); CRRC10(system flow)

Executive Lead: Chief Operating Officer

Date added to CRR: June 2020
Last reviewed: Jan 2022

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.	The effectiveness of the Vaccine over time is unknown. Not all staff are currently fully vaccinated. 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. Staff lateral flow testing commenced in December 2020 is voluntary and numbers reporting results routinely has been dropping following move to order own	Booster vaccines to be offered to staff and priority groups, in line with national guidance. National requirement for front line staff to be fully vaccinated by April 2022 PPE supplies are assessed continuously to identify and escalate any potential risks to PPE supplies. Reporting of staff results via the LTHT local system has been maintained (rather than

	kits.	national system reporting) to support local report and follow-up by CSUs of staff testing. Lateral Flow devices have been used to support some first line testing of staff outbreaks.
Specialty level plans, including local actions to mitigate most significant risks.	The risks of reducing or stopping routine and planned procedures, including diagnostics and referrals are not uniformly distributed.	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 and all new patients awaiting a surgical procedure have their clinical prioritisation documented
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. Roll out of vaccine nationally continues to the general public in line with national guidance.
Laboratory testing capacity in place through increased operating hours and improved turnaround times to a standard 12 hours in place from 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 pilots undertaken (May 2020).	Capacity of labs to achieve national expectation on staff testing. Availability of reagent. Staff sustainability in pathology. Resilience of the Telepath system supporting all Pathology results as system is now very old and upgrades are overdue.	Pathology team working with national procurement and supplies team to achieve testing targets and stable reagent/ kit supplies. Operational plan and guidance in place in line with national guidance for testing of non-elective and planned/electives admissions.

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.	Review of nosocomial rates in order to reduce volumes of routine testing being monitored via Tactical Testing group, which was established in April 2020 and continue to meet at a frequency defined by current situation/ conditions. Staff testing service stood down from w/c 10/05/2021 - but restarted for shift critical staff using Point of Care Testing in July 2021.
Clinical Advisory Group (CAG) established 24 March 2020 to review Covid-safety arrangements, concerns raised by clinical teams, including issues related to medical ethics, application of national guidance re planned and elective treatments (recovery plans). Weekly collaborative critical care clinical prioritisation review by LGI and SJUH CSUs to support listing of clinically urgent patients and to match listed activity to anticipated capacity Operational Infection Prevention Control (OIPC) Group established to review guidance and recommendations relating to infection prevention and control, including updated national guidance related to patient pathways.	Critical Care capacity can change overnight due to staffing absence or high numbers of unplanned admissions and result in on day cancellations Still restricted to National Guidance for the NHS.	Increase in ACC workforce planned through September and October. Further increases planned through November to January 2022. Risk assessed social distancing and IPC measures in low risk pathways in outpatients and day case / elective admission areas to increase the productivity of this capacity.
Weekly quality review meeting led by the Chief Medical Officer and Chief Nurse, including serious incidents,	None	

complaints related to potential harm as a consequence of delays in treatment due to the ongoing operational response to the coronavirus pandemic.		
Bed modelling for elective, non elective COVID19 and Flu surges developed with mitigating plans	Model is based on latest National and local information of COVID19 and has limited certainty.	The winter modelling is reviewed weekly at Corporate Operation meeting to understand impact of winter schemes, actual activity against the model and COVID19 and any additional action/responses required for the month ahead.

CRRC3: Patient harm – falls and hospital acquired pressure ulcers (COVID-19)	C = 4	16	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
	L = 4		1	2	3	4	5	6	8	9	10	12	15	16	20	25
									Target Score					Initial/Current Score		

Risk Description: There is a risk of hospital-acquired harm to patients related to pressure ulcers and falls due to 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)

Executive Lead: Chief Nurse

Date added to CRR: March 2021
Last reviewed: Sept 2021

Committee reviewed at:
Quality and Safety Assurance Group

Controls	Gaps in Control	Further Mitigating Actions
Risk assessment framework and clinical guidelines/care plans for staff in practice	Variable compliance with completion of documentation. Mixed models of paper and digital risk assessment documentation.	Joint Strategic clinical nursing documentation group provides strategic oversight for transfer of paper records to digital format. Working group established to progress the digitalisation of nursing documents which reports into the Joint Strategic Clinical nursing documentation group
Ward metrics/audit process – ward assurance visits	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 completed April 2021 with improvement action plan on-going and monitored at QSAG
Governance framework – Perfect Ward review meeting, specialty and CSU Quality Assurance (governance) meetings.		Nursing Quality review meetings commenced May 2021 with all clinical CSU's to review patient safety outcomes and data. Repeat Nursing Quality review meetings scheduled

		from October 2021
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 corporate pressure ulcer/falls panel.
Quality Improvement Faculty falls/pressure ulcers		
Safety huddles/enhanced care	Demand for enhanced care has increased and CSW workforce shortfalls.	On-going CSW recruitment currently 98 WTE vacancies (from July 2021 finance ledger). Bi-annual establishment review process to identify additional enhanced care need requirements.
Specialist support – Tissue Viability team	Capacity to provide support to all clinical areas.	External review – tissue viability service completed September 2020, action plan monitored through QSAG. 3.0 WTE additional posts recruited to in the team.
NHSE guidance on hospital visiting (COVID-19), including exceptions for patients with specific care needs. LTHT SOP in place to support risk assessment of visitors to specific patients	Reduced footfall in hospital wards, including visitors and volunteers	

