The Leeds Teaching Hospitals NHS Trust

CORPORATE RISK REGISTER

September 2021

Summary Corporate Risk Register September 2021

CRR No.	Former CRR No.	Nature of Risk	Date added to CRR	Executive Lead	Current Risk Score	Last Reviewed By RMC	Next Review By RMC	Link to LIM Value Stream	CRR Page No.
		Safety and Quality Risk							
CRRS 1	CRR 1	Inadequate nurse staffing levels	May 14	Chief Nurse	16	Aug 21	Feb 22		4-6
CRRS 2	CRR 18	Insufficient Medical Staff to deliver service	May 14	Chief Medical Officer	16	Apr 21	Oct 21		7-8
CRRS 3	CRR 2	Healthcare acquired infection	Mar 19	Chief Nurse	16	Aug 21	Feb 22		9-12
CRRS 4	CRR 33	Harm due to clinically related behaviours that challenge linked to organic, mental health or other reasons	May 15	Chief Nurse	16	Jun 21	Dec 21		13-16
CRRS 6	CRR 42	Risk of a viral pandemic	May 18	Chief Operating Officer	15	Sept 21	Mar 22		17
CRRS 11	CRR 35	Power failure/lack of IPS/UPS resilience due to electrical infrastructure	Aug 15	Director of Estates & Facilities	16	Jul 21	Jan 22		18-20
CRRS 16	-	Risk of re-commencing normal activity levels due to reduced capacity (COVID-19)	Jun 20	Chief Operating Officer	20	Sept 21	Oct 21		21-27
CRRS 17	-	Staff Health, Safety and Wellbeing During the COVID-19 Pandemic	Jun 20	Director of Human Resources	16	Sept 21	Oct 21		28-42
CRRS 18	-	Failure or complete outage of the Patient Administration System	Aug 20	Chief Digital Information Officer	15	May 21	Nov 21		43
CRRS20	-	Delivery of the Leeds & West Yorkshire Vaccination programme	Dec 20	Chief Medical Officer	16	Sept 21	Oct 21		44-48
CRRS21	-	Patient harm – falls and hospital acquired pressure ulcers (COVID-19)	Mar 21	Chief Nurse	16	Sept 21	Mar 22		49-50
		Financial Risk							
CRRF 1	CRR 9	Failure to deliver the financial plan 2021/22	May 14	Director of Finance	15	May 21	Nov 21		51-53
CRRF 3	CRR 44	Risk relating to commercial pressures arising from delays in delivering the refurbishment of the Generating Station Complex (GSC) at LGI	Oct 18	Director of Estates & Facilities	15	Jul 21	Jan 22		54
CRRF 4		Risk of failure to deliver the hospital of the future project.	May 20	Director of Finance	16	May 21	Nov 21		55-60
CRRF 5		Risk of failure to deliver the pathology project.	May 20	Director of Finance	16	May 21	Nov 21		61-64
		Performance and Regulation Risk							
CRRP 1	CRR 12	Failure to achieve Emergency Care Standard	May 14	Chief Operating Officer	20	Jun 21	Dec 21	ED LGI	65-67
CRRP 2	CRR 13	18-week RTT target non-compliance	May 14	Chief Operating Officer	20	Jun 21	Dec 21	Ophthalmology/ Cardiac Surgery	68-70
CRRP 3	CRR 15	62-day cancer target	May 14	Chief Operating Officer	16	Apr 21	Oct 21	MDT & Pancreatic Breast Only	71-74
CRRP 4	CRR 23	Failure to achieve 28 day cancelled operations target	May 14	Chief Operating Officer	16	Mar 21	Sept 21	Cardiac	75-77
CRRP 5	CRR 31	Patient flow and capacity for emergency admissions (health economy)	Sept 15	Chief Operating Officer	20	Jul 21	Jan 22	MMPS	78-81
CRRP 6	CRR 32	Levels of medical outliers	May 15	Chief Operating Officer	15	Apr 21	Oct 21		82-84
CRRP 7	CRR 45	52-week RTT target non-compliance in spinal injuries and colorectal	Oct 18	Chief Operating Officer	16	Apr 21	Oct 21	Neurosciences	85-86

		services							
CRRP 8	CRR 22	Patients waiting longer than 6 weeks following referral for diagnostics tests	May 14	Chief Operating Officer	16	Jun 21	Dec 21	Breast cancer	87-88

