The Leeds Teaching Hospitals NHS Trust

CORPORATE RISK REGISTER

July 2020

Summary Corporate Risk Register July 2020

CRR No.	Former CRR No.	Nature of Risk	Date added to CRR	Executive Lead	Current Risk Score	Last Reviewed By RMC	Link to LIM Value Stream	CRR Page No.
		Safety and Quality Risk						
CRRS 1	CRR 1	Inadequate nurse staffing levels	May 14	Chief Nurse	16	May 20		4-6
CRRS 2	CRR 18	Insufficient Medical Staff to deliver service	May 14	Chief Medical Officer	16	May 20		7-8
CRRS 3	CRR 2	Healthcare acquired infection	Mar 19	Chief Nurse	16	May 20		9-11
CRRS 4	CRR 33	Violence due to organic, mental health or behavioural reasons	May 15	Chief Nurse	15	May 20		12-14
CRRS 6	CRR 42	Risk of a viral pandemic (e.g. influenza or COVID-19)	May 18	Chief Operating Officer	25	Aug 20		15-22
CRRS 8	CRR 47	Risks arising from Britain's withdrawal from the EU -	Mar 19	Chief Operating Officer	16	Jul 20		23-24
CRRS 11	CRR 35	Power failure/lack of IPS/UPS resilience due to electrical infrastructure	Aug 15	Director of Finance	16	Jul 20		25-27
CRRS 14	-	Inability to provide a cardiac catheter laboratory service	Oct 19	Chief Medical Officer	16	Apr 20		28
CRRS 15	-	Failure to provide radiology images and reporting due to loss of the PACS system	Dec 19	Chief Digital and Information Officer	16	May 20		29-30
CRRS 16	-	Risk of secondary harms due to reduced capacity (COVID-19)	Jun 20	Chief Operating Officer	20	Aug 20		31-35
CRRS 17	-	Staff Health, Safety and Wellbeing During the COVID-19 Pandemic	Jun 20	Director of Human Resources	20	Aug 20		36-44
		Financial Risk						
CRRF 1	CRR 9	Failure to deliver the financial plan 2020/21	May 14	Director of Finance	15	Jan20		45-46
CRRF 2	CRR 40	Insufficient capital resources	Mar 18	Director of Finance	16	Aug 20		47-48
CRRF 3	CRR 44	Risk relating to commercial pressures arising from delays in delivering the refurbishment of the Generating Station Complex (GSC) at LGI	Oct 18	Director of Finance	15	Jul 20		49
CRRF 4		Risk of failure to deliver the hospital of the future project.	May 20	Director of Finance	16	May 20		50-53
CRRF 5		Risk of failure to deliver the pathology project.	May 20	Director of Finance	16	May 20		54-56
CRRF 6		Risk of failure to deliver the innovation district project	May 20	Director of Finance	16	May 20		57-58
		Performance and Regulation Risk						
CRRP 1	CRR 12	Failure to achieve Emergency Care Standard	May 14	Chief Operating Officer	20	May 20	ED LGI	59-60
CRRP 2	CRR 13	18-week RTT target non-compliance	May 14	Chief Operating Officer	20	May 20	Ophthalmology/ Cardiac Surgery	61-62
CRRP 3	CRR 15	62-day cancer target	May 14	Chief Operating Officer	16	May 20	MDT & Pancreatic Breast Only	63-66
CRRP 4	CRR 23	Failure to achieve 28 day cancelled operations target	May 14	Chief Operating Officer	16	Aug 20	Cardiac	67-70
CRRP 5	CRR 31	Patient flow and capacity for emergency admissions (health economy)	Sept 15	Chief Operating Officer	20	May 20	MMPS	71-72
CRRP 6	CRR 32	Unsustainable levels of medical outliers	May 15	Chief Operating Officer	15	May 20		73-74
CRRP 7	CRR 45	52-week RTT target non-compliance in spinal injuries and colorectal services	Oct 18	Chief Operating Officer	16	May 20	Neurosciences	75-76
CRRP 8	CRR 22	Patients waiting longer than 6 weeks following referral for diagnostics tests	May 14	Chief Operating Officer	16	May 20	Breast cancer	77-78

Corporate Risk Register - Key

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

Risk CRRS1: Registered Nurse Staffing levels may not meet safest possible standards	**C = 4**	16	**Very Low Risk**			**Low Risk**			**Medium Risk**		**High Risk**		**Significant Risk**			
			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/ Last reviewed date:
May 2020

Committee reviewed at:
Resource Management Group

Controls	Gaps in Control	Further Mitigating Actions
Continued focused recruitment of both general and specialist registered nurses.	Inability to reduce vacancy gap due to decrease in supply of qualified registered nurses regionally and nationally. Impact of COVID pandemic in relation to progression through NMC pre-registration Nursing programmes. Impact of COVID pandemic in relation to flight restrictions delaying arrival of international nurses. Impact of COVID pandemic in relation to closure of NMC OSCE test centres. International nurses not able to register with the NMC.	Recruitment of 200 international nurses through Health Education England (HEE) Global Learning Practitioner programme and international recruitment agencies. Ensuring eligible international nurses can join the temporary NMC register.
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	SafeCare pilot agreed and implementation commenced. NSSR to remain during the transition period for all CSU's. See also CRRS6 - Covid Corporate Risk (control 10)

	staff. Impact of COVID pandemic and temporary pause in the implementation of SafeCare.	Daily staffing meetings instigated in relation to COVID Pandemic to ensure appropriate distribution of resources. NSSR updated to reflect additional requirements in relation to COVID pandemic.
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.	Operational staff bank group and non-medical operational roster group re-commenced to address roster and temporary staffing management. Both groups report to the Nursing, Midwifery and AHP Workforce group to ensure Trust wide oversight and governance. PWC will audit the safer staffing return (Hard Truth's data) as part of the Trusts audit schedule. In response to COVID pandemic all clinical areas have reviewed their nurse establishment in response to surge plans and staffing requirements. See also CRRS6 - Covid Corporate Risk (control 10)
Introduction of new registered roles to support workforce	New role with a limited evidence base on patient outcomes. Impact of COVID pandemic has resulted in all clinical apprenticeships being paused for 4 months until June 2020. Potential delay in cohorts qualifying.	Adherence to best practice and safer staffing guidance. Quality impact assessment to be undertaken as sufficient numbers qualify and are deployed to fully staff a roster. Future You programme implemented to create workforce plan, recruitment and retention strategy for the Nursing Associate role. Situation being monitored in partnership with education providers. Target to resume

		programmes at the earliest opportunity to reduce the impact on learner progression.
Use of temporary workforce (bank and agency)	Ability to respond to increase in demand as part of silver command Contract for temporary staffing for completes in September 2020. Risk to supply depending on the outcome of the procurement process	Procurement process started and alternative options of bringing temporary staffing in house to be reviewed by the end of Q1
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.
Additional agency registered nursing support provided as part of winter surge plans. 1500 additional hours to be deployed across Cardio respiratory, ESM and AMS from December 2019 to end of May 2020.	Impact of a sudden reduction in nursing hours with no new supply. Impact of COVID pandemic has resulted in a steady decrease of agency hours and potential delays in the arrival of international nurses.	Contract extended from March 2020 to the 31st May 2020. Deployment of international nurses to be focused within the three CSU's to mitigate the reduction in agency support. Monitoring of staffing requirements through daily staffing meeting. See also CRRS6 - Covid Corporate Risk (control 10)

CRRS 2: Insufficient Medical Staff to deliver service	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 of insufficient medical staff to deliver a timely service to patients and achieve the safest possible levels of care.
The main cause of which is gaps in trainee rotas which lead to non-compliant or non-feasible rotas and planned changes to the organisation of Internal Medicine Training from August 2020, worsened by Covid 19.
This may result in clinical services under pressure; delays in responding to the deteriorating patient; and/or poor experience in training for junior doctors, which could result in training posts being removed – causing further rota gaps.

Executive Lead: Chief Medical Officer

Date added to CRR: May 14
Last reviewed: May 20

Committee reviewed at:
Resource Management Group

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

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

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

Risk Description:
Effective management systems are not in place or sufficient to protect patients from the risk of hospital acquired C difficile 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.

May result in serious harm or death to a patient, prolonged LOS, unsatisfactory patient experience significant financial loss; loss stakeholder confidence; and/or a material breach of CQC conditions of registration

Executive Lead:
Chief Nurse

Date added to CRR: Mar 19
Last reviewed: May 20

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 March 2021. IPCT currently running 2 systems In response to the COVID-19 pandemic all IPC resource was re-directed to support the Trust response. No further report generation development work was undertaken. IPCT stopped running two systems and switched to the PPM+ daily report.	IPC team have software to identify all ALERT organisms to support clinical teams risk assessments and recognise increased incidence of infection across pathways. Organism specific risk assessment eform creation phase1 (CPE March 2019) phase 2 (MRSA March 2020) PPM+ team recreating the alert functionality of ICNET planned completion May 2020. Reporting functionality being created planned completion September 2020. IPCT running two systems to provide QA. The IPCT recovery plan includes resuming the IT development work that is essential to be able to monitor performance and reduce risk of Healthcare Associated Infection (HCAI).
Training Policies and Guidelines Mandatory Infection Prevention and Control Training to all staff, with an	Compliance with policies - Human Factors and System issues. Only policy, guideline	Quality Improvement methodology adopted with a Trust wide HCAI collaborative and LIM

overarching Infection Prevention and Control Policy and a suite of Guidelines and SOPs	and SOP related to COVID-19 Pandemic have been updated.	utilised in response to lessons learnt from incidents. All guidelines risk assessed and extensions agreed where required.
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.	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 to be developed with the CSU's in line with the recovery plan to provide ultraclean areas.
Antimicrobial Stewardship: Policies and Standards, City Wide Group, Ward Rounds and day 3 IV antimicrobial review	Worldwide shortage of antimicrobials.	Contribution to national planning from MMPs and a robust process for notification and identification of alternatives in place.
Detection through monthly surveillance monitoring and assurance through monthly ward health checks	Surveillance software to identify new cases of infection ceased to be supported from June 2019 and will be decommissioned by March 2021. Suspended during COVID-19	IA new national ambition to reduce healthcare Gram - negative blood stream infection by 50% by March 2021 across the whole health and social care sector has been launched. Service to be re-provided within PPM+ 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 ward health check to be recommenced.
Recovery and lessons Learned Management of outbreak guidance - ward closures, Outbreak Control Group meetings and city wide response	CSU's Manage the Outbreak Meetings with support from Consultant Microbiologists, IPCT, Antimicrobial Pharmacists and DIPC/DDIPC. The specialist support is a limited resource. During COVID-19 Pandemic, identification of increased	Previous evidence based learning used to support the actions that need to be taken within CSU's. Consultant Microbiologists continued to provide CSU level IPC review and stewardship remotely during COVID-19 Pandemic. Key CSU's to contribute to a table

	incidence of infection has continued though the ability to investigate these has been compromised.	top thematic review of all GNBSI cases that occurred during the COVID- 19 Pandemic incident phase (March 22 to May 31st 2020)
Monitored through the Infection Prevention and Control Committee	Suspended during COVID-19 Pandemic	Microsoft Teams meeting arranged for 2nd of June 2020 for CSU's to identify any gaps, evaluate performance and agree the Trust AMS/HCAI annual plan for 2020/21
Commenced route cause analysis investigation for all gram negative bloodstream infections to identify contributory factors	It is unclear the proportion of BSIs that are avoidable. Routine infection investigations and meetings suspended during COVID-19 Pandemic. All investigations conducted related to COVID-19	Development of a BSI bundle completed. Pilot wards to test and evaluate the bundle by March 2020, rolling out Trust wide and evaluate the whole bundle by March 2021. LTHT patient population temporarily reduced and emphasis on standard infection control precautions combined with focussed IPC advice and training at ward level for COVID-19 also impacts on reducing other HCAI's. Following evaluation of the learning identified from the GNBSI review a planned programme of GNBSI incident investigation will be implemented.