CRRC4: 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 increase in department attendances, insufficient rostered workforce to meet the timely needs of patients and long delays in patient placement into the hospital bed base. This can lead to a congested department impacting on patient outcomes, patient experience, increased infection risk, staff morale, non-compliance with required national standards, patients in the department for longer than 12 hours and financial penalties. COVID19 has become endemic in relation to presentations and admissions. Challenges with inpatient flow continue due to the required changes inpatient placement pathways both within and out with the hospital. Hospital occupancy levels have risen reflecting change in patient demand.

Executive Lead: Chief Operating Officer

Date Added to CRR May 2014
Last reviewed: Jan 2022

Committee reviewed at:
Finance & Performance Committee

Controls	Gaps in Control	Further Mitigating Actions:
CSM status reports, bronze escalation meetings chaired by Associate Director of Operations and silver meeting aligned to the operational response guidance in place. -There is a Bronze and Silver command escalation process both within LTHT and across the city system.	Increased number of patients within the core bedbase with no reason to reside impacting on hospital capacity and ability to place new patients who require an acute bed placement.	Early identification of patients without a reason to reside in hospital and referral to the newly launched Transfer of Care hub at SJUH site for review of the patient's on-going care needs. (Purpose of the transfer of care hub is to reduce time waste in the referral to decision to service time and increase the home first policy) Escalation process updated to ensure senior leadership input earlier into the patient pathway to resolve issues.
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 bed overview.	Focus through the ECS accountability weekly meeting on key enablers to timely care and alternatives to admission where appropriate. Plan to re-focus Unplanned Care programme with increased oversight and governance regarding non elective flow and discharge. ED Patient 2 hourly safety rounds completed and recorded with assurance checks completed and

		long waiting patients (more than 12 hours from bed request) reviewed and reported to weekly quality meeting. Centralised bed allocation operational model currently being implemented at SJUH following successful implementation at LGI.
Patient streaming in place to most appropriate route e.g. GP, Minor injuries, Minor illness service, Same Day Emergency Care Units(SDEC)	Medical, older adult SDEC model current estate and footprint constraints Acute Medicine Consultant workforce constraints Access to SDEC model via 111First	Continued monitoring of 95% compliance and breach analysis for patients streamed away from ED. Continue to maximum opportunity for SDEC pathways and alternatives to admission as clinically appropriate. 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.	The estate footprint constraints. Requirement to consistently fully staff the extended footprint so it can be consistently used including the Extended Observation Unit at LGI.	Both St James's and LGI A&E footprint has increased. Nurse and medical staffing review in progress to ensure patient safety and timeliness of care across a larger footprint. LGI A&E has a modular build to support internal A&E flow. Minor Injury and Minor illness services remain centralised at LGI out with the A&E footprint. Minor injury PDSA commencing regarding redirection of this patient group to agreed Urgent treatment services across the city.
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 weekly SROG and STaR. "LTHT Transforming services-Unplanned Care programme reviewed and establishment of newly agreed work streams with increased focus on LTHT opportunities to improve early decision making, alternatives to attendance and /or admission and

		reducing delays for inpatients and improving outcomes City Same Day Response Board established and chaired by LTHT Medical Director for unplanned care. City System Flow Programme Board established with LTHT engagement.
System level mutual aid actions (system wide agreed tactical options to be considered during periods of escalating pressures)	Ability of system partners to respond in a timely fashion and with known effect.	Monitoring of Mutual Aid actions through System Resilience Operational Group and STaR.
Winter and COVID planning with CSU's and system partners for 2021/22	Unpredictable activity levels	Operational response guidance developed and monitored through daily operational processes developed and refined in time for winter 21/22 CSU owned winter schemes monitored for implementation and impact weekly.
COVID19 modelling in place for further wave response in order to proactively manage and support flow and admissions across LTHT.	Novel modelling with a 7day forward view only. Unknown impact of potential variants	Modelling versus actuals is reviewed a minimum of weekly to enable responsive configuration of services, state of readiness and red/amber/green beds by site.

CRRC5: 18-week RTT target non-compliance	C = 4 L = 5	20	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
									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 resulted in a reduction in non-urgent face to face outpatient clinic activity and the majority of elective surgical activity to allow staff to be released to support additional critical care and inpatient capacity. This was required to support increased COVID19 admissions. As a result of suspending this activity, the number of patients waiting over 18 weeks increased significantly.

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.