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: May 2014
Last reviewed: Aug 2021

Committee reviewed at:
Workforce Committee

Controls	Gaps in Control	Further Mitigating Actions
Continued focused recruitment of both general and specialist registered nurses.	Inability to reduce vacancy gap due to decrease in supply of qualified registered nurses regionally and nationally. Increase in nursing turnover post Covid-19.	Recruitment of 340 international nurses through Health Education England (HEE) Global Learning Practitioner programme and international recruitment agencies by August 2021. All recruitment now completed for this cohort. 75 WTE additional international nurses to be recruited by December 2021 to mitigate increase in turnover.
Roster management and daily Nurse Staffing Status Report (NSSR) to ensure appropriate distribution of resources.	Currently no Trust wide live system for monitoring acuity and dependency to provide more consistent evidence based approach for real time deployment of staff. Two systems in place, NSSR turned off for St James site and SafeCare professional judgement in place. LGI and CAH still on NSSR.	SafeCare roll out agreed and implementation commenced. Progress and performance monitored by SafeCare project board chaired by the Director of HR. Daily staffing meetings to ensure appropriate distribution of resources chaired by Director of Nursing (Operations). SafeCare professional judgement and NSSR risk assessments reviewed

		and appropriate mitigations put in place.
Safer staffing guidance and escalation pathway to ensure operational oversight and appropriate mitigation in safe deployment of staff. This includes the out of hours, assessment, assurance and escalation for safe nurse staffing guidance.	Variance in practice across CSU's in relation to roster governance and management. Impacts on safer staffing returns (Hard Truths) and timely release of vacant shifts to bank and agency. Increased demand for critical care capacity (Level 2/3 beds) in response to Covid-19 and recovery work. High levels of vacancy across ACC.	Safer staffing resources, escalations and safer staffing policy available on the Trust intranet. All safer staffing documentation reviewed and monitored through the Nursing, Midwifery, AHP Workforce Group (NMAWG). Temporary wards (seasonal and surge capacity) included in external safer staffing return once opened for full roster period of six weeks. Roster management master classes for ward leaders and matrons to commence September 2021 to improve roster governance. 28 Critical Care trained internationally recruited nurses arrived in March 2021 and registered with the NMC. Remaining 32 nurses arriving in July/August 2021. Investment plans utilising funding from NHSE/I submitted from Critical Care and other surge specialties to provide clinical training and Health and Wellbeing support to the nursing workforce.
Introduction of new registered roles to support workforce	New role with a limited evidence base on patient outcomes. Impact of COVID pandemic has resulted	Adherence to best practice and safer staffing guidance. Nursing Associate deployment reference group commenced to support governance and assurance of new role. Future You programme implemented to create

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

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 2014
Last reviewed: April 2021

Committee reviewed at:
Resource Management Group

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

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

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

Risk Description:
Effective management systems are not in place or sufficient to protect patients from the risk of hospital acquired Clostridium difficile infection, Methicillin Sensitive *staphylococcus aureus* (MSSA)bloodstream infection(BSI), respiratory infections and bloodstream infections caused by multi-resistant organisms caused by insufficient compliance with infection prevention procedures, including hand hygiene, decontamination, environmental cleaning and insufficient training.

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

Executive Lead:
Chief Nurse

Date added to CRR: Mar 19
Last reviewed: Aug 2021

Committee reviewed at:
Infection Prevention and Control Committee

Controls	Gaps in Control	Further Mitigating Actions
Risk Assessment: Patient level assessment of risk on administration/arrival/transfer (filled in patient care record) IPC/Microbiology risk assessment completed electronically in PPM. IPC alert mechanism incorporated into electronic patient record (PPM+).	The risk assessment process is partly electronic and partly manual which means that this is not always 100% successful. The ICNET software is no longer supported by the Company and planned decommissioning will complete during March 2021 which will leave LTHT without an established mechanism for identifying transmissible infections. As part of the IPC pandemic recovery plan the team are currently using a combination of PPM+ results, alerts and the unsupported system to increase the ability to detect infections however subsequent investigation is demonstrating that some individual cases are being missed.	IPCT running two systems to provide quality assurance. LTHT has secured funding and commenced implementation of new ICNET technology including the Surgical Module. Implementation of phase 1 -lab package to be completed by October 2021 Phase 2 -surgical model implementation due to commence October 2021. Existing HCAI reports continue to be used to monitor trust wide performance, on-going. Any new reporting requirements will need to be risk assessed and provided through PPM +. COVID 19 reports are being generated directly from PPM. On-going
Training Policies and Guidelines: Mandatory infection	Compliance with policies - Human factors	Quality Improvement methodology adopted