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

Risk Description:	Executive Lead:
There is a risk of inconsistent responses to patients at risk of disturbed behaviour; leading to aggression/violence resulting in physical harm to patients, visitors and staff. The result is the potential for a fatality, serious harm or litigation against the Trust.	Chief Nurse
	Date Added to CRR/ Last reviewed date: May 2020
	Committee reviewed at: Joint LTHT/LYPFT forum

Controls	Gaps in Control	Further Mitigating Actions
Policy for Conflict Resolution (Reducing violence and aggression in the workplace) and establishment of Security Co-ordinators.	Concern that the policy is not being put into operation across patient areas- in particular that the environmental and patient specific risk assessment tools are not being completed and used to inform care planning	Trust wide group on Managing patients and the public with challenging behaviour chaired by Chief Nurse established in August 2019. Reports progress to Quality Management group. Proposed the establishment of a Trust wide Quality Improvement collaborative to focus on improving staff confidence and knowledge. Due to the COVID- 19 pandemic the launch of the QI collaborative has been temporarily deferred.
Restraint and Restrictive Intervention Policy	Concern that the policy is inconsistently imbedded into care delivery. specific concern: - restraint prevention strategies used infrequently - requirements for reporting restraint are not followed across services	Trust wide Communication about the policy increased.
24/7 service provision from Liaison Psychiatry service	Evidence that up to date risk	LTHT Mental Health Team now have access to

	assessment/care planning is not always shared from LYPFT to LTHT in timely way.	LYPFT electronic patient record systems and can share essential information with LTHT clinicians where there are gaps in essential information relating to current FACE Risk / care planning etc. Identified that LYPFT higher trainees (on-call over weekends) do not have access to PPM; arrangements in place for sharing their notes with Liaison for upload to PPM+ whilst access resolved
Enhanced Care Procedure and Restraint Care Plan bundle rolled out trust wide	Some evidence that the Restraint Care plan bundle is not yet being used for all patients who meet the criteria- potential risk to safety if proportionate restriction/restraint not being used and monitored; also potential risk of disproportionate restraint/restriction being used without monitoring	new restraint care plan bundle incorporated into annual Enhanced Care audit
Acute Liaison Psychiatry service 1 hour response in ED implemented	Although this means a quicker response to initial referral for support from ALPS; the 1 hour response time does not have significant impact for patients who have long waits in ED or base wards after the initial contact with psychiatry.	A programme of regular education regarding mental health presentations in ED has been implemented to further support ED in management of this patient cohort
CAMHS referral pathways clarified for patients aged 0-18	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	out of hours practitioners (Liaison service)can be called for advice/attend mental health patients below age of 18
Mental Health and related topics training and education offered for new and existing nursing staff	Currently not mandated across medical and nursing staff or linked to a TNA	QI collaborative will identify all current training offered (internally and by LYPFT) in order to identify commonality/core skills training for

	It may be useful to consider recruiting RMNs or unregistered staff with MH experience into the LTHT workforce.	future model
New clinical guideline " Use of Rapid Sedation/Rapid Tranquilisation" in place	Concern that it is not embedded despite Comms and that it is incorporated into Mandatory MCA training	
Standalone MCA/MHA team in place to give advice/support to front line staff	Limited capacity given implementation of MCA Amendment Act in 2020.	recruitment plan agreed to increase operational capacity of the team during 2020
Public facing information campaign regarding Zero tolerance for violence to health care staff		

CRRS 6: Risk of a viral pandemic (COVID-19)	C = 5 L = 5	25	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 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: Aug 2020

Committee reviewed at:
Risk Management Committee

Controls	Gaps in Control	Further Mitigating Actions:
1. Incident Command Centre established to co-ordinate response to pandemic in line with national NHSE guidance, supported by Gold, Silver and Bronze command with supporting tactical group. Daily Trust communication from Medical Director - Strategy and Planning. 3 times weekly Executive Director huddle.		
2. Trust Pandemic Plan.	Treatment and testing phase not an option for Coronavirus response. Flu pandemic plan did not cover all surge plan requirements.	Plans to increase testing to support identification of +ve and -ve patients and staff (cross ref to control 7).
3. CSU and corporate functions Business Continuity Plans.	The scope of the Trust's Business Continuity approach is a loss of single element of Supply Space Service or System for 7 days. Staff loss scenario planning is not sensitive enough to include loss of staff and redeployment	Incident Command Centre/Silver Command in place to provide daily oversight of staff absence, including mitigating actions and monitoring number of staff self-isolating and number of staff returned to work (by CSU and corporate team).
4. Leeds Outbreak Plan; Operational Response Guidance (ORG), in conjunction with partners.	The COVID-19 positive rates for areas where the LTHT pathology lab processes test samples, which includes care homes,	Continue to lobby NHSE for comprehensive infection rates across the whole health care community.

	are known to the Trust but community infection rates remain unknown. This could limit the Trust Response to any future waves of the pandemic.	Liaise with Trusts in other areas to scope their approach to planning for up surges in demand and services, particularly those experiencing a second wave of infection.
5. Plan agreed by tactical group to expand critical care capacity from 75 to 290 beds across St James's and LGI location, set out in surge/capacity plan. Additional capacity critical care (level 3) provided through establishment of Nightingale hospital for Yorkshire & the Humber region –operational from 21 April 2020 (maximum 500 beds).	Insufficient staff for additional critical care capacity when pandemic reaches peak levels.	Staffing plan overseen by NHSE/I working in conjunction with Trust leads from Yorkshire and Humber region.
6. Infection Control procedures (including Personal Protective Equipment), training for staff, support from IPC and CSUs – safe checking procedures. Procurement procedures to ensure supplies of PPE are delivered to ward areas; assurance to staff re volumes procured. Daily monitoring of fit testing reporting initially to Silver Command, including CSU risks. Visiting times restricted to reduce contact/transmission in line with national guidance, including critical care (Critical Care Network 4 April 2020).	Insufficient stocks of supplies and national logistics issues Low level of trust uptake of FFP3 testing ahead of pandemic Changes to fit testing/checking requirements due to mixed stock of FFP3 masks Frequent changes to guidance from PHE before final guidance issued 2 April 2020 Extended expiry date (FFP3 masks) in use, in line with guidance from PHE/HSE – reports from staff in critical care that elastic straps have snapped.	Trust working with national supplies team. Fit testing programme for staff. Forecasting tool implemented by procurement team. Fit checking process implemented following advice from IPC and review at CAG 24 March 2020. National guidance issued by PHE 2 April 2020, daily communications issued to staff in COVID-19 Bulletin. Supplies liaised with Health & Safety team and IPC re FFP3 masks that have passed expiry date – risks due to extended expiry dates. Reviewed by IPC fit testing team and liaised with critical care.

7. Increased laboratory capacity for testing samples (patients); daily target increased to 500 samples daily (regional) from w/c 6 April 2020. Testing target/numbers monitored and reviewed daily at Silver Command. Capacity to test increased to 1500 samples/day as a result of additional equipment, which has enabled tests to be done simultaneously. In addition, laboratory operating times have increased to 07.30-22.30. Panther machine operational from June 2020, turnaround time standard reduced to 12 hours. Staff testing in place from 30 March 2020 in line with national guidance from PHE. Plan agreed with CSUs to prioritise staff testing; swabs taken by central team supported by dental nurses, operational 7 days/week – drive-through facility + home testing kits delivered. Testing extended to all non-elective admissions in line with guidance issued by NHSE/I 24 April 2020, including patients who are asymptomatic. Care home testing commenced w/c 20 April - care home resident and staff testing with community partners and Yorkshire and Humber wide laboratories. Testing for elective admissions commenced 26 May 2020. Asymptomatic staff testing and antibody testing implemented May 2020.	Capacity of labs to achieve national expectation on staff testing Availability of reagent Staff sustainability in pathology Resilience of Telepath Logistics of cohorting patients (infection prevention and control) to comply with guidance to extend testing to all non-elective admissions w/c 27 April 2020 and elective admissions from 26 May 2020.	Pathology team working with national procurement and supplies team on reagent supplies to achieve testing targets. Operational plan agreed to comply with guidance to extend testing to all non-elective and elective admissions (May 2020).

8. Procurement procedures to provide equipment to critical care areas. Trust Board approved emergency powers (26 March 2020) to support procurement for continued supply of goods via use of Single Tender Waver. Local procurement (visors) reviewed by IPC and approved by Executive Directors/CAG.		
9. Estates and facilities team plan tailored to the ability of the estate to provide high flow oxygen to clinical areas in line with surge plan. Estates and Facilities team reviewed plans in line with NHSE/I Estates and Facilities Alert NHSE/I 2020/001 (use of high flow oxygen therapy devices), NHSE/I 2020/002 (oxygen usage) and NatPSA/2020/002/NHSPS (interruption of high flow nasal oxygen during transfer). Oxygen supply in Gledhow Wing and Lincoln Wing (St James's location) enhanced – transferred to new 54mm rising oxygen main, enabling wards to draw up to 200l/m oxygen; surge plan updated 10 April. Process established – if any patients require > 10L/min oxygen flow, triggers respiratory/critical care intervention and audit by CSM of overall oxygen usage for that ward.	Risk to disruption of supply Risk to delivery of required flow to all surge areas	Further assessment of oxygen requirements at LGI and St James's location to continue to ensure oxygen is provided in line with surge/capacity plan.
10. Nurse staffing surge plan, including deployment of staff from other areas, nursing staff working in non-patient facing roles, return to practice, student nurses. Training programme implemented, including e-learning resources and guidance on returning to practice in clinical areas.	Staff absence due to contact/symptoms in line with PHE guidance. Recruitment of sufficient numbers of nurses with the appropriate skills in line with the surge/capacity plan.	Staff absence/mitigating actions overseen daily at ICC/Silver Command.