Rules on pre-operative isolation, social distancing, cleaning of contact points and pre-screening questions on arrival to outpatient departments means that capacity for face to face activity is reduced. Similarly, these requirements also reduce the utilisation of theatre capacity.

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: December 2021

Committee reviewed at: Finance & Performance Committee

Controls	Gaps in Control	Further Mitigating Actions:
Implementation of telephone and video conferencing facilities have enabled non-face-to-face appointments to be delivered.	Not suitable for patients where investigation or examination is required	Opportunities are being explored to maximise the use of this method of engaging with patients.
Triage of referrals enables identification of some patients at risk of harm if appointments are delayed.	Quality of referrals from GPs can vary.	Delivering easier access to consultant opinion for GPs ahead of referral through enhanced advice and guidance systems Focus on improving Advice and Guidance. This is

		also included as part of our activity planning submission.
Delivery contracts have been revised to link to H2 planning guidance to focus on key outcomes. 104 week delivery trajectories agreed with each CSU	Prolonged social distancing restrictions will limit activity and may result in continuing growth in waiting lists. Demand variation from winter modelling / Covid modelling will impact elective delivery	Re-establishment of social distancing group reporting into tactical recovery group will assist with guidance on social distancing measures and link with operational IPC group. Risk assessed social distancing and IPC measures in low risk pathways in outpatients and day case / elective admission areas to increase the productivity of this capacity
Single points of access in some specialties will allow onward referral of routine activity to AQP's spreading burden across providers	AQPs will be subject to same restrictions on activity as LTHT.	
Effective advice and guidance can support primary care decision making and reduce unnecessary referrals	Absence of system to support capture of advice into EPR prevents roll-out to all specialties.	System requirements being scoped as part of business case development.
Development of guidance and offer of support in development of patient initiated follow up (PIFU) pathways helps reduce unnecessary appts in outpatients releasing capacity for other patients.	Some pathways require remote monitoring or use of apps - no current portal link to EPR	Work underway with DIT colleagues to explore potential for implementation of patient portal.
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.	Proposal developed to reallocate all P4 patients above 80 weeks as P3 patients to support booking of long waiting patients
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	Additional medical payments agreed to support additional activity specifically for treatment of long waiting patients
Independent sector capacity likely to be available to support during recovery phase.	Capacity available for higher volume outpatient activity is limited. Contract change means IS only accepting IPT of low complexity high tariff patients in a limited number of specialties.	Further specialties have had above tariff contracts agreed to support treatment of long waiting patients
Use of external theatre resource to staff LTHT theatre capacity to 100% of pre-covid	Activity still likely to be reduced due to inefficiencies associated with social distancing and patient isolation in the pre and post operation pathway	Further extensions of insourcing support requested to February 2022
ICS Elective coordination group established to support regional recovery of admitted waiting list through a collaborative approach to increase elective capacity in low complexity / high volume specialties	Providers at different stages of recovery RE internal capacity and management of P2 patients. Payment mechanism is a barrier to shared working approaches	WYAAT Elective Coordination group offering capacity for specialties at risk of not delivering zero 104 week waits. CHFT will support LTHT urology patients, HDFT with ENT. All Trusts supporting reimaging of Adult Spines patients
Develop ~~sites~~ Elective hubs (CHOC & WGH) to increase elective activity that can be delivered. Reallocation of elective theatre allocations to support specialties with capacity and demand mismatch	Currently requires dedicated capital and revenue to support the development of these sites and will not be delivered before Summer 2022 Re-allocation reduces capacity for other specialties	CHOC business case in development for two additional theatres plus ward with Higher observation bed capacity. WGH business case in development for 2 additional theatres. Purchase order completed for staffed Vanguard theatre to be installed at WGH in Feb/March 2022. Additional scoping for a second mobile theatre at WGH being undertaken. Allocations linked to WL position as well as ability to treat P2 patients

Weekly collaborative critical care clinical prioritisation review by LGI and SJUH CSUs to support listing of clinically urgent patients and to match listed activity to anticipated capacity	Critical Care capacity can change overnight due to staffing absence or high numbers of unplanned admissions and result in on day cancellations	Increase in ACC workforce planned through September and October. Further increases planned through November to January 2022

CRRC6: 62-Day Cancer Target	C = 4	16	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
	L = 4		1	2	3	4	5	6	8	9	10	12	15	16	20	25
									Target Score					Current Score	Initial Score	

Risk Description:

There is a risk that the Trust will not treat 85% of patients within 62 days in line with the 62 day referral to treatment constitutional standard

This is due to the volume of 62 day patient backlog, the April- October 2021 increases in 2ww referrals in Breast and Skin, alongside an imbalance between capacity and demand, for key pathways/ at key pathway points. This is exacerbated by variable waiting list management, insufficient control over pathways of care and higher than expected demand (for acute and urgent care) alongside the long standing issue of late referral for tertiary treatment from other providers for some patients.