prevention and control training to all staff, with an overarching Infection Prevention and Control Policy and a suite of Guidelines and SOPs.	and system issues.	with a Trust wide HCAI collaborative and LIM utilised in response to lessons learnt from incidents. Incident command structure in place for COVID-19 related gaps in compliance to ensure a rapid approach to learning and trust wide dissemination.
Environmental Controls: Environmental decontamination programme and standards, segregation and safe disposal of waste process, programme of water safety and IPC design incorporated into refurbishments and new builds.	Limited access to decant facilities to support a rolling programme of deep cleans. No routine HPV conducted during COVID-19 Pandemic. Limited ability to support the IPC design into refurbishments and new builds. Multi-resistant Pseudomonas likely to be caused by environmental factors in water supply and water drainage within the haematology and BMTU specialty. Outbreak meetings have identified on-going issues with the design of the environment including sinks showers and drains in the near patient environment which may provide the point source Limited side room capacity	Optimise every available area when a clinical area becomes free. Opportunities have been taken to undertake HPV when a ward has been returned to cold elective activity as part of the recovery plan. A forward plan for deep cleaning is being developed with the CSUs in line with the recovery plan. Close liaising with Head of Estates (Capital) who will escalate higher risk projects to IPC Matrons. Alternative technology being explored. Temporary cessation of patient showering whilst a focused review of all water outlets and design is completed by the trust water safety committee and the trust Authorised person for water. July and August 2021. Weekly screening of inpatients. Commenced May 2021 until environmental factors has been addressed. Water filters applied to all water outlets. May 2021 Daily monitoring of water outlets, June 2021 until all estates remedial work has been completed. Twice weekly decontamination of drains June

	Large parts of the estate have natural ventilation only. An options appraisal for understanding where further mechanical ventilation is required and can be delivered.	2021 on-going. Planned re design and removal of problem outlets. Corporate planning are undertaking a review of side room capacity and an options appraisal to deliver further side room capacity is being developed by end of July 2021. Estates have undertaken a review of the ventilation Trust wide and Mechanical ventilation installed in Respiratory Speciality Unit. Trust wide Ventilation Safety Group being established September 2021. Estates and IPC to develop a Trust wide ventilation group.
Antimicrobial Stewardship: Policies and Standards, City Wide Group, Ward Rounds and day 3 IV antimicrobial review	Worldwide shortage of antimicrobials.	Contribution to national planning from MMPs and a robust process for notification and identification of alternatives in place.
Detection: Monthly surveillance monitoring and assurance through monthly Perfect Ward meetings and additional hand hygiene audits and ward assurance visits.	Surveillance software to identify new cases of infection ceased to be supported from June 2019 and will be decommissioned by March 2021. LTHT has secured funding and commenced implementation of new ICNET technology.	IPC currently accessing two systems to cross check results. In addition, the IPC Leadership team continued to review the HCAI performance at Trust level and the Consultant Microbiologists provided CSU level review and feedback. HCAI assurance monitoring through the Perfect Ward to be recommenced. Implementation ICNET phase 1 -lab package to be completed by October 2021 Phase 2 - surgical model implementation due to commence October 2021

Recovery and lessons Learned: Outbreak Management. Incident investigations. City wide Outbreak response group.	CSUs manage the Outbreak Meetings with support from Consultant Microbiologists, IPCT, Antimicrobial Pharmacists and DIPC/DDIPC. During COVID-19 Pandemic, identification of increased incidence of hospital acquired infection has significantly risen. There is limited specific resource to respond to this.	Previous evidence based learning is used to support the actions that need to be taken within CSUs. The Infection Team continues to provide CSU level IPC review and stewardship remotely as part of COVID-19 recovery plans. Mutual aid provided by the Corporate Nursing Team and Quality Team.
HCAI assurance is monitored through the Infection Prevention and Control Governance Structure. Covid-19 assurance is monitored through the Trust tactical response and IPC governance structure. Board oversight is provided through the Infection Preventions and Control Board Assurance Framework, published by NHSE in May 2020. **Cross-ref: CRRS17**		
Organism specific root cause analysis investigation adopted for all HCAIs to identify contributory factors and lessons learnt.	Previously, it was unclear what proportion of GNBSIs were avoidable and there were few datasets on the underlying risk factors for preventable GNB infections at LTHT. Continuous CSU-led investigation, Stop the Line STL/RCA documentation and IPC-led collation of results is required to understand which interventions are likely to reduce risk to patients.	Investigation for all GNBSIs underway. A review panel is to be established by the Infection Team to identify the actions that need to be taken to prevent the avoidable cases. IPN attendance at all GNBSI RCA and STL Weekly RCA tracker issued to all CSU's - including line list of outstanding incident review documents to assist with identifying lessons learnt in a timely manner.