Staffing ratios in line with NMC and NHSE/I guidelines – and professional judgement, as agreed by Head of Nursing, overseen by Chief Nurse. Stop the Line process revised in line with surge plan. Daily review of staffing absence and clinical availability of staff working in non-patient facing roles, co-ordinated by Corporate Nursing team.		
11. Recruitment of volunteers co-ordinated by Patient Experience team and HR, including fast tracking recruitment procedures, DBS. Regional plan led by NHSE/I to co-ordinate volunteer recruitment and deployment across Y&H Region.		
12. Medical staffing surge plan, including training for doctors in the management of patients with respiratory conditions. Junior doctor rotas from 1 April 2020 paused in line with guidance from HEE, to enhance workforce with staff who are familiar with clinical areas in the Trust. FY1 (junior doctor) graduates brought forward from 1 August start date, commenced in May.	Recruitment of sufficient numbers of doctors with the appropriate skills in line with the surge/capacity plan.	Medical staffing oversight led through daily Incident Command structure, support by Medical Education team.
13. Arrangements for staff to work at home in line with national guidance to reduce risk of contact/infection. IT support to fast-track remote access requests; VPN (remote access) capacity doubled to enable staff to access hospital systems and solution to allow access to a limited number of applications from non-Trust devices, including PPM+. Dial-in meetings implemented using Microsoft Teams to reduce risk of contact between staff on site, maintain social distancing.	Infrastructure for remote working, including computer hardware and access to hospital systems, including VPN.	Review led by Digital team to identify requirements for remote working, prioritisation supported by Associate Director of Operations. Microsoft teams available for all staff to use from April 2020.
14. Suspension of routine and planned procedures including diagnostics and referrals, in line with	Patients requiring treatment for cancer and treatment that would support	Cancer diagnosis, treatment and care continued in line with NHSE/I advice dated 30 March 2020.

NHSE/I/PHE guidance issued 17 March 2020, to provide capacity to meet the admission demand, including critical care and respiratory. Outpatient appointments reviewed, converted to telephone consultations where clinically appropriate. Clinical triage process in place for 2ww suspected cancer referrals. All emergency treatments and interventions have been conducted taking into account the latest NHSE/I, Royal Colleges, national societies COVID-19 guidance. Specialty cancer MDTs undertaken risk assessments and established process for tracking patients that have been deferred. Clinical guide for the management of essential cancer surgery for adults during the COVID-19 pandemic published 7 April 2020 and identifying highest risk patients who need to shield published 10 April 2020 –reviewed by Corporate Ops/Cancer Board and implementation plan agreed. **Cross-reference CCRS16.**	patients in their daily living. Patients may not attend hospital when they require treatment due to concerns and heightened publicity about impact on the NHS of COVID-19. Vaccine not currently available to provide wide spread (population) immunity and unlike to be available for some time.	Stepped recovery plan (phase 1-3) developed to re-establish routine and planned services, working with WYAAT partners, reviewed at EMG 29 April 2020. Quality Impact Assessments undertaken not being provided, overseen by the Corporate Operations team, May 2020. Framework developed with guidance by Quality Governance team w/c 4 May 2020. QIAs completed by CSUs 15 June 2020, reviewed at Corporate Ops meeting 23 June and EMG 24 June. To be discussed at Quality Assurance Committee 2 July 2020, risks scoring 15> to be reviewed with CMO, Chief Nurse and COO.
15. Work with partners to urgently discharge patients who have been assessed to be medically optimised for discharge (MOFD), in line with national guidance issued 17 March 2020, to provide capacity to meet the admission demand, including critical care and respiratory.	Resilience of community providers (staff and capacity) Financial sustainability of private sector providers	Community providers plan to recruit staff and volunteers to enhance workforce.
16. Capacity in the Independent Sector (IS) plan for the treatment of patients, including stroke services, from 3 April 2020. Standard Operation Procedure produced to set out operational and governance arrangements. CQC notifications submitted.		

Cross reference CRRS16		
17. Plan agreed by tactical group to expand mortuary capacity: 344 body storage spaces May 2020 (282 permanent, 62 temporary). Active management of bodies stored in mortuary for > 30 days reduced to 14 days. Trust is a partner in excess death arrangements with Leeds City Council to establish temporary mortuary arrangements.	Insufficient on-site mortuary capacity to meet demand when pandemic reaches peak levels.	City wide temporary mortuary planned from 1 May with capacity for 1400 and scope for further 1000 if required.
18. Suspension of routine reporting to release capacity in line with the communication issued by NHSE/I 28 March 2020, including streamlining Board and supporting committees.	Emerging risks to quality and safety not reviewed and escalated through established governance structure.	Move from bi monthly Board meetings to monthly - with streamlined reports, Quality issues to be addressed by full Board as per legal advice and not delegated to QAC; to be reviewed end of June 2020. Quality and safety risks reviewed through ICC and monthly Risk Management Committee, Quality Management group. Committees to be re-established July 2020.
19. Resources provided to support staff welfare, health and well-being, including clinical psychology support, arrangements in place for potential staff death in service, overseen by Director of HR. Pressing the Pause Button – daily communications to support staff from clinical psychology. **Cross reference CRRS17**	Staff not aware of services on offer	Regular communications via a variety of methods
20. Plan in place to support staff in getting to work. Accommodation provided for staff to facilitate access to work and social distancing/reduce family contact. Facilities team arranged free car parking for staff April – June 2020. Partnership with local supermarkets, including	Staff unable to get to work due to child care arrangements.	Plan for additional nursery spaces to be operationalised. All managers asked to review staffing plans over the summer holidays to ensure sufficient staff are at work.

Morrison's to delivery groceries on site for staff. **Cross reference CRRS16**		
21. Clinical Advisory Group (CAG) established 24 March 2020 to review concerns raised by clinical teams, including ethical issues), including guidelines re visiting times, end of life care pathways support to families, ceilings of care.		

CRRS 8 Risk: Britain's exit from the EU	C = 4	16	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
	L = 4					Target Score								Current Score	Initial Score	

Risk Description:
There is a risk to the continuity of clinical and non-clinical services
Due to an unmanaged EU exit with 'no deal' which could include; loss of EU citizens from the workforce or delayed supply of consumables, pharmaceutical products, medical devices or radioactive materials
Resulting in possible delayed diagnosis and treatment and patient harm

Executive Lead: Chief Operating Officer

Date added to CRR: Feb 19
Last reviewed: Jul 2020

Committee reviewed at: Emergency Preparedness Group

Controls	Gaps in Control	Further Mitigating Actions
National co-ordination and assurance of suppliers and direction on holding additional (6 weeks) stock of consumables, medical devices and pharmaceuticals	Detail on specific products held in stockpile is unclear Lack of clarity on escalation and co-ordination of issues nationally National guidance in respect of risks surrounding elements of the UK EU Trade Deal was expected sometime after 1st February 2020 but has not yet been received. PPE stockpiles established to cover the EU withdrawal period have been exhausted during the Covid-19 pandemic There are national concerns relating to the availability of drugs and pharmaceuticals after the EU withdrawal.	On-going liaison with NHS Procurement.
CSU risk assessment and information sharing events		
Supplies and procurement processes and plans for product shortages in place		
Action and readiness tracker for LTHT based on Operational Readiness Guidance from DHSC		

Multi-agency and LTHT Incident response plans and business continuity plans in place		
EU exercises to test scenarios and contingencies carried out in February 2019		
Task and Finish Group in place		
LTHT EU exit co-ordination plan in place		

CRRS 11: Power Failure due to Electrical Infrastructure/lack of IPS/UPS resilience	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 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 Finance

Date added to CRR: Aug 15
Last reviewed: Jul 20

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	This handbook provides the Estates on-call	The handbook is reviewed annually.

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

	electric shock and provide increased local electrical resilience.	shortfalls in UPS and IPS provision in clinical category Grade A areas is required. Electrical Action cards for all category A areas are being developed by Estates and will be passed to the relevant clinical triumvirate teams for review and explanation as required. Once agreed these should be situated at the entrance to all Clinical Category A areas detailing the expected impacts of electrical failure and the actions required by staff. Completion Autumn 2020 (delayed due to Covid).

CRRS 14: Inability to provide a cardiac catheter lab 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 that adult and children's intervention through the 6 catheter labs will be compromised due to the age and unsafe nature of the equipment. This may result in harm to patients or an inability to diagnose and treat patients.

Executive Lead: Chief Medical Officer

Date added to CRR: Oct 19
Last reviewed: April 20

Committee reviewed at: Finance & Performance Committee

Controls	Gaps in Control	Further Mitigating Actions
Negotiated extended service cover and warranty with catheter lab manufacturers.	Short term contingency with risk that parts may not be available in the event of a breakdown.	Best effort contract in place labs 1 and 4 with access to limited stock and/or decommissioned equipment parts. Labs 2, 3, 5 and 6 covered by Phillips Managed Equipment Service (MES) subject to replacement timescales being adhered to.
Use Catheter Lab capacity in associated CSU's/hospitals.	Reliance on limited capacity within NHS Trust catheter labs in the region. Only available for non-complex activity.	Agreement for York, Pinderfields and Calderdale to perform own PPCI cases in hours rather than referred to Leeds.
Managed Equipment Service in place with schedule to replace current lab over a 3 year period.	The replacement programme has been delayed due to the time taken to implement the contract which has led to labs becoming obsolete in the interim period. Capital programme for replacing the labs now includes a fallow year resulting in labs 1 and 5 not being replaced until September 2022.	Review option to accelerate planned replacement of labs 1 and 5.
Use Children's CSU hybrid theatre.	Children's facility which may take priority.	Agreement to use children's hybrid theatre for adult and paediatric congenital patients. Lab 1 unavailable for planned procedures.

Risk CRRS15: Failure to provide radiology images and reporting due to loss of the PACS system	**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 that the Trust fails to provide radiology images and reporting due to loss of the PACS system as a result of its age resulting in delays in service delivery, poor patient experience, delayed report turnaround time and late diagnosis.

Executive Lead: Chief Digital and Information Officer

Date Added to CRR:
Dec 19

Last reviewed date:
May 2020

Committee reviewed at:
Finance & Performance

Controls	Gaps in Control	Further Actions Planned:
Upgraded current system in 2017	Despite the upgrade to the system in July 2017, the system is still vulnerable to failure with many single points of failure. Despite the procurement of a new system the implementation of the new EI software has not yet happened. This is multifactorial and includes the integrations not developed by AGFA at this time, system architecture not agreed by both parties and emerging risks regarding updating images following PAS updates	On-going work to secure go live date in 2019 has not been achieved. A programme group and contract board have been established with regular meetings in place. Executive support has been secured to progress significant risks to service delivery
Radiology contingency plan when PACS is not available is to print hard copy of urgently required images. Radiology need to revise their stock levels of printing film to mitigate any loss of service	Printing out images is not feasible for CT and MRI due to the high volume of images produced for each patient. CD's can be produced but not all PC's have CD readers. Work is on-going by radiology staff to assess the use of memory sticks for BCP	In the event of an emergency, key images could be printed for patients undergoing emergency surgery

The availability of the images on the modalities themselves will allow for reporting of cases if appropriate. Radiologists need re-directing to modalities to report direct	The storage is not infinite depending on how long an outage lasts it may be necessary to save images to CD until PACS functionality is restored	
Radiology CSU Business Continuity Plan in place	Needs annual review to ensure it is kept up to date- the options for PACS are limited	
Business Continuity suite of documents available on the Radiology drive available to all radiology staff	Under review in line with Trust policy	
Installation of the new AGFA EI	This has been in progress for many months and as yet is not able to be rolled out due to a number of issues, including lack of assurance regarding the robustness of the roll out to address multiple pathways and user requirements both within and outside Radiology	New EI should be installed in 2020. In the meantime I/T have procured additional storage capacity which should be installed by mid-January 2020.