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: Dec 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, as well as overall and will scrutinise actions to improve performance.	None	None
The Trust has a cancer operational policy in place which has been approved by the Trust Board.	None	Annual review in line with required updates
The national guidance on reporting methodology being consistently applied.	None	None
The Trust maintains and publishes timed pathways, agreed with the local commissioners and any other	Referrals from other providers do not always occur in a timely manner to	All pathways with significant 62 day and 2ww backlogs reviewed in Oct/Nov 2021 with

Providers involved in the pathway, taking support from the WY&H Cancer Alliance for key areas	support delivery of 62 performance. LTHT capacity does not match the demand to deliver treatment within 62 days.	detailed recovery plan developed focussed on areas can deliver. To be presented at Executive meeting 29th Nov 2021. Pathology KPIs developed and monitoring/ recovery actions agreed. Radiology KPI development underway in Q3, following actions to address CT and MRI capacity issues.
The Trust maintains a valid cancer specific PTL and carries out a weekly review for all cancer tumour pathways to track patients and review data for accuracy and performance.	Awareness of 62 day Breach risks are not always clearly visible to CSU management teams	Corporate Cancer Team weekly 2WW and 62 day risks oversight meeting with CSUs refreshed to include use new reports that support better identification of patient at risk of breaching and long waiters for attention. New weekly review with Cancer team of overall position and actions to be undertaken with CSUs/ escalated to ADOP where required (supported by CSU delivery review meetings where required).
LTHT 2ww referral volumes back to normal levels and flowing into the system as per normal process.	2ww referrals have continued to increase to higher levels that previously seen causing increased activity and delivery challenges particularly in Breast (2 spikes), Skin and Colorectal	Colorectal/ Endoscopy mitigations successful. Skin recovery actions in place using AQPs and review of referrals/ images process with CCG/Primary care Breast mitigations not able to keep up despite additional sessions, Medinet, and IS/ AQP use. WY&H Cancer Alliance wide mutual aid requested at November 2021 Board meeting.
Capacity and demand analysis and reporting for key pathway elements to support timely delivery is carried out systematically and routinely.	Capacity & demand modelling has been completed for all elements of every pathway, however this is not easily repeatable or routinely reported to	CSU by specialty issues related to 2ww, 62 day backlog and recovery actions required reviewed end Oct/ early Nov with paper going to Executives 29th Nov 2021.

	support early intervention/ planning Radiotherapy capacity is currently not sufficient due to planning staff gaps and impact of delivering new expansion plan (machines need to be taken out to be replaced - completion by end of summer 2022)	Pathology agreed recovery actions /KPIs in place with Radiology being developed (to be in place in December 2021). P2 prioritisation for theatre and HDU capacity continues and will be supported by December refresh of backlog clearance run rate requirements versus actual capacity in place. Clinical prioritisation process for radiotherapy developed and deployed in October 2021 to reduce harm to those patients requiring more urgent treatment. Request for support from ODN and other northern radiotherapy providers not been possible due to similar capacity constraints Position is reviewed monthly with improvements in wait times for lowest priority patients expecting to be seen in January 2022.
MDT coordinator central resource to track and escalate patients at risk of breach or harm is in place supported by weekly high risk meetings with CSUs and Cancer team	MDT staffing gaps are significant and recruitment has proved difficult despite rolling advertisement of the role across multi-media platforms alongside NHS jobs	Cancer management team supporting routine validation to ensure CSUs/ coordinators are focussing on highest risk patients for attention. Agency support in place and optimised Other avenues of recruitment/ training (apprentice, etc.) being urgently explored. Health and Wellbeing work being undertaken by new manager of the MDT team to identify issues that have led to high turnover and actions to

		address where possible.
Weekly review of the longest (over 104 day) waiting patients is in place with escalation to Associate Medical Director for Cancer/ Treating Clinician or Lead Clinician/Clinical Director where required.	Volume can be challenging	To focus on those pathways where patients are at higher risk of cancer progression due to wait (e.g. bladder) and those patients where care is not progressing
Root cause breach analysis is carried out for each pathway not meeting current standard.	Root cause analysis is not always carried out for the 10 previous breaches across all non performing pathways	Due to continued volume of current breaches, a weekly cancer team review of all patients on the 2ww, 31day and 62day cancer pathway has been introduced with challenge by the Associate Medical Director of Cancer where required. This alternates between the 10 longest waiting patients and the 10 patients that have just missed the standard This will be fed into the new ADOP chaired CSU wekly delivery review meetings.
Weekly surgical/ HDU prioritisation processes continue to be in place, with additional operating accessed in the Independent sector where possible/ appropriate. Clinical triage process established and continues weekly for HDU cases should any further surges result in the requirement to reduce/ suspend cancer surgical activity Capacity for cancer surgery and key pathway steps is prioritised for access/ listing and in line with most recent NHSE/I guidance. Pre-op COVID testing/preparation guidelines in place.	Bed, theatre, HDU staffing and patient priorities not optimally aligned due to continuing acute bed pressures. Volume of acute and COVID patients has continued to impact upon the ability for cancer surgical activity to return to normal levels/ recover to that planned despite P2 and CC prioritisation (booking into capacity available but still not sufficient in all areas)	Teams to continue to access Independent Sector capacity and to use surgical prioritisation to support allocation of theatre capacity. Cancer surgical recovery requirement re backlog and routine run rate being refreshed and fed through Planned Care Programme board to review any possible additional actions. Separate Planned Care and Cancer Programmes now established - reporting progress and oversight. Continued COVID19 modelling undertaken using 7 day forecast model to predict the average expected inpatient admissions and discharges for Covid-19 patients and impact on elective and cancer care.