CRRS 4: Harm due to clinically related behaviours that challenge linked to organic, mental health or other reasons	C = 4 L = 4	16	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
									Target Score					Current Score	Initial Score	

Risk Description:
There is a risk of inconsistent responses to patients at risk of clinically related challenging behaviour; leading to agitation/aggression/violence resulting in physical harm to patients, visitors and staff. The result is the potential for a fatality, serious harm or litigation against the Trust.

Executive Lead:
Chief Nurse

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

Committee reviewed at:
LTHT MHLSG

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

24/7 service provision from Liaison Psychiatry service now meeting PLAN standards and Acute Liaison Psychiatry service 1 hour response in ED implemented		
Enhanced Care Procedure and Restraint Care Plan bundle rolled out trust wide. Restraint Care plan bundle added to latest version of Restraint Policy as a mandated staff action	Some evidence that the Restraint Care plan bundle is not yet being used for all patients who meet the criteria- potential risk to safety if proportionate restriction/restraint not being used and monitored; also potential risk of disproportionate restraint/restriction being used without monitoring	Comms to HoN and Matrons and Restraint Quality and Safety briefing sent Trustwide in November 2020 Trustwide Restraint nursing audit planned for Q1 2021 Head of Mental Health Legislation will complete audit report and recommendations - likely to include request for Care plan to be imbedded as PPM form / requirement for nursing handover
QI collaborative- supporting patients who may present with clinically related challenging behaviours has been re launched post COVID lockdown and will inform these elements. QI collaborative relaunched on 2/10/2020. 7 high volume areas involved in QI with support from expert faculty members	Covid restrictions have limited activity possible across pilot wards	A range of interventions being trialled across pilot areas - e.g. focussed safety huddles, drop in service from experts, trialling of distress tools.
CAMHS referral pathways clarified for patients aged 0-18 A new CAMHS Crisis team has been operational from the beginning of 2020 the service offers - 7 day week 08.00-00.00	CAMHS not co-located in hospital and less robustly embedded into LTHT governance - leading to some variation in accessing timely psychiatric support for patients aged 0-18	Camhs in-reach referral pathway redesigned / camhs Crisis team resource incread and now includes Dr able to complete on ward MHA assessments. CAMHS representatives now identified for strategic / operational governance meetings
Mental Health and related topics training and education offer being refreshed - lypft/lthth training delivery group developing TNA and working with QI De-escalate collaborative Tender developed for 2 levels of training: E learning and face-to-face de-escalation and safe	Currently not mandated across medical and nursing staff or linked to a training needs analysis (TNA) Current restrictions in place regarding face-to-face training	2 x tenders now awarded to deliver de-escalation training across LTHT - currently in content development stage. Leeds Survivor Led Crisis Service have now

restraint packages	Front line nursing staff not currently trained to use safe holding or physical restraint with patients who may need these techniques in order to deliver care safely. Specific face to face training has been commissioned to begin to address this gap but this has been postponed following decision by CAG regarding the infection risks related to Covid.	delivered 12 sessions on managing self-harm /suicidal ideation - next phase to evaluate/review and roll out another block of sessions - July 2021 CAG to review face to face training decision in July 2021 Specific TNA to be developed to ensure: face-to-face restraint training is targeted at high risk staff groups/areas; training offer is evaluated by clinical experts prior to roll out and skills and practice impact monitoring is robust - ready in June 2021 for Exec sign off.
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 Monitored through datix but evidence that not always reported through datix as a separate incident	Now Embedded into Restraint/restrictive intervention policy and mandatory training To combine intelligence from Datix with the trustwide nursing restraint audit results - trustwide communication plan to be developed July/august 2021
MCA/MHA and LD/Autism teams expanded to include additional clinical nurse specialists and now carry liaison	Referrals increasing rapidly and team members required to use safe restraint	LD team identified as cohort for early training once face -to-face training is available again

case load to support ward staff	techniques to facilitate safe treatment for complex LD presentations despite not having in-date training	
Public facing information campaign regarding Zero tolerance for violence to health care staff	Campaign paused during Covid-19	Campaign was re-launched in October 2020