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

Risk Description:
There is a risk of secondary harms to patients and potential fatalities as a consequence of delayed treatment due to a reduction in inpatient and outpatient capacity. This follows the suspension of some cancer pathways based on individualised clinical risk/benefit assessment, and all routine and planned procedures, including diagnostics and OP referrals, in line with NHSE/I/PHE guidance issued 17 March 2020. This was to provide capacity to meet the admission demand relating to COVID-19, and implementation of the phase 2 recovery plan.

Executive Lead: Chief Operating Officer

Date added to CRR: June 2020
Last reviewed: Aug 2020

Committee reviewed at:
Risk Management Committee

Controls	Gaps in Control	Further Mitigating Actions:
1. COVID-19 recovery and responsive delivery plan (phase 1-3) developed to re-establish routine and planned services, working with WYAAT partners, presented to EMG 29 April 2020 and EMG 6 May 2020.	Vaccine and antibody tests not currently available to identify wide spread (population) immunity and unlikely to be available for some time. Supply of PPE may not be sustained to meet changing demand and will limit the level of recovery activity that can be delivered; supplies will need to be prioritised for high risk areas. Reduction in the number of inpatient hospital beds due to the requirements for social distancing in line with national recommendations.	Escalation plan for potential second surge developed. Trust working with local and national procurement teams to maintain supplies of PPE. Forecasting tool implemented to track stock levels against forecast activity. Escalation at national and regional level by Director of Finance and Chief Executive. Group established with representation from IPC, Corporate Ops, nursing and medical directorate to agree plan for individual wards, working in conjunction with CSUs.
2. Specialty level plans, including local actions to mitigate most significant risks.	The risks of stopping all routine and planned procedures, including diagnostics and referrals are not uniformly	Quality Impact Assessments undertaken by CSUs in June to identify risk to planned services not being provided, overseen by the Corporate

	distributed. Routine referrals from GPs are not currently being received. Urgent and cancer referrals continue to be referred and managed and all referrals are triaged on an ongoing basis to assess clinical priority.	Operations team. Framework developed with guidance by Quality Governance team. Reviewed at EMG 24 June 2020, risk scoring 15> to be reviewed with CMO, Chief Nurse and COO July 2020. 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. Surgical teams across the Trust have reviewed their revised theatre allocations and subsequently prioritised clinically urgent patients (including cancer patients). All diagnostic waiting lists have been clinically reviewed and patients have been prioritised as urgent/can be delayed or low risk and have been sent back to referrers to be re-referred after COVID-19 if test still deemed clinically necessary. Clinical Directors are having ongoing discussions with clinical colleagues in Primary Care to discuss and manage risks; to be reviewed wit partners 17 June.
3. Outpatient appointments reviewed, converted to telephone consultations where clinically appropriate.	Outpatient environments may not be suitable to maintain recommended social distancing (2 meters).	Steering group established to work on implementing environmental social distancing measures across all hospital sites to facilitate the safe reintroduction of our services.

	Reduction in outpatient capacity due to requirements to maintain social distancing. Telephone consultations may lead to missed or delayed diagnosis.	Outpatient team working with CSUs to develop plans re telephone consultations and prioritised visits. To reduce risk and manage potential harm to patients, clinicians have clinically reviewed patients on all outpatient waiting lists to assess clinical priority. Where non-face to face appointments are not suitable, outpatient activity has been moved away from main SJUH/LGI sites wherever possible. Only essential face to face activity has been maintained. Clinical assessment and triage process in place at specialty level.
4. Clinical triage process in place for 2ww suspected cancer referrals.	Patients requiring investigation and/or treatment for cancer may choose not to attend hospital due to concerns and heightened publicity about impact on the NHS of COVID-19. As diagnostic services start to resume, prioritisation of referrals, where possible, and according to individual risk is required.	Cancer diagnosis, treatment and care continued in line with most recent NHSE/I guidance. Further triage and testing has been introduced where appropriate for cancer pathways. LTHT has continued to receive 2ww referrals. Every patient has been contacted either by letter or telephoned by a clinical specialist and triaged. Following this; patients are triaged into high, intermediate or low risk of cancer based

		on all available evidence.
5. All emergency treatments and interventions conducted taking into account the latest NHSE/I, Royal Colleges, national societies COVID-19 guidance.	Patients may choose not to attend hospital when they require treatment due to concerns and heightened publicity about impact on the NHS of COVID-19, 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. Urgent and cancer referrals continue to be referred and managed and all referrals are triaged on an ongoing basis to assess clinical priority.
6. Specialty cancer MDTs undertaken risk assessments and established process for tracking patients that have been deferred. In line with most recent NHSE/I advice, clinical guidance for the management of essential cancer surgery for adults during the COVID-19 pandemic is being followed.		Pre-op COVID testing/preparation guidelines in place and regularly updated in line with emerging guidance The patient tracking system has been adapted to ensure patients whose treatment has varied from standard protocol, or whose cancer pathway has been paused (be that in diagnostic or treatment phase) can be recorded, tracked and quantified. Weekly surgical oversight by a group of consultants on both LGI and SJUH sites in conjunction with the corporate cancer team.
7. Capacity in the Independent Sector (IS) in place for the continued treatment of patients, including stroke services, from 3 April 2020. Standard Operating Procedure produced to set out operational and governance arrangements.	Supply of PPE may not be sustained to meet changing demand and will limit the level of recovery activity that can be delivered; supplies will need to be prioritised for high risk areas (PPE supplies by NHS provider, LTHT). National contract ends 30 June 2020,	Trust working with local and national procurement teams to maintain supplies of PPE. Dashboard (forecasting tool) developed by trust procurement team to track supplies of PPE by clinical area to support local response. Contract to be reviewed in conjunction with IS

	extension not currently agreed.	and commissioners (June 2020).
8. Clinical Advisory Group (CAG) established 24 March 2020 to review concerns raised by clinical teams, including clinical concerns re planned and elective treatments.		
9. West Yorkshire and Harrogate Health and Care Partnership Stabilisation and Reset Plan, phase 1-3 (May 2020)		
10. Additional diagnostic capacity (CT scan) provided at NHS Nightingale Yorkshire & the Humber from 8 June 2020.		
11. Daily review of formal complaints and incident reporting data to identify potential harms; ensuring timely intervention to mitigate further harm and identify any themes and trends for actioning		

Risk CRRS 17: 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 comply with Government Guidelines (Working Safely during COVID-19), resulting in potentially fatal harm and a further depleted and dispirited workforce.

Executive Lead: Director of Human Resources

Date added to CRR: June 2020
Last reviewed: Aug 2020

Committee reviewed at:
This will be considered at the Workforce Committee at its meeting in July

Controls Note the controls listed are based on the sections of the Working Safely during COVID 19 guidance.	Gaps in Control	Further Mitigating Actions
Thinking about Risk and Managing Risk (Lead - Chris Carvey)		
Health and wellbeing Leads in all CSUs to keep in contact with those self-isolating/Shielding etc.		
Mental Health and wellbeing advice available via Intranet, Staff Connect and Facebook Group.	Lack of sustainable psychological support to staff including a source of funding	Working with LYPFT to identify a sustainable support model Approaching national charities as a potential source of funding
The Trust Board will have direct oversight in relation to managing this risk with Assurance provided by the Workforce Committee and Infection Control Committee.		
The Trust's short and medium-term People Priorities have been reviewed in light of the COVID-19 pandemic recognising the new working environment and risks.		
The Workforce Committee has been re-established to oversee progress against the updated People Priorities and		

associated risks.		
National guidance is available in relation to managing risk during the pandemic. This guidance is regularly updated and mechanisms are in place via the Incident Command Structure to ensure the latest guidance is being followed.	There is a projected cost of around £750,000 of health and wellbeing of staff over two years with no identified funding stream	
Specific COVID Workplace Risk Assessments developed to be completed by all areas with assurance to be provided by the Health & Safety annual Assurance Process	Formal assurance that assessments have been completed not yet available.	Managers asked to display posters (as recommended in the Working Safely during COVID 19 document) to display workplace assessment has been undertaken. Ongoing programme of inspections by accredited Health and Safety representatives.
Specific PPE risk assessments undertaken for all clinical areas.		
Occupational health guidance and risk assessment template for staff with underlying health conditions and pregnancy is in place and is regularly updated.		
Programme of positive action is in place to provide assurance that all precautionary measures have been taken for BME colleagues, including personal communication to all BME colleagues.	Assurance that checklists have been completed for BME colleagues.	Continue to seek assurance in relation to the remaining BME colleagues.
Organisational assurance framework for individual employee risk assessments agreed by Executive Team and EMG. This covers all currently identified vulnerable groups. A personal communication will be sent to all employees to ensure they are aware of this.		
On-going 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.	Staff not fully complying with social distancing requirements leading to increased risk of transmission and or requirement for staff to isolate.	Ongoing and proactive communications to seek to change staff behaviour
Who Should go to Work (Lead - Chris Carvey)		

Staff are encouraged to work from home wherever practicable - communicated via COVID Bulletin. This is supported by Working from Home Guidance and the roll out technology to support home working, for example Microsoft Teams.	Availability of IT such as laptops or mobile devices with VPN access is a limiting factor for homeworking Absence of a plan for a safe return to work for all employees who are shielding	Home and agile working workstream to continue to develop arrangements to facilitate new ways of working, including increasing the technological support. Develop a return to work plan for employees who are shielding
Blended working with staff combining home working and attendance at the workplace is encouraged to reduce the number of staff in the workplace at any time to enable social distancing for staff in the workplace.		
Where it is only practicable for a proportion of a team to work from home at any one time, cohorting and rostering of home working has been encouraged. In these circumstances, staff who are required to stay away from the workplace due to shielding or isolation are prioritised for home working.		
Occupational health guidance and risk assessments in place to identify vulnerable staff who are required to work from home or who should be priorities for home working.		
Workers in roles that are critical for business and operational continuity, safe facility management or regulatory requirements and which cannot be performed remotely have been identified		
Planning for minimum number of people on site to operate safely and effectively has taken place via Tactical Meetings		
The wellbeing of people working from home is undertaken by Line Managers and health & Wellbeing Leads - advice issued via COVID Bulletin, weekly email, Trust Internet and closed Facebook Group		
Social Distancing at Work (Lead - Jo Buck)		
The requirements for social distancing have been	• Ensure all areas have completed the	• Review completion of the