CRRC7: 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:
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. This has been exacerbated by the COVID 19 pandemic which has reduced operational flexibility to list and treat patients due to the impact of staff absence, patient testing and isolation, and reduced elective green and amber critical care, inpatient and day case capacity because of social distancing and cleaning requirements, and the endemic demand of COVID 19 patients on LTHTs inpatient capacity.

Executive Lead: Chief Operating Officer

Date added to CRR: May 2014
Last reviewed: Sept 2021

Committee reviewed at:
Finance and Performance Committee

Controls	Gaps in Control	Further Mitigating Actions Planned:
Planned and Cancer Care Programme of Work To support elective recovery a programme of work led by the Medical Director of Operations and supported by the ADOPs for Planned and Cancer care was established in October 2020 to focus on increasing Critical Care, inpatient and day case capacity, and improving efficiency and patient experience within the elective pathway (Pre-op, Peri-op, and Post op), which will develop and strengthen the controls for CRRP 4. The projects include - British Association of Daycase Project - Enhanced Care Areas - Improved Scheduling & 6-4-2 theatre planning process		

- Pre-optimisation - Theatre pathway efficiency The programme reports monthly to the Tactical Sponsorship group chaired by the COO		
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. Prompt starts for all elective theatre lists to automatically send for patients who don't require a critical care bed	Co-ordination of theatre/ ward and critical care capacity does not always align leading to greater risk of cancellations Patients requiring critical care are unable to automatically proceed to theatre	
Daily/weekly Trust / CSU planning All CSUs have weekly access meetings to identify available theatre capacity for additional sessions, manage risks and review cancellations and discharge and theatres KPI's using the LTHT scheduling tool. The scheduling project Collaborative CSU process to 'book' patients into an admission area by appointment and lock down of list order to improve patient flow and reduce risk of late starts and subsequent on day patient cancellations Daily email prompt to CSUs highlighting their 28 day breach risks Weekly collaborative critical care clinical prioritisation review by LGI and SJUH CSUs to support listing of clinically urgent patients and to match listed activity to anticipated capacity	Critical Care capacity can change overnight due to staffing absence or high numbers of unplanned admissions and result in on day cancellations	Ongoing work to enhance the scheduling tool with the 'Monte-Carlo simulation' which will support scheduling and utilisation.

Daily critical care review by Medical Director for Operations, ADOP for escalations, clinical leads for General Surgery and Cardiac Surgery, and ACC CSU CD or HoN.		
Monthly planning Multidisciplinary BADs Daycase project identifying CSUs and individual procedures through PLICS and Model Hospital that could be treated as day case to reduce need for IP beds and risk of cancellation Proactive reduction in normal operating levels during Jan, Feb and March which should reduce the cancellation numbers due to seasonal pressures Use of Independent sector to increase available capacity and treatment options for patients	Day case capacity is still impacted by COVID 19 requirements that hinder high volume pathways and treatment of more patients as a day case. Theatre staff and surgeons are not always available to undertake additional activity in response to peaks in demand Independent sector contract restricts type of patient able to be transferred for treatment	Relaunch of 6-4-2 process and expectations for Surgical & Theatres CSUs BTLW at LGI will design bespoke admission and discharge areas for day case pathways. SJUH estate strategy reviewing options to consolidate day case estate and pathways at SJUH Business case being developed for additional theatres at WGH to support increased day case activity away from the main site pressures Increase theatre and day case capacity available over the weekend to spread demand and offer more opportunities to rebook patients GIRFT project to be embedded in Theatre efficiency project to ensure appropriate patient pathway is followed Work with the CCG to assess viability of increasing tariff for the Independent sector to increase the volume of capacity available

CRRC8: Patients waiting over 52 weeks for treatment across a range of services.	C = 4 L = 5	20	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
									Target Score						Initial & Current Score	

Risk Description:

There is a risk that patients may have excessive waits for treatment as a result of on-going constraints on activity and the backlog of patients waiting for treatment resulting from the Trusts response to Covid-19 . In some specialties waiting times are likely to exceed 52 weeks for both outpatient and admitted waiting lists, with a small number of specialties having patients waiting more than 104 weeks for treatment.

This may result in a poor experience and harm to patients, significant external scrutiny and impact on the Trust's reputation through media coverage. There has previously been the risk that financial penalties would be imposed or payments required to release additional capacity internally or from other providers.