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

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

Executive Lead: Chief Operating Officer

Date added to CRR: May 2018
Last reviewed: Sept 2021

Committee reviewed at:
Risk Management Committee

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

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 Estates & Facilities

Date added to CRR: Aug 2015
Last reviewed: July 2021

Committee reviewed at: Finance and Performance Committee

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

	done when power interruptions occur but does not assist with the shortcomings of the installed systems.	
Increased interleaving of circuits in Clarendon Wing i.e. there is now more flexibility as to where power to wards/departments is directed from, increasing resilience.	This interleaving work has improved the resilience in Clarendon at Ward/Department level but not improved the local bedhead interleaving provision.	When Wards/Departments are refurbished in the future local interleaving should be carried out as per HTM 06-01.
Comprehensive review across the Trust with completed documentation detailing precise location of all key electrical infrastructure equipment	The detailed electrical review information is stored in hard copy at both Silver Command positions but would require in-depth electrical knowledge to fully understand.	Reviewed annually and updated as resilience is improved.
HTM's are not retrospective and areas were designed to comply with best guidance at the time of design and construction	Although HTM's are not retrospective HTM 06-01 was introduced in 2007 but work to move the Trust towards full electrical compliance is slow due to shortage of decant facilities and Capital shortages to carry out wholesale Ward/Department/Theatre improvements.	
A UPS/IPS infrastructure was installed to support Geoffrey Giles Theatres 1 to 8 and Recovery in 2017. Theatres 1-8 have been connected to the system in 2020/21. Theatre 9 has UPS but is not connected to the central system and is scheduled to be connected before it is due for lifecycle replacement.	Although the UPS/IPS infrastructure has been installed (£600,000) to support Geoffrey Giles Theatres 1 to 8 and Recovery the final connection and rewiring of Theatre 9 & Recovery is still required. If there is a power failure within these theatres the only system with inbuilt battery back-up are the Operating Lights.	Capital investment is required to connect the available IPS/UPS infrastructure Theatre 9 & Recovery in Geoffrey Giles Theatres, which is now planned in 2021/22.
Some areas (e.g. J1) are fitted with the required UPS provision but not fitted with Isolated Power Supplies (IPS).	A number of clinical category 5 areas as required by HTM 06-01 are not fitted with IPS to safeguard the patient from the risk	IPS should be installed to all clinical category A areas in-line with HTM 06-01 when areas are refurbished. Awareness of the electrical

	of electric shock and provide increased local electrical resilience.	shortfalls in UPS and IPS provision in clinical category Grade A areas is required, work is on-going to supply electrical action cards, this will be completed by spring 2021.
UPS/IPS systems have been installed in a number of clinical category A locations in 2020 including those detailed above in Geoffrey Giles; Cath Labs 3 & 4; Jubilee Wing MRI; 2no. Clarendon Wing B Floor NHS MRIs; Theatre 17 Jubilee Wing; Theatres 1 & 2 CAH. L43 Neonates (Clarendon Wing); Maternity Theatres & Recovery (Gledhow Wing) and ARCU (Gledhow Wing) have being upgraded and fitted with compliant UPS/IPS systems in 2021.	There are still a number of Clinical category A areas without UPS/IPS systems.	£350k in programme for UPS/IPS installs, the priority order for which is under review between Estates and Clinical teams.