proactively communicated to all staff and managers	Workplace Assessment. • Advice available to managers who are competing the Workplace Assessment • Insufficient funding available to provide all physical social distancing prompts e.g. signage, screens / barriers. • Virus transmission between staff is 10 to 20 times higher than the average rate of transmission.	Workplace Assessment as part of the Annual Health and Safety Controls Assurance Process. • Provide advice and support to managers via the Health and Safety team, HR and Capital Planning. • Encourage working from home and flexible working solutions as the first response to ensure socially distanced non-clinical areas. • Capital planning to review all requests for physical prompts, to highlight non-physical options and to prioritise those that are most needed
Temporary closure of staff gyms and arrangements put in place to facilitate social distancing in areas such as staff rest rooms, canteens and shared/public areas.		**In light of recent Government guidance work will commence to put in place measures to support the reopening of the staff Gyms.**
A social distancing workstream has been established with several work streams that cover the areas outlined in the national guidance.		
Social Distancing group is installing physical prompts including signage and screens/barriers		
Managing your customers, visitors and contractors (Lead - Helen Christodoulides & Jon Craven)		
Restriction of Visitors to Patients is in place including wearing of face coverings/face masks	Vaccine and antibody tests not currently available to identify wide spread (population) immunity and unlikely to be available for some time.	Visiting guidance is being reviewed every 2 weeks by Director of Nursing (Operations) Screening checklist for visitors to be

		completed prior to visiting appointments made by clinical teams
Operational plan for the placement of patients in relation to COVID 19	Sustained compliance with operational plan (see CRR16)	Standard Infection Prevention and Control precautions
Restriction on Visitors to other areas e.g. Sales Reps are in place	Using the working Safely during COVID 19 as a guide conduct a gap analysis against the guidance	Development of an action plan to ensure appropriate action to mitigate any gaps.
Estates, Facilities, Capital, PFI Providers and Supplies contractors carrying out work on Trust premises have own risk assessments in place	Control of contractors in other CSU's may not be as robust	CSU's to review the Safe Management of Contractors Procedure and ensure suitable risk assessments are in place prior to work commencing on site.
Cleaning the workplace (Lead - Craige Richardson)		
Staff are encouraged regarding regular hand washing and surface cleaning - Communicated via COVID Bulletin	Using the working Safely during COVID 19 as a guide conduct a gap analysis against the guidance	• Risk assessment tool for working safely during Covid 19 pandemic" developed and is currently being completed by local managers. • Local development of an action plan to ensure appropriate action to mitigate any local gaps.
Hand gel and cleaning wipes provided and available in all areas.		
Staff are encouraged to opening windows and doors frequently to encourage ventilation		
Switched routine cleaning to the use of Chlor-clean for all cleaning with disposable cloths.		
Housekeeping staff have ensured the cleaning of objects and surfaces that are touched regularly e.g. door handles/light switches etc.		
In some areas signage is displayed regarding Social distancing for toilet areas		
Housekeeping staff have ensured enhanced cleaning in		

Public areas		
Good Mechanical ventilation is in place in some areas to ensure air flow is changed every hour.		
PPE and face Coverings (Lead - Gillian Hodgson)		
Risk assessments are in place and national guidance is being followed.	National guidance can change at short notice.	All clinical areas have PPE posters on entrance 27.04.20 Continue to review and implement changes to national guidance through the Bronze Commanders, ICC and Daily Briefs.
Identification and use of Latex products is recorded on each General H&S Risk Assessment for every and ward and dept and Latex products. Usually gloves, are restricted for use in certain areas e.g., Theatres	There may at some point be a shortage of nitrile/vinyl gloves in the supply chain and a 'Push' delivery of Latex gloves may occur making the use of these more widespread N.B., the use of disposable gloves are deemed to be essential items of PPE in some clinical and non-clinical settings	Delivery of Latex gloves will be highlighted via the Daily Update (15/06/20to LTHT to raise awareness as there will be further risk assessment required by managers in order to prevent susceptible individuals, staff and patients, coming into contact with Latex products.
Employees are requested to declare any known sensitivity/allergy to Latex upon commencement of employment via Occupational Health processes and are subject to annual health surveillance measures	That staff previously not sensitive to latex become so due to re-introduction of latex gloves	COVID-19 bulletin 15/06/20 advised staff, Managers of this possibility. To update risk assessment, raise awareness, staff to direct any queries to their line manager in the first instance, consider advice/referral from Occupational Health.
Daily Bulletin used to update staff and explain requirements for fit testing	The daily bulletin may not reach all staff.	Incident co-ordination centre set up (02/03/20) to respond to escalations which include receiving any concerns about access to fit testing. Twice daily Silver command structure (commenced 28th February 2020) reviewed the operational requirement for fit testing daily with all CSU's. Fit testing facilities shared through Bronze Commanders

		locally through daily local team huddles .Formal Bronze command for all areas established 16th March 2020. Planned Fit testing arrangements are shared on the Trust internet site.
Incident Command Structure used to ensure adequate on-going provision of PPE	Supply of PPE may not meet demand during the phase 2 recovery period. (Cross-reference CCRS16).	09/04/20 PPE levels are reviewed daily and an escalation process triggered if less than three days' supply is identified. Redistribution of PPE stock can be mobilized across site within 24hrs.through silver command to ensure adequate provision of PPE.
An approved supplier of Hand Cleansing & sanitising products is used by LTHT which results in approved products being used for hand cleansing and sanitising	LTHT has experienced non-delivery of the approved supplies of Hand Cleansing & sanitising products which has resulted in 'Push' deliveries of alternative non-approved products released into the supply chain which may create/exacerbate skin health problems for our workforce, especially if perfumed etc N.B., The use of skin cleansing/sanitising products is essential in order to reduce the potential of infection risk to both our staff and patients alike.	March 2020.Procurement assesses all Hand Cleansing & sanitising products before general use. Regular contact with SC Johnson/Deb to establish how/when normal service/supplies will be restored. A communication was circulated by H&S via the Daily Update in May to remind staff of the importance of skin care when hand washing is so frequent.
Workforce Management (Lead - Jo Buck)		
Advice has been given for staff to be split into teams or groups where practicable.	• Using the working Safely during COVID 19 as a guide conduct a gap analysis against the guidance. • Process required for regular staff testing for Super Cold Areas. • Margin of error of the Test	• Further work in relation to Cohorting of the workforce being undertaken. • Staff testing in place for test and trace • Workplace Action checklist

		developed and linked to annual Health and Safety Process
Maintain consistent pairing where 2 person deliveries are required		
Shops within the Trust are using Electronic payment methods		
The Trust is developing Communication/Training materials for workers prior to returning to site.	• Further work required to identify all staff that are shielding - staff recording issues on ESR • Work in progress to support staff that have been shielding - possibility of some staff returning to work on 1/8/20	• HR team contacting all staff that have been self-isolating over 14 days to check if these staff are shielders and records updated once known • Workshops planned for w/c 20.7.20 for staff shielding and for their respective managers
Testing in place for symptomatic staff and/or household members. Enough capacity and home testing available. Good levels of performance against turnaround time. This is actively monitored through the Incident Command Structure.		
Inbound and Outbound Goods (Lead - Chris Slater)		
Measures to minimise person to person contact for deliveries in place.	• There are on-going discussions with suppliers about on-site requirements. • There is less control over 3rd party goods deliveries for retail	• The Trust is moving to an off-site centre for deliveries to minimise cross=contamination and contact with Trust staff. Premises close to the StJUH site have been acquired and racking will be in place from 23 July 2020with a view to stock being delivered there from the end of July 2020 • Guidance for suppliers is being

		developed and will be available from early July 2020
Pick up and drop off collection points, procedures, signage and marking have been devised		
Methods to reduce frequencies of deliveries for example by ordering larger quantities have been undertaken particularly for PPE		
Where possible single workers unload/load vehicles		

CRRF 1: Failure to deliver the financial plan for 2020/21	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:
There is a risk that the Trust does not achieve its financial targets in 2020/21
Due to the inability to deliver the Waste Reduction Programme and planned activity levels due to delayed discharges, the impact of urgent care pressures on patient flow, changes to secondary care provision in other local trusts and the impact of COVID-19. May result in the possible loss of PSF funding from the DH.

Executive Lead: Director of Finance

Date added to CRR: May 14
Last reviewed: Apr 20

Committee reviewed at: Finance & Performance Committee

Controls	Gaps in Control	Further Mitigating Actions
Board owned financial plans	Implementation risks for Waste Reduction Programmes Although support from the PSF is protected, this does not help the Trust's overall cash position	Implementing the other centrally managed projects as per the plan. Work with the Trust's partners Asset sales
CSU ownership of realistic budgets and run rate based forecasts linked to the Integrated Accountability Framework launched in 2017.		
Operation of the financial performance framework		Transacting the performance management framework to ensure that CSU's fully identify and deliver their waste reduction targets and manage any pressures within the resources available.
Agreement with Leeds CCG and Specialist Commissioners for Aligned Incentive based contracts for 2020/21.	Impact of Leeds partners response to urgent care pressures	Work with the Leeds health economy to find a solution to the severe urgent care pressures facing the Trust within the resources available to the economy Effective implementation of the Aligned incentive contract with Leeds CCG and NHSE

		Specialised Commissioning including effective mechanisms to re-patriate NHS work currently done in the private sector
Implementation of Finance the Leeds Way Improvement Plan		
Integrated Care System (ICS) Financial Plan and Control Target	In 2020/21 the Trust will be monitored as part of the Integrated Care System (STP) control target which will need to establish an effective financial framework to ensure delivery of the target. Receipt of at least 15% of the Trust's Provider Sustainability Funding (PSF) will be reliant on delivery of the overall ICS control target	Work with the ICS to agree a framework and attempt to over-achieve the Trust control target to provide additional flexibility to the ICS
National funding arrangements due to COVID-19 to replace existing contract income and cover additional costs are in place.	Underlying financial control and performance maybe jeopardised.	Trust delegations in Standing Financial Instructions (SFI) remain in place.

CRRF 2: Insufficient Capital Resource	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 to the continuity of clinical services and a potential failure to comply with new medical devices regulations (Regulation EU 2017/45) by May 2020, due to the Trust having insufficient capital resources in the current and future financial years to replace ageing equipment and maintain the estate building and engineering infrastructure across clinical and support departments and to support the initial stages of Building the Leeds Way and an inability to demonstrate compliance with the Health Institution Exemption criteria in the medical devices regulations, resulting in potential significant harm to patients and unsafe conditions for staff, visitors and residents.