Executive Lead: Chief Operating Officer

Date Added to CRR May 2015

Last reviewed date: Nov 2021

Committee reviewed at:
Finance and Performance

Controls	Gaps in Control	Further Actions Planned:
Surgical teams across the Trust have reviewed their revised theatre allocations and subsequently prioritised clinically urgent patients (including cancer patients). This continues to be reassessed in line with updated clinical prioritisation	Increased COVID19 admissions may result in the suspension or reduction of elective activity.	The PAS system has now been updated to include the recording of P status within the patient's 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. In line with national guidance issued on 10 May 2021, by NHSE/I 'Clinical prioritisation of waiting lists for endoscopy and diagnostic procedures', the Trust have nearly completed clinical prioritisation of diagnostic waiting lists using national D codes, which is expected to be complete by end August/ early September 2021. A process has now been established for adding the

Clinical validation of all follow-up patients waiting beyond anticipated review date requested to determine if patient suitable for discharge, conversion to PIFU, requiring of urgent review or able to wait	Volume of reviews has delayed validation in some areas. Validation does not deliver any additional capacity in areas where backlog continues to grow Volume of patients means that capacity to undertake reviews is limited and may require cancellation of clinics	P category to the patient's record at the time of Decision to Admit and the Diagnostics D code at time of test request. Patient safety, quality or governance risks are escalated through CSU Governance Meetings in line with Quality Governance Framework. CSUs will highlight specific risks through their CSU risk registers. COVID19 modelling undertaken using 7 day forecast model to predict the average expected inpatient admissions and discharges for Covid-19 patients and confidence intervals. Longest waits prioritised for validation. Specialties with known risks already prioritise. Review of patients waiting > 104 weeks to be undertaken by risk management/corporate ops medical leads in December 2021 to identify potential harm, to agree process for ongoing patient harm review by specialty teams.
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 in all specialties 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.	Adult Spines elective lists will begin to be delivered at CHOC by Q4 Elective schedule reallocated in WGH & DBDU to support specialties with longest waiting lists (Urology & Colorectal) Proposal developed to reallocate all P4 patients above 80 weeks as P3 patients to support booking

		of 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 (e.g. virtual reviews) can deliver additional capacity. Service Delivery Contract's includes KPI on reducing longest outpatient waits – this will be monitored on monthly basis Working group established to explore possibility of additional off-site outpatient capacity being delivered.
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.	
Use of Insourcing Company to increase available theatre sessions began July 21	Case complexity suitable for insourcing team reduces ability to treat more complex patients	Insourcing team used to support low complexity / high volume pathways Theatres & Anaesthesia CSU anticipate return to pre-covid provision of theatre capacity by the end of September 2021 except for a small number of theatres which will continue to be supported by an insource theatre team Insourcing contract extended until December 2021. Further extensions requested to February 2022.
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.	LTHT continues to negotiate additional activity directly with the Independent sector providers as local contracts either above tariff, or providing consumables, kit and devices directly to support more complex work.
Develop ~~peripheral hospital sites~~ Elective hubs (CHOC & WGH) to increase elective activity that can be delivered	Currently requires dedicated capital and revenue to support the development of	CHOC business case in development for two additional theatres plus ward with Higher

	these sites and will not be delivered before Summer 2022	observation bed capacity. WGH business case in development for 2 additional theatres. Purchase order completed for staffed Vanguard theatre to be installed at WGH in Feb/March 2022. Additional scoping for a second mobile theatre at WGH being undertaken.
Outpatient appointments reviewed, converted to telephone consultations where clinically appropriate	Outpatient environments may not be suitable to maintain recommended social distancing (2 meters). Reduction in outpatient capacity due to requirements to maintain social distancing (currently delivering approximately 99% normal baseline outpatient activity) Increased COVID19 admissions may result in the suspension or reduction of outpatient activity and staff may need to be reallocated to support inpatient or critical care areas. Volume of reviews has delayed validation in some areas.	Social distancing measures well embedded within outpatients setting. Outpatient team have worked 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 Contracts have been agreed at CSU level which will include focussed KPI on reducing longest outpatient waits - this will be monitored on monthly basis. COVID19 modelling undertaken using 7 day forecast model to predict the average expected inpatient admissions and discharges for Covid-19 patients and confidence intervals. Weekly review of progress to be reviewed and reported by Corporate GM Investigation of additional potential capacity being undertaken with Corp Planning colleagues.
Clinical Advisory Group (CAG) established 24 March 2020 to review concerns raised by clinical teams, including clinical concerns re planned and elective treatments. Weekly collaborative critical care clinical prioritisation review by LGI and SJUH CSUs to support listing of clinically	Critical Care capacity can change overnight due to staffing absence or high numbers of unplanned admissions and result in on day cancellations	Increase in ACC workforce planned through September and October. Further increases planned through November to January 2022

urgent patients and to match listed activity to anticipated capacity. Operational Infection Prevention Control (OIPC) to review guidance and recommendations relating to infection prevention	Still restricted to National Guidance for the NHS	Risk assessed social distancing and IPC measures in low risk pathways in outpatients and day case / elective admission areas to increase the productivity of this capacity