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

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

Executive Lead: Chief Operating Officer

Date added to CRR: June 2020
Last reviewed: Sept 2021

Committee reviewed at:
Risk Management Committee

Controls	Gaps in Control	Further Mitigating Actions:
COVID19 Response Review Group now established to proactively prepare for any further surges in COVID19.	Roll-out of vaccine commenced in December 2020. Availability of vaccine will impact on pace of roll out can be undertaken. Vaccines may be less effective against new variants of COVID 19 Supply of PPE may not be sustained to meet changing demand and will limit the level of activity that can be delivered; supplies will need to be prioritised for high risk areas. Staff lateral flow testing commenced in	Booster vaccines to be offered to staff and public Leeds COVID19 Vaccination Centre at Elland Road opened 20/01/2021. Staff in priority groups invited to book for their vaccination. Roll-out of vaccine continues to all staff in line with JCVI guidance. PPE supplies are assessed continuously to identify and escalate any potential risks to PPE supplies. Reporting of staff results via the LTHT local

	December 2020 is voluntary and numbers reporting results routinely has been dropping following move to order own kits	system has been maintained (rather than national system reporting) to support local report and follow-up by CSUs of staff testing. Lateral Flow devices have been used to support some first line testing of staff outbreaks.
Specialty level plans, including local actions to mitigate most significant risks.	The risks of reducing or stopping all routine and planned procedures, including diagnostics and referrals are not uniformly distributed.	In line with NHSE/I and college national guidance; all CSUs have undertaken clinical prioritisation of the elective, diagnostic and outpatient waiting lists through their sub-speciality clinical teams in order to assess clinical risk and reduce harm to patients - this continues to be reviewed on a regular basis and all new patients awaiting a surgical procedure have their clinical prioritisation documented
Surgical teams across the Trust have reviewed their revised theatre allocations and subsequently prioritised clinically urgent patients (including cancer patients). This continues to be reassessed in line with updated clinical prioritisation.	Increased COVID19 admissions may result in the suspension or reduction of elective activity.	The PAS system has now been updated to include the recording of P status within the patient's waiting list entry. This is now available to report. Weekly review is undertaken by Corporate General Manager to assess completeness of P category recordings and any waiting list entries with no P category are followed up. In line with national guidance issued on 10 May 2021, by NHSE/I 'Clinical prioritisation of waiting lists for endoscopy and diagnostic procedures', the Trust have nearly completed clinical prioritisation of diagnostic waiting lists using national D codes, which is expected to be complete by end August/ early September 2021.

		A process has now been established for adding the P category to the patient's record at the time of Decision to Admit and the Diagnostics D code at time of test request. Any patient safety, quality or governance risks are escalated through CSU Governance Meetings in line with Quality Governance Framework. CSUs will highlight specific risks through their CSU risk registers. COVID19 modelling undertaken using 7 day forecast model to predict the average expected inpatient admissions and discharges for Covid-19 patients and confidence intervals.
Outpatient appointments reviewed, converted to telephone consultations where clinically appropriate.	Outpatient environments may not be suitable to maintain recommended social distancing (2 meters). Reduction in outpatient capacity due to requirements to maintain social distancing (currently delivering approximately 99% normal baseline outpatient activity).	Steering group established to work on implementing environmental social distancing measures across all hospital sites to facilitate the safe reintroduction of our services. Outpatient team have worked with CSUs to expand the volume of remote consultations and prioritised visits. (Increased by 45%). To reduce risk and manage potential harm to patients, clinicians have clinically reviewed patients on all outpatient waiting lists to assess clinical priority. Service Delivery Contracts have been agreed at CSU level which will include focussed KPI on reducing longest outpatient waits - this will be monitored on monthly basis.

Clinical validation of all follow-up patients waiting beyond anticipated review date requested to determine if patient suitable for discharge, conversion to PIFU, requiring of urgent review or able to wait.	Increased COVID19 admissions may result in the suspension or reduction of outpatient activity and staff may need to be reallocated to support inpatient or critical care areas. Volume of reviews has delayed validation in some areas. Validation does not deliver any additional capacity in areas where backlog continues to grow	COVID19 modelling undertaken using 7 day forecast model to predict the average expected inpatient admissions and discharges for Covid-19 patients and confidence intervals. Weekly review of progress to be reviewed and reported by Corporate GM. Investigation of additional potential capacity being undertaken with Corp Planning colleagues.
LTHT 2ww referral volumes back to normal levels and flowing into the system as per normal process. Capacity for cancer surgery and key pathway steps is in place	2ww referrals have returned to higher levels that previously seen causing increased activity and delivery challenges. Patients requiring investigation and/or treatment for cancer are still choosing not to attend hospital due to concerns and heightened publicity about impact on the NHS of COVID-19. Volume of acute and COVID patients is impacting upon the ability for cancer surgical activity to return to normal levels/ recover.	Cancer diagnosis, treatment and care continued in line with most recent NHSE/I guidance. COVID19 modelling undertaken using 7 day forecast model to predict the average expected inpatient admissions and discharges for Covid-19 patients and confidence intervals. Clinical triage process established should any further surges result in requiring the suspension of activity. Clinically led weekly planning for Critical Care/ theatre activity in place, with daily confirmation meeting to maintain focus on cancer/ P2