Executive Lead: Director of Finance

Date added to CRR; May 18
Last reviewed: Aug 20

Committee reviewed at: Finance & Performance Committee

Controls	Gaps in Control	Further Mitigating Actions
Five year capital plan and annual programme 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 may restrict spend in 2020/21	Capital plan to be refreshed in September 2020
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).	£14.4m is available for B&E in 2020/21, this reduces in 2021/22 to £6.1M. There is no contingency in the Capital plan for 2020/21 for any emergency failures. There may be further reductions in the amount of available Capital due to the Covid pandemic.	Once BTLW is completed at LGI this will remove circa £62M from the Trust backlog figure of £122M.
Estate risk adjusted backlog register updated annually to assist prioritisation of annual investment.	2019/20 Estates backlog review identified a backlog figure of £122m to bring the estate to condition 'B' standard. Note that this excludes additional costs that are dependent upon the project solution chosen (for example fees, VAT, decanting and temporary services to other areas)	Continued funding to complete annual external backlog reviews (Statutory and Physical condition) as per DOH guidance.
Agreed Estates and Facilities B&E Capital Allocation Procedure in place to ensure available Capital is spent on	The limited amount of B&E Capital is focussed on the known high risk items, no	

the correct priorities	additional funding is available for new risks in year and the significant number of items on the E&F risk register and backlog register.	
Trust Capital spent on backlog is increasing year on year which is currently focussed on BtLW.	Available B&E Capital is insufficient to make a significant reduction in the backlog figure for areas across the Trust not affected by BtLW.	As risks increase due to the lack of available B&E Capital they would be added to the E&F risk register and escalated to the CRR if required.
Estates and Facilities Risk Review Group meet every 2 months to ensure focus on reducing risk and backlog with available Capital.	The number of E&F risks greater than 10 is increasing year on year.	Robust oversight of the capital programme to ensure the capital allocation is spent in year.

Risk CRRF 3: Risk of further delays in delivering the refurbishment of the Generating Station Complex (GSC) at LGI	C =		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 =															

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 Finance

Date added to CRR: Oct 18
Last reviewed: Jul 20

Committee reviewed at: Finance and Performance Committee

Controls	Gaps in Control	Further Mitigating Actions

Risk CRRF 4: Risk of failure to deliver the hospital of the future project.	**C = 4** **L = 4**	16	**Very Low Risk**			**Low Risk**			**Medium Risk**		**High Risk**		**Significant Risk**			
			1	**2**	**3**	**4**	**5**	**6**	**8**	**9**	**10**	**12**	**15**	**16**	**20**	**25**
									Target Score					Initial & 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 in the programme; specification and quality matters; a lack of capital funding; as a result of stakeholder engagement matters; and/or inadequate resourcing. If the project is not delivered LTHT will have: insufficient capacity to meet service demand; will have high levels of backlog maintenance and resultant service challenges; will not be able to improve efficiency in a number of areas including estates utilization; will have maternity services on 2 sites and will not be able to centralize in line with commissioner requirements; and will have limited opportunities to further transform clinical services.	**Executive Lead:** Simon Worthington **Date Added to CRR:** May 2020 **Last reviewed date:** May 2020 **Committee reviewed at:** Building Development Committee

Controls	**Gaps in Control**	**Further Mitigating Actions**
A robust Programme and Project Delivery governance structure has been established to support the delivery and implementation of the Hospitals of the Future ("HofF") Project managed through a Programme Execution Plan ("PEP") and HofF Project Initiation Document ("PID").	Process for delivery effectiveness review with all stakeholders to be established (to also include key external stakeholders and strategic partners as appropriate i.e. CCG; wider staff and patients). Establishment of Finance Workstream to review all financial issues for consistency, integration, accuracy and affordability (combination of Programme Team and Corporate Teams) Integration of funding delivery plan with Leeds Cares delivery plan through formal agreement.	• Complete annual audit of governance arrangements - Jan2021 • Ensure strategic partners and stakeholders are clear as to where they are aligned within the governance arrangements- on-going • Engage in regular networking with other HIP schemes to ensure governance structure is best practice and effective - quarterly meetings. • WYATT updates to ensure integration of plans with other WY NHS Trusts - twice yearly. • Ensure regular reviews are completed of the recruitment process and skills mix requirements to ensure sufficient resources with right skills available when required – i.e. alignment with delivery programme -

		monthly.
The Programme Team have identified a risk/contingency allowance based upon a quantified risk assessment established at the Outline Business Case Stage – this is supported by a robust change management process governed through the Project Board.	Ensure LTFM updates reported to Programme Board to ensure any actions required including integration with other services in LTHT are monitored and escalated as appropriate. Market updates on economic factors to Programme Board and financial due diligence reports to be complete on key market contractors/ suppliers.	• Financial risks tracked and monitored monthly by Programme Management Group and through Finance Workstream. • Pathology scheme £8million shortfall identified in OBC and allocated against HofF contingency following discussions with NHSI/E. Procurement exercise commencing May 2020 and due to complete September 2020. • External advisors required to update regularly on key policy changes on-going at advisor briefings. • Further work is underway to identify cost implications associated with Net Zero Carbon. IT advisors appointed on Digital Hospital. Report to BDC September 2020. • LTFM to be reviewed and updated twice yearly to capture any financial changes (and identify risks) in costs/income/inflation. • Monitor delivery through stakeholder engagement and review other developments to ensure plans develop in line with timescales and provide sufficient capacity - monthly. • Further work underway to identify financial implications of Net zero carbon and digital hospital as outside original scope - on-going. • Regular monitoring and soft market testing/engagement of construction partners to ensure able to deliver project in timescales and in budget - monthly updates Programme Mgt Group.

		• Quarterly update and workshop sessions with Leeds Cares to ensure integration of plans between LTHT and Leeds Cares. • It is considered that any impact upon the development and implementation of the Programme and Project Resourcing Plan of Covid 19 can be minimised. The Programme Team are proceeding with the process to shortlist, interview and where appropriate appoint full-time resources for those posts that were released. There is not expected to be a significant impact upon the procurement of external resources.
The Programme Team have established and implemented a Project Assurance Process relating to all key design, specification and contract documents.	Programme board to review quality assessments of all "key" external advisors.	• Use of specialist/professional advisors with quality and deliverables monitored through PMG - monthly. • Review of Trust assurance processes through PwC internal audit process - on-going. • Introduce DHSC Gateway Review process following issue of central DHSC guidance - on-going. • Regular discussion with NHS regulators on procurement strategy, legal advisors and partners. Details in OBC - updates at least every month.
A Programme Level Communications and Engagement Plan has been established that is supported by a Hospitals of the Future Project specific stakeholder communications engagement plan.	Stakeholder feedback process to be developed and implemented.	• Public Consultation process completed (Maternity & Neonates) 6 April. Initial preliminary analysis expected by the end of April with Scrutiny Board review scheduled for May 2020.

		• Trust website and Intranet established with information on plans, programme etc. - on-going. • Delivery Plans monitored by Programme Board and Building Development Committee - monthly. • The Trust is planning, prior to the commencement of the next stage of the process, a detailed engagement and planning process that will seek to involve Commissioners in key workstreams and/or sub-workstreams (e.g. strategic fit and finance). - September 2020.
Regulatory review process for all capital developments within NHS and public sector before approval of scheme and contract close to ensure scheme within Trust/ regulator affordability envelope and approvals/authorisations.	Feedback to Commissioners on any affordability changes.	• Review by NHSE/I, DHSC, HMT at each stage to ensure compliance with guidance and to provide further assurance on-going. • DHSC guidance limits on changes to key assumptions without further approval to ensure plans are delivered with realistic assumptions - on-going. • Monthly updates to PMG, Programme Board and Building Development Committee on affordability issues.

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

Risk Description:
There is a risk that the Pathology Project fails to meet its objectives as a result of: delays in the programme; specification and quality matters; a lack of capital funding; as a result of stakeholder engagement matters; and/or inadequate resourcing.
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; will find it more challenging to attract high quality workforce with the right skills; will not be able to reduce backlog maintenance; will have limited opportunities to contribute to the implementation of the WYAAT network Pathology strategy and will not be able to centralise and transform services for patients with reduced testing times.

Executive Lead:
Simon Worthington

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

Committee reviewed at:
Building Development Committee

Controls	Gaps in Control	Further Mitigating Actions
A robust Programme and Project Delivery governance structure has been established to support the delivery and implementation of the Pathology Project managed through a Programme Execution Plan ("PEP") and Pathology Project Initiation Document ("PID").	Process for delivery effectiveness review with all stakeholders to be established. Establishment of Finance Workstream to review all financial issues for consistency, integration, accuracy and affordability (combination of Programme Team and Corporate Teams)	• Complete annual audit of governance arrangements. • Governance structure reviewed by NHS regulators as part of OBC review currently underway. • Trust Board assurance structure will monitor integration of scheme within LTHT and other organisations - on-going. • Pathology CSU governance and performance monitoring processes ensures risks/challenges/issues highlighted with evaluation of consequences - monthly. • Ensure regular reviews are completed of the recruitment process and skills mix requirements to ensure sufficient resources with right skills available when required –

		i.e. alignment with delivery programme - monthly.
Design solution proposes change across the WYAAT Pathology Network and for the building/Pathology Process to be developed as the most technologically efficient and advanced solution as possible.	Regular design and business process feedback back into WYATT to ensure flexibility, appropriate business and service processes are established across the network and that other network changes meet requirements and agreed milestones.	• Preparation and on-going up-date of a list of assumptions surrounding the design solution and the influences/impact on the wider WYAAT Pathology Network (i.e. technology) to be prepared and circulated. • Change Management Plans to identify impact of the design solution on other elements of the WYAAT Network (and Pathology business processes) and fed into the WYAAT Programme - on-going. • Review of similar schemes to ensure best practice implemented at LTHT - annual. • The Pathology Design Brief was developed to a much greater level of detail prior to COVID-19 (primarily due to its scale and linked with the procurement strategy) and will be sufficient (subject to refinement and further cost analysis) to commence a procurement process to select a Supply Chain Partner through the P22 Framework. The Programme Team have issued several tenders relating to the appointment of specialist external advisors in connection with the delivery of the Pathology Enabling Works. There was a good level of response. Weekly update meetings of key members of the Project Team are scheduled to ensure progress in line with milestones. • NHSE/I have confirmed receipt of the OBC as submitted in March 2020 following the BDC Committee Meeting. NHSE/I have

		indicated that there may be a delay to the review and approvals process due to some specialist resources having been diverted to support the COVID-19 response. The Trust has identified and implemented a mitigation response (as agreed with NHSE/I) confirming that it will continue with the P22 Procurement Process.
Tender returns must be in line with forecast capital costs to ensure scheme is within approval and Trust affordability requirements. Deliverability of technical solution will be fully evaluated through the procurement phase. Planning application submitted for the scheme.	Programme Board Report to be prepared summarising the outcome of planned soft market testing exercise with P22 partners.	• Detailed Project Plan agreed with NHSE/I to ensure delivery in line with key milestones and inflation forecasts - reviewed in monthly meetings NHSi. • Soft market testing commencing with P22 Framework Partners to ensure resources in place with partners and sufficient interest for robust competition for scheme within P22 framework parameters - May 2020. • Regular updates with P22 team at NHS Estates to ensure approval of key decisions and documents - quarterly.

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

Risk Description:
There is a risk that the Innovation District fails to meet its objectives as a result of: delays in the programme; specification and quality matters; a lack of capital funding; as a result of stakeholder engagement matters; and/or inadequate resourcing.
This will result in a failure to implement project objectives and participate in the Innovation District in Leeds and economic re-generation for the City.