CRRC9: Patients waiting longer than 6 weeks following referral for diagnostics tests	C = 4	16	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
	L = 4								Target Score					Initial Score & Current Score		

Risk Description:
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 85-90% of normal levels and is expected to remain at this level throughout the remainder of 2021/22.
Performance will therefore remain challenging due to reduced levels of activity and increased demand as cancer, IP and OP elective activity recovery is undertaken with the on-going risk of COVID-19 admissions requiring higher levels of IP diagnostic provision than previously seen.

Executive Lead: Chief Operating Officer

Date Added to CRR: May 2014
Last reviewed: January 2022

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 routine 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 continue to be prioritised.	Unexpected levels of demand. Outpatient activity may be reduced or cancelled if required which may impact on diagnostic backlog position	Weekly review of operational status will be continued, with outsourcing/ additional OP capacity sourced where possible
Weekly Tactical meetings now moved to Monthly Diagnostic Tactical workstream, chaired by Radiology CD supported by ADOP with input from all	Data available to all diagnostics teams is not the same, with limitations in data from some clinical systems (e.g. CRIS and Cardiobase) to	Awaiting embedding of Endoscopy and PAS system upgrades and then will review options for better reporting oversight 2022/23

relevant CSUs. Processes in place to support recovery and any additional COVID requirements.	support management and recovery planning. Support from IT is constrained to support better data production.	
Weekly Diagnostic month end breach prediction process continues to be in place.	Unexpected levels of demand may result in activity being reduced or cancelled to support increased in COVID-19 admissions and reallocate resource.	Weekly monitoring of position and supporting actions re- instated. Review of IP requesting with key specialties now stood up as a recovery work programme to try and address increasing IP demand for MRI and CT
Equipment replacement programmes agreed for MRI, CT and Cath Laboratories during 2020/21 to 2024/25.	Impact of plans being progressed on Diagnostic recovery if mitigating action plans do not align.	MRI replacement and expansion (by 1 more unit) plans completed in 2020/21. 1st 2 new Cath labs in now in place. Mobile MRI remained in place to end of August 2021 to further support recovery. Due to staffing issues and summer increases in demand, this was brought back in mid-October with additional van sourced from end of November 2021 (both staffed). Use of independent sector/ AQPs continues for CT, MRI and Ultrasound where available, with additional staffed CT mobile being pursued.

CRRC10: Insufficient capacity and patient flow across the health care system for emergency admissions	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				Current Score	Initial Score

Risk Description:
Failure to maintain adequate capacity to meet the needs of patients requiring admission, caused by demand outstripping capacity and complexity of patient flow associated with the COVID19 pandemic. This has led to high bed occupancy levels impacting on our ability to maintain elective operating as per the activity plan and timely non elective admissions. This has resulted in non-compliance with national standards,12 hour national reported 12 hour breaches, poor patient outcomes and patient experience.

Executive Lead: Chief Operating Officer

Date Added to CRR: Sept 2015
Last reviewed date: Dec 2021

Committee reviewed at:
Finance & Performance Committee

Controls	Gaps in Control	Further Mitigating Actions:
Continued focus on ambulatory models of care to offer alternatives to admission wherever safe and possible to do so. Use of Virtual wards for Frailty and Respiratory to prevent admission and/or support early discharge.	Use of SDEC not fully utilised across all services as yet. Estate and workforce constraints.	Implemented further Ambulatory Surgical pathways in LTHT utilising newly recruiting Emergency General Surgeons to reduce pressure on SAU and provide urgent surgical review and intervention for patients. Medical SDEC model scoped and delivered in August 2021 to deliver alternatives to admission and same day care on the St James's site. LGI SDEC model also being scoped to identify missed opportunity. Heart Failure ambulatory care unit to be in place for mid December 21.
LTHT escalation process and full capacity plans by CSU - bronze, silver and gold command in place. Decision management tool updated with risk assessed actions listed for consideration.	Awaiting system escalations update	Full review of escalations and DOP process completed in November 2021.
DOP / CSM in and out of hours support and co-ordination.	Live information to enable real time oversight	Embedding daily management within the Operational Centre. Daily data suite to enable