		acitivity.
All emergency treatments and interventions conducted taking into account the latest NHSE/I, Royal Colleges, national societies COVID19 guidance.	Patients may choose not to attend hospital when they require treatment due to concerns and heightened publicity about impact on the NHS of COVID19, including those requiring clinically urgent treatment.	Partnership working with health and social care, media communications to encourage people to attend hospital if treatment is required. Roll out of vaccine nationally continues to the general public in line with national guidance.
Specialty cancer MDTs undertaken risk assessments and established process for tracking patients that have been deferred. In line with most recent NHSE/I advice, clinical guidance for the management of essential cancer surgery for adults during the COVID-19 pandemic is being followed.		Pre-op COVID testing/preparation guidelines in place and regularly updated in line with emerging guidance. Guidance related to pre-operative self-isolation periods have been reviewed and self-isolation period has now been reduced to three days. LTHT referral volumes now back up to 100% and flowing in to the system as normal. Normal cancer tracking processes have now resumed to manage patient pathways. Separate Planned Care and Cancer Programmes now established - reporting progress and oversight. New IS contract now in place from 1 April with activity being IPT to IS where appropriate.
Laboratory testing capacity in place through increased, operating hours and improved turnaround times to a standard 12 hours in place from June 2020).	Capacity of labs to achieve national expectation on staff testing Availability of reagent	Pathology team working with national procurement and supplies team to achieve testing targets and stable reagent/ kit supplies.

Staff testing commenced from March 2020 in line with national guidance from PHE. Testing extended to all non-elective admissions (April 2020) and planned/elective admissions (May 2020). Care home testing in place (April 2020). Asymptomatic staff testing and antibody testing pilots undertaken I May 2020. Lateral Flow Staff Testing commenced in December 2020. Public Health Laboratory requirement for LTHT to undertake Genomic sequencing. This requires use of same staff and equipment as routine COVID19 testing utilises at present.	Staff sustainability in pathology Resilience of the Telepath system supporting all Pathology results as system is now very old and upgrades are overdue. Logistics of cohorting patients (infection prevention and control) to comply with guidance to extend testing to non-elective and planned/electives admissions. Prevalence rate of asymptomatic tested patients. Any surges in routine COVID19 testing will need ongoing service provision.	Operational plan and guidance in place in line with national guidance for testing of non-elective and planned/electives admissions. Review of nosocomial rates in order to reduce volumes of routine testing being monitored via Tactical Testing group, which was established in April 2020 and continue to meet at a frequency defined by current situation/ conditions. Staff testing service stood down from w/c 10/05/2021 - but restarted for shift critical staff using Point of Care Testing in July 2021.
Clinical Advisory Group (CAG) established 24 March 2020 to review concerns raised by clinical teams, including clinical concerns re planned and elective treatments. Weekly collaborative critical care clinical prioritisation review by LGI and SJUH CSUs to support listing of clinically urgent patients and to match listed activity to anticipated capacity	Critical Care capacity can change overnight due to staffing absence or high numbers of unplanned admissions and result in on day cancellations	Increase in ACC workforce planned through September and October

Daily critical care review by Medical Director for Operations, ADOP for escalations, clinical leads for General Surgery and Cardiac Surgery, and ACC CSU CD or HoN.		
Weekly quality review meeting led by the Chief Medical Officer and Chief Nurse, including serious incidents, complaints related to potential harm as a consequence of delays in treatment due to the ongoing operational response to the coronavirus pandemic.		
Use of Insourcing Company to increase available theatre sessions began July 21	Case complexity suitable for insourcing team reduces ability to treat more complex patients	Insourcing team used to support low complexity / high volume pathways Theatres & Anaesthesia CSU anticipate return to pre-covid provision of theatre capacity by the end of September 2021 except for a small number of theatres which will continue to be supported by an insource theatre team

Risk CRRS17: Staff Health, Safety and Wellbeing During the COVID-19 Pandemic	C = 4 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 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: Sept 2021

Committee reviewed at: Workforce Committee and Infection Control Committee

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

Health & Safety Annual Assurance Process. Managers asked to display posters (as recommended in the Working Safely during COVID 19 document) to display workplace assessment has been undertaken. The annual health and safety assurance process included COVID workplace risk assessments. The results of this process have been reported to the Health & Safety Committee and no concerns were raised. As part of the controls assurance process, 292 areas recorded that they had undertaken a stress risk assessment in the previous 12 months.		
Specific PPE risk assessments undertaken for all clinical areas.		
Occupational health guidance and risk assessment template for staff with underlying health conditions and pregnancy is in place and is regularly updated.		
Programme of positive action completed to provide assurance that all precautionary measures required at the time have been taken for BME colleagues.		
Organisational assurance framework for individual employee risk assessments agreed by CAG and Executive Team. This covers all currently identified vulnerable groups and is reviewed regularly in light of emerging evidence, last reviewed 15 June 2021 with planned review date of 20 September 2021.		
A personal communication sent to all employees from the Director of HR & OD to ensure they are aware of the vulnerable groups and actions required in in relation to risk assessment. 99.4% completed. Additional communication sent to all males aged over 50 requiring them to complete an updated Risk Assessment.	Assurance that individual risk assessments are updated in accordance with changing guidance (for example the changed guidance re Extremely Clinically Vulnerable individuals) or changing personal circumstances.	Initial PWC Audit Report received. Recommendations and actions being considered. Report and actions to be reported to Health and Wellbeing Committee in September 2021 to agree actions, which will be assured by Workforce Committee.

Risk Assessments now built into the Corporate Induction process. Assurance process, to ensure all Villa Care staff have had a risk assessment, discussed and agreed with Director of Nursing. Health and Wellbeing Conversations Launched Trustwide which include the need to review risk assessments	Updated guidance makes explicit the responsibility of LTHT to ensure risk assessments are in place for students, bank and agency staff.	Review existing measures in place to ensure this, updating where there are gaps by October 2021.
Ongoing programme of corporate communications, through the COVID bulletin and other channels, to ensure all staff are aware of the latest guidance and encourage them to adhere to all guidance. Regular Coffee Mornings now in place with all Clinically Extremely Vulnerable staff		
Who Should go to Work (Lead – Jo Buck/Chris Carvey)		
Staff are encouraged to work from home wherever practicable - communicated via COVID Bulletin. This is supported by Working from Home Guidance and the roll out technology to support home working, for example Microsoft Teams. Workstream established with Executive Leads. Teams encouraged to work together to agree an approach which allows all staff to support service delivery whilst minimising unnecessary on-site attendance and protecting vulnerable employees. Latest staff survey results shows remote/home workers scored most highly across the majority of themes, including support from team and line manager.	Availability of IT such as laptops or mobile devices with VPN access is a limiting factor for homeworking. Small number of staff who are unable to return to pre-covid workplace due to health issues.	Home and agile working workstream to continue to develop arrangements to facilitate new ways of working, including increasing the technological support. Resolving on a case by case basis using personal people management and a MDT approach.

Blended working with staff combining home working and attendance at the workplace is encouraged to reduce the number of staff in the workplace at any time to enable social distancing for staff in the workplace.		
Where it is only practicable for a proportion of a team to work from home at any one time, cohorting and rostering of home working has been encouraged. In these circumstances, staff who are required to stay away from the workplace due to shielding or isolation are prioritised for home working.		
Occupational health guidance and risk assessments in place to identify vulnerable staff who are required to work from home or who should be prioritised for home working.		
Workers in roles that are critical for business and operational continuity, safe facility management or regulatory requirements and which cannot be performed remotely have been identified		
Planning for minimum number of people on site to operate safely and effectively has taken place via Tactical Meetings		
The wellbeing of people working from home is undertaken by Line Managers and health & Wellbeing Leads - advice issued via COVID Bulletin, weekly email, Trust Internet and closed Facebook Group. Mental Health First Aiders and Health and Wellbeing champions are being trained across the organisation to support both home and onsite workers with 138MHFAs and 185 HWB champions in place in August 2021		
Advice and guidance issued to managers and employees in relation to shielders and engagement events undertaken for both managers and returning employees. Review workshop held with shielders on 3rd September 2020. An additional 1.7m people nationally were advised to shield		

from February 2021. No significant impacts on service delivery were escalated due to this change. From 