Executive Lead:
Simon Worthington

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

Committee reviewed at:
Building Development Committee

Controls	Gaps in Control	Further Mitigating Actions
Governance structure in place for delivery of the Innovation District objectives involving all key stakeholders within Trust and also with other partner/members of the Innovation District Strategic Board. All sources of finance and funding will be evaluated in the OBC stage to assess affordability and deliverability within current environment.	Feedback from Project Boards of each partner organisation within Innovation Project.	• LTHT Programme Board meeting monthly and agreed project plan established. Further project documentation to be developed as part of the process to develop the OBC Strategy document. Workshops being arranged to define the project scope, objectives, and options for business case development. • Financial due diligence will be undertaken on all possible strategic delivery partners. Use of external advisors with specialist knowledge to ensure evaluation of partners - on-going.
Use of specialist advisors and partners. Review of other schemes to ensure deliver best affordable scheme delivering project objectives for LTHT and		• Specialist advisors carried out review of possible options for site and reviewed market assessment options/potential.

Innovation partners.		Reports to be reviewed in accordance with Project and Programme governance arrangements - on-going.
Completion of Business Case outlining key options, benefits, objectives, risk, finance requirements, economic options and agreed scope by summer. Update on progress reviewed at each Programme Management Group meeting. Business Case aligned to the HMT 5 Case Model.	Identification of NHS regulatory requirements for scheme completion and approvals required by other partners.	• Members of project team/workstream leads identifying specific requirements within area of responsibility for example finance, economic to ensure data available and currently under development for OBC before review in line with governance structure - annual process.
A Programme Level Communications and Engagement Plan has been established that is supported by a Innovation District Project specific stakeholder communications engagement plan.	Stakeholder feedback process to be developed and implemented.	• Engagement currently being undertaken with a range of strategic and supplier-based stakeholders to support the definition and scoping of the Project – outputs of this engagement to be summarised and submitted for Programme Board review - on-going.

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

Risk Description:
Failure to achieve the 95% compliance threshold against the 4-hour Emergency Care Standard, caused by an increase in attendances and insufficient patient flow. This can lead to a congested department impacting on patient outcomes, patient experience, staff morale, non-compliance with required national standards and financial penalties.

Executive Lead: Chief Operating Officer

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

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 capacity e.g. Package of Care, delays in accessing Community Care Beds.	Early identification of patients suitable for CCB/MOFD bed base and discharge to assess community beds.
Daily monitoring and reporting of 4 hour performance	Timeliness of bed allocation by CSUs to ED Absence of real time electronic bed state and real time beds overview.	Revised focus of Unplanned Care Programme to include Leeds Improvement methodology (A3) for: Improvement in Non-admitted performance SJUH site. Timeliness of bedback forms part of CSU delivery contracts improvement in overall compliance with the 95% standard at LGI Centralised operational model currently being tested and forms part of a PDSA to be reviewed post COVID.
Patient streaming in place to most appropriate route e.g. GP, Minors, Frailty, Jamma.	Estate footprint constraints	Continued monitoring of 95% compliance and breach analysis for patients streamed away from ED. Model currently being developed which identifies other estates options for LGI & SJUH. Forms part

		of the overall estates strategy.
Creation of space for a Rapid Assessment Unit at SJUH as a result of the transfer of Jamma, Frailty and Minors.	Estate footprint constraints	St James's RAU model in place since April 2019. LGI rapid Assessment Unit currently in pilot phase to develop RAU model based on learning from SJUH. RAU functional both sites however further estates solution at the LGI required to allow for maximum utilisation.
System level action plan including Newton Europe recommendations being implemented and monitored through SRAB / A&E Delivery Board.	Community capacity to support timely transfer of patients from acute bed base. Complexity of discharge pathways.	Decision making work stream to continue to implement work plan and wider actions/recommendations to be monitored through SRAB. ARC programme internal to LTHT to commenced from October 2019 with rollout over the next 18 months.
Weekly Operational Winter Group (partner meeting) in place to review themes and actions required to help facilitate improved patient flow. System level trajectory for reduction in numbers of Super stranded patients agreed with partners in place	Continue with high numbers of Super stranded / MOFD patients within a hospital setting.	Actions to deliver trajectory by **March 2020** Implementation / progress SRAB action plan **ongoing** Super-stranded trajectory of 319 delivered linked to system response in light of COVID - will need to ensure sustainability post COVID.
System level mutual aid actions (system wide agreed tactical options to be considered during periods of escalating pressures)	Ability of system partners to respond in a timely fashion	Monitoring of Mutual Aid actions through System Partnership Resilience Group and Operational Winter Group
Winter planning sessions with CSU's for 2020/21	Unpredictable activity levels	Operational response guidance developed and monitored through daily operational processes developed and refined in time for winter 20/21

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

Risk Description:
There is a risk that the Trust will not deliver 18-week RTT performance either because outpatient activity has been limited to urgent patient reviews or patients suitable for remote review.
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 14
Last reviewed date: May 20

Committee reviewed at: Finance & Performance Committee

Controls	Gaps in Control	Further Actions Planned:
Liaison with CCG and GPs have significantly reduced referral numbers.	This is a temporary measure likely to cease in early May 2020.	
Rapid roll-out 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	Use of Patient Knows Best system to enable patients to upload care information for review by clinical teams.
Triage of referrals enables identification of some patients at risk of harm if appointments are delayed.	Quality of referrals from GPs can vary.	
Delivery contracts with CSUs will enable improved management of recovery trajectories	Prolonged social distancing restrictions may limit activity and result in continuing growth in waiting lists.	
Single points of access in some specialties will allow onward referral of routine activity to AQP's spreading burden across providers	AQPs will be subject to same restrictions on activity as LTHT.	

Work with commissioners to control growth in referral rates where appropriate alternate pathways exist.		
Recovery plans to allocate available theatre, critical care, ward and staff capacity to areas of greatest clinical risk.		
Use of Royal College guidance to prioritise elective activity to improve planning for capacity allocation to patients with greatest clinical need.		
Established arrangements are in place to allow additional outpatient and inpatient activity to be scheduled outside normal working hours - likely to be required during recovery phase	Pension taxes had reduced number of additional sessions provided by consultant staff	
Independent sector capacity likely to be available to support during recovery phase	Need to confirm how available capacity to be used in conjunction with NHSE/I guidance and commissioners.	

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

Risk Description:
There is a risk that the Trust will not treat 85% of all patients who are on a 62 day referral to treatment pathway before March 2020 (as per submitted NHSI Trajectory) or 85% of Internal and referral by Day 38 patients until Jan 2020. This is due to the risk of late referral from other providers, an imbalance between capacity and demand, variable waiting list management, insufficient control over pathways of care or higher than expected urgent care demand.

This may result in poor timeliness of care, unsatisfactory patient experience, and unacceptable delays for patients, deterioration in staging at the point of treatment with worsened clinical outcomes and/or deterioration in LTHT's governance rating.

COVID 19
The Trust has invoked its Emergency Response Arrangements due to a viral pandemic (COVID-19) causing the absence of significant numbers of Trust staff and large increase in demand which could overwhelm the Trust's ability to deliver routine care and result in potential fatalities and significant financial loss.

Executive Lead: Chief Operating Officer

Date added to CRR: May 14
Last reviewed: May 20

Committee reviewed at:
Finance and Performance Committee

Controls	Gaps in Control	Further Actions Planned:
The Trust Board has a named Executive Director responsible for delivering the national cancer waiting time standards.	None	None
The Board receives 62 day cancer wait performance reports for each individual cancer tumour pathway, not an all pathway average and will scrutinise actions to improve performance.	None	None
The Trust has a cancer operational policy in place which has been approved by the Trust Board. This has recently been updated to reflect the service delivery changes.	None	None
The Trust maintains and publishes a timed pathways, agreed with the local commissioners and any other Providers involved in the pathway, taking advice from the Cancer Alliance for the following cancer sites:	Referrals from other providers do not always occur in a timely manner to support delivery of	WY Alliance has in Sept employed a co-ordinator to support improved timeliness of IPTs through co-ordination between referrer

lung, colorectal, prostate and breast	62 performance	and LTHT. Impact to be assessed end **April 2020** IST analyser tool is being used as part of the diagnostic work on the optimal pathways groups in prostate, colorectal and lung. Prostate most advanced and service changes to deliver optimal pathways commenced in Sept. Impact assessment end Nov 19 Optimal pathway group in lung and colo-rectal established Upper GI commenced October 19. Breast and Pancreas are both value streams as part of LIM.
The Trust maintains a valid cancer specific PTL and carries out a weekly review for all cancer tumour pathways to track patients and review data for accuracy and performance.	Awareness of 62 day Breach risks are not always visible to CSU management teams	Production Boards (PB) in use in most CSUs containing cancer risks and forward booking profile. Corporate Cancer Team PB reviews weekly 2WW and 62 day risks to alerts CSUs New cancelled ops and 28 day re-booking process established and significant improvements seen - Review **end Dec 2019**
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 breeches.	All CSUs are reviewing the RCAs and incorporating lessons learnt into huddles. Also forms part of the discussions at PTL review meetings and CSU huddles.
Capacity and demand analysis for key elements of some but not all of the pathways not meeting the standard (1st outpatient appointment; treatment by modality) is carried out systematically and routinely.	Capacity & demand modelling is not routinely completed for all elements of every pathway	Engagement with NHSI on the use of their Capacity & Demand modelling tool in key pathways initially through 19/20 - this forms part of the optimal pathways work for those pathways included.

		For all other pathways agreement with informatics on how to specifically identify cancer capacity and demand is needed - will report at end **Dec 2019**
An Improvement Plan is prepared for each pathway not meeting the standard, based on breach analysis, and capacity and demand modelling.	The use of the IST analyser tool is not yet embedded routinely in the key pathways to review breaches - not considered a useful tool to track following a number of pathways trialling.	This will be incorporated into the optimal pathways work using the IST analyser tool to provide CSUs with a clear understanding of where the pathway blocks are and which patients are at risk of breaching - not all optimal pathways have been completed but should be **end of Dec 2019** WY Alliance have, in Sept employed a co-ordinator to support improved timeliness of IPTs through co-ordination between referrer and LTHT. Impact to be assessed **end Dec 19** Developing streamlined diagnostic processes through LICS/early diagnostic programme to get to diagnostics earlier and reduce diagnostic demand. - **end Dec 2019**
The national guidance on reporting methodology being consistently applied.	None	None
A clinical review of 104 day patients undertaken.	None	Process has been shared and reviewed by the IST team working with LTHT.
COVID 19 In response to the Trust enacting it's Emergency Response Arrangements due to a viral pandemic (COVID-19) LTHT have identified a number of actions to mitigate risk in relation to the diagnosis and treatment of cancer including • Cancer diagnosis, treatment and care continued in line with NHSE/I advice dated 30 March 2020.	None	

• Specialty cancer MDTs have undertaken risk assessments and established process for tracking patients that have been deferred. • LTHT continues to receive 2ww referrals and patients are being triaged by phone where possible or contacted by letter. • Patients have received information on what to do/who to contact if symptoms progress • Changes have been made to PPM to allow recording and future auditing of variance from standard treatment protocol during the current pandemic. • A group of consultants supported by the corporate cancer team have been established for weekly oversight on LGI and SJUH sites to review and support prioritisation, decision making and support the development of recovery plans. • A COVID related 'holding' list of patients on cancer pathways has been created within PPM. This summary report identifies patients whose pathway has been paused whether at diagnostic or treatment stage. • Weekly review/oversight by Cancer Board • All CNS teams continue to support patients by telephone • Corporate Cancer Team in conjunction with Maggies have opened a patient support line that operates 7 days a week including bank holidays • Proposals for a phased recovery are being developed internally, mindful of local issues & national policy decisions. • LTHT cancer leads are working with WY&H Alliance and partner organisations to develop robust recovery plans which ensure priority is given to the timely treatment of cancer patients. • Cancer Board convening weekly to commence planning and review of cancer recovery		

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

Risk Description:
There is a risk that the Trust does not achieve the 28 day cancelled operations target due to acute activity pressures, critical care capacity, availability of theatre time, patient flow and the impact on elective bed availability, resulting in delays to patient treatment and possible harm and financial penalties

COVID 19
The Trust has invoked its Emergency Response Arrangements due to a viral pandemic (COVID-19) causing the absence of significant numbers of Trust staff and large increase in demand which could overwhelm the Trust's ability to deliver routine care and result in potential fatalities and significant financial loss. This has led to an increased risk of patients having their planned procedure cancelled.

Executive Lead: Chief Operating Officer

Date added to CRR: May 14
Last reviewed: Aug 20

Committee reviewed at:
Finance and Performance Committee

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

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

Oversight Monthly meetings with CSU's who experience the highest numbers of 28 day breaches to understand the reasons for cancellations and why they are unable to rebook patients within 28 days		Creation of a "user friendly" guidance document of the standard & update the Elective Treatment Access Policy Introduction of weekly review of breach risks, including an oversight email to CSUs highlighting their breach risks for the month
COVID 19 In response to the Trust enacting it's Emergency Response Arrangements due to a viral pandemic (COVID-19) LTHT suspended routine and planned procedures including diagnostics and referrals, in line with NHSE/I/PHE guidance issued 17 March 2020, to provide capacity to meet the admission demand, including critical care and respiratory. In response LTHT is planning it's recovery response as outlined below • Proposals for a phased recovery are being developed internally, mindful of local issues & national policy decisions. • LTHT cancer leads are working with WY&H Alliance and partner organisations to develop robust recovery plans which ensure priority is given to the timely treatment of cancer patients. • Cancer Board convening weekly to commence planning and review of cancer recovery	Capacity may not be sufficient to meet likely demand	Options appraisal is being developed which will aim to maximise the capacity available whilst minimising the risk to staff and patients of COVID 19, including all LTHT sites, the Independent sector and partner organisations More operating capacity created to support the delivery of services from 25th May 2020. All CSUs have undertaken 2 rounds of PTL validation based on national guidance and a further round is due at the end of July. From this work Theatre allocations are made for each specialty to reflect the volume of the most urgent patients they have. CSUs continue to work with IS providers to provide additional capacity based on clinical priority. Spire (Leeds) also working up a plan to deliver Level 2 CC capacity which will support additional activity. All patients listed for elective surgery self-isolate for 2 weeks and have a COVID swab within 72hrs of surgery, therefore the implications and disruption to patients' lives of a cancellation are significant. To reduce the likelihood of cancellation • CSUs are listing patients up to 3 weeks in advance which allows for all prep work to be completed

		and reduce on day problems • CSUs are utilising the Theatre scheduling tool to reduce the likelihood of overbooked lists • CSUs are working in close collaboration with Critical Care to even out demand • Some CSUs are holding a reserve list of patients who can be scheduled at the last minute if a cancellation does occur to ensure the theatre time is utilised

CRRP 5: 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 emergency admissions, caused by increasing demand and insufficient patient flow. This can lead to high bed occupancy levels impacting on our ability to maintain elective operating, non-compliance with national standards, poor patient outcomes and patient experience.

Executive Lead: Chief Operating Officer

Date Added to CRR: Sept 15
Last reviewed date: May 20

Committee reviewed at:
Finance & Performance Committee

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

DOP / CSM out of hours support and co-ordination.		
Robust bed modelling analysis to identify known activity surges Operational Response Guidance in place from November 2019. Winter planning sessions to be undertaken and operational guidance in place from **Nov 2019**	Physical capacity	Opel 4 actions to be further developed and incorporated into the operational Guidance - Feb 2020
Management of Long Length of Stay patients (Stranded patients)	Ageing population with complex comorbidities leading to increased demand on health and social care services without the required community infrastructure to keep people in their own home (particular at time of crisis) Multiple ward moves in patient pathway leads to increase length of stay.	Complete (system level) all actions outlined within Newton Europe recommendations. **Monthly monitoring through SRAB** Roll out of ARC programme across LTHT wards from **Oct 2019.** Roll out commenced across cohorts 1&2. Full rollout expected within 18 months of go-live date - rollout currently on suspended due to COVID. Patient pathway review in Medicine and Elderly to review non-clinical ward moves by **Nov 2020**
City wide OPEL escalation and mutual aid actions.	Discharge to assess process of not fully established	Feed into System level Winter Review meeting
Maximum utilisation of community care beds and Early Supported Discharge models.		Decision making workstream to continue to implement work plan and wider actions/recommendations to be monitored through Systems Resilience Assurance Board
Additional capacity in partnership with Villa care to provide a ward capacity on Beckett Wing in times of extreme demand	Ability of private providers to deliver the required care packages to enable early transfer for patients from a hospital setting.	Escalate patient flow concerns through weekly ODG / Operational Winter Group. **Weekly**

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

Risk Description:
Risk of patients being cared for in non-designated areas, high number of outliers in wards and overnight admissions to Surgical Assessment Unit (SAU), caused by demand outstripping available capacity and reduced outflow from the acute bed base. This can lead to poor patient outcomes, poor patient experience increased out of hours transfers and a failure to comply with national performance standards (e.g. ECS compliance and Last Minute Cancelled Operations).

Executive Lead: Chief Operating Officer

Date added to CRR: May 15
Last reviewed: May 2020

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 capacity e.g. Package of Care, delays in accessing Community Care Beds.	Early identification of patients suitable for CCB/MOFD bed base
Demand prediction model established and winter plan matched against key pressure points. Decision Management Tool in place including options for extremis, subject to silver command decisions.	Estate capacity	CSU winter workshops to be held for 2020/21 and actions to be updated within Operational Response Guidance following Winter Workshops **November 2020**
Operational Response Guidance developed and early escalation of risk of patients being care for in NDAs through to the on-call teams.	High numbers of MOFD / Super stranded patients within LTHT.	Decision Management Tool forms part of operational response guidance to be updated reflecting learning from previous winter - **Nov 2020**
Continued focus on ambulatory models of care to ensure admission avoidance wherever safe and possible to do so Daily consultant ward rounds across all CSUs.	Continue with high numbers of Super stranded / MOFD patients within hospital bed base. (Currently achieving required trajectory as a result of COVID response - monitor sustainability through recovery period)	Systems level trajectories agreed and actions agreed to deliver reduction in super stranded numbers LIM work on SAU to further enhance ambulatory models of care. Enhanced surgical cover by **Dec 2020**

CSU surge plans in place.		
Dedicated outlier team to provide consistency of cover to patients being cared for outside of ESM bed base.	Winter pressures / Nurse staffing 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. **Refreshed Operational Response by Nov 2020**
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 **March 2020 - Improvement trajectory of 319 delivered as a result of COVID response. Work with system partners to ensure sustainability post COVID.**
Continued system level work to strengthen community models and allow maximum utilisation of Community Care Beds.	Discharge to assess pathway not in place	Review as part of system wide winter review meetings admission protocol/criteria to be reviewed and managed through decision making workstream.

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

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

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

Executive Lead: Chief Operating Officer

Date Added to CRR May 15
Last reviewed date: May 20

Committee reviewed at:
Finance and Performance

Controls	Gaps in Control	Further Actions Planned:
Prioritisation of waiting lists in line with Royal College guidance identifies patients at most risk of harm from long waits enabling prioritisation of priority.	None	
Recovery planning recognises the need to deliver capacity for long waiting patients.	None	Development of flexible phased plans to deliver additional capacity
Additional theatre and inpatient bed capacity may be provided by re-allocation of theatre sessions and bed capacity to those with longest waits	Existing surgeons must be allocated to cover additional sessions, which can stretch teams if more sites need cover. Reallocation of capacity may result in growing waits in other services.	Potential use of IS capacity to deliver additional theatre and bed capacity.
Additional outpatient sessions are relatively easy to schedule and outpatient waiting lists can reduce quickly if clinicians are available	Social distancing rule may result in less efficient use of outpatient capacity	Roll out of new working models (eg virtual reviews) can deliver additional capacity.
Established arrangements in place to allow additional outpatient and inpatient activity to be scheduled outside	Relies on staffing throughout overtime and additional hours.	

normal working hours.		
Independent sector capacity used to deliver activity where possible	Providers in Leeds deliver activity using LTHT surgeons increasing risk of burnout. Capacity outside Leeds has failed to deliver significant capacity with high rejection rate and may be required by local Trusts.	

Risk CRRP8: 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			
	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 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. The impact of actions taken to protect patients and staff during the COVID -19 lockdown period has led to a position where although waiting lists for these tests have been significantly reduced , activity levels have been at much reduced levels, focussed on urgent patients only . Areas where the test involves an aerosol generating procedure (endoscopy, bronchoscopy and lung function tests) have been restricted to acute needs only.

Executive Lead: Chief Operating Officer

Date Added to CRR:
May 2014
Last reviewed date:
May 20

Committee reviewed at:
Finance & Performance

Controls	Gaps in Control	Further Actions Planned:
Weekly COVID-19 Tactical meeting to manage process during lockdown and recovery in place, chaired by ADOP with clinical input from all CSUs.	Data available to all diagnostics teams is not the same, with limitations in data from some clinical systems (e.g. CRIS and Cardiobase) to support management and recovery planning. Support from IT is constrained to support better data production.	Recovery planning commenced week beginning 20th April 2020. Waiting lists across all diagnostic areas (2ww, 6ww, planned/surveillance) are being quantified and recovery priorities established at CSU level.
Weekly Diagnostic month end breach prediction process continues to be in place.	Normal actions to highlight and provide additional capacity to address key pressure areas are suspended during the COVID-19 period.	
Monthly Operational Delivery Contract escalation process for those CSUs not achieving the 99% standard or where risks persist.		
Diagnostic Improvement Board in place with key workstreams for all 4 major diagnostics services agreed.	Diagnostics Board has been suspended until September 2020.	Opportunities identified as part of previous Diagnostics Board work will be fed into recovery action planning where appropriate.

Equipment replacement programmes agreed for MRI, CT and Cath Laboratories during 2020/21. 1st phase commenced for MRI and CT.	Progress of next phase for MRI, CT and Cath laboratories unclear due to capacity required for COVID recovery. Radiology replacement plans depend on NHSE funding.	Meeting with Deputy Medical Director on 1st May to review Cath Laboratory options. Radiology including planned replacements as part of their recovery planning until position with NHSE funded replacement becomes clear.