	System available capacity reporting	expected demand, capacity and opportunity by CSU and site. System weekly reporting of closed capacity and COVID-19 impact in care homes and interim placements. Weekly city bronze and sliver meetings to understand system capacity and response.
Robust bed modelling analysis to identify known activity surges. Operational Response Guidance in place. Seasonal planning sessions have been initiated to mitigate anticipated spikes in patient demand. Detailed inpatient bed modelling has been undertaken in conjunction with the University of Leeds, which incorporates the city COVID19 prevalence rate and children's RSV and expected elective and non-elective activity.	Physical capacity. COVID19 surge planning with certainty. Impact of increased patients who no longer need to reside in LTHT.	Internal bed modelling has also been used at LTHT on a daily basis to assess current demand against current capacity. Covid ward escalation and de-escalation plans agreed and in place. Weekend on call team briefed every Friday with a detailed plan for surge in critical care, inpatient areas, COVID-19 and children's Hospital. The COVID19 modelling forecasts inpatient numbers one week ahead in advance 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 COVID19 prevalence to forecast COVID19 admission numbers. The Children's Hospital has developed a regional RSV surge plan for potential surge in under 2 year olds. The winter modelling is reviewed weekly at Corporate Operation meeting to understand impact of winter schemes, actual activity against the model and any additional actions required for the month ahead.
Management of Long Length of Stay patients (Stranded patients)	Rise in number of patients that do not meet the Reason to Reside within the Hospital	The Leeds Improvement Method value stream with an RIPW will now focus on Home First to support earlier discharge in a patient's pathway.

	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) System workforce availability to meet demand Multiple ward moves in patient pathway leads to increase length of stay. Electronic Criteria Led discharge document implementation required	Reason to Reside National requirement was implemented with patient's receiving a daily review to understanding why patients are in hospital. LTHT daily data collected and submitted Nationally. Data is themed to understand pathway opportunities. . No Reason to Reside information now shared with city bronze group weekly and discussed in system daily huddle. Implementation plan for Criteria led discharge. Agreement in principle that Expected Date of Discharge for patients who do not have a Reason to Reside in Hospital will be updated via the Transfer of Care Hub (system referral and allocation centre) Home First model being scoped with system partners to ensure patient assessments take place in their usual place of residence to identify additional needs. "Spot purchase" of beds or services to support discharge
Maximum utilisation of community care beds and Early Supported Discharge models.	.	Patients requiring a temporary community bed placement under the age of 60 will be able to access the Villa Care 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 for discharge.
Additional capacity in partnership with CCG and Villa care to provide 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 System Resilience Operational Group (SROG).

CRRC11: 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 hour's 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: Oct 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 a timely completion of the referral (EDID) to a central community referral point (SPUR) where patients are clinically triaged to an alternative 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 and Influenza predictions. Decision Management Tool in place including options for extremis, subject to silver command decisions.	Estate capacity/ workforce availability	Unplanned care Board and programme established with associated reducing delays and improving patient outcome tactical programme to deliver mitigations for the Winter modelled scenarios for 2021/22- Actions and updates raised and agreed through tactical forum. Operational Response Guidance Decision management tool for Adults and Children's services to be updated for end of October 2021Leeds System Decision Management tool to be developed with city partners to ensure co-ordinated response to pressures across

		organisations.
Operational Response Guidance developed and early escalation of risk of patients without a designated bed is through to the on-call teams.	High numbers of No Reason to Reside / Super stranded patients within LTHT.	Decision Management Tool forms part of the 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 wherever safe and possible to do so. Daily consultant ward rounds across all CSUs.	Continue with high numbers of Super stranded / No Reason to Reside patients within hospital bed base.	System level reduction in the number of patients remaining in hospital without a Reason to Reside has been agreed with City partners. LIM work on SAU to further enhance ambulatory models of care. Enhanced surgical cover in place. Medical SDEC for Younger and Adult patients launched in August 2021 to increase admission avoidance and improve ambulatory pathways. Further opportunity for renal, hepatology and gastro specialties SDEC to be hosted in the established medical SDEC next to the Emergency Department. Enhanced MSAA planned for November 2021 to enable an SDEC model for the LGI site for adults.
CSU surge plans in place.		
Dedicated medical ward team to provide consistency of cover to patients being cared for outside of the traditional SIM bed base. Redesign of outlier process and model to concentrate medical patients outside SIM 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 surges. Refreshed Operational Response in October 2021 Development of a new medical model for general medicine to enable Consultant cover and leadership for the medicine specialty.
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 and winter.
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 National Discharge guidance. System partners to maintain Discharge to Assess bed capacity through using a spot purchase model. System plan developed to reduce the number of patients in hospital without a Reason to Reside. Criteria for the Virtual Frailty ward to be reviewed and linked to SDEC for older people to maximise admission avoidance as appropriate.
NHS England/Improvement - Alliance 16 programme 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.	As the Alliance programme comes to an end in November 2021 the Tactical Group – Reducing Delays, Better Outcomes for patients has been launched to improve and standardise internal ward level process, including MDT to reduce delays for patients.

CRRF 1: Failure to deliver the financial plan for 2021/22	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 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: Nov 2021

Committee reviewed at:
To be reviewed at the next Finance & Performance Committee on 24-11-21

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	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

Reduction identification and CSU forecasts for the following year		identify and adapt to changes
Quarterly Fundamental Review of the Trusts Financial Position to Finance and Performance Committee setting out the risk range of the in year financial position and executive owned mitigations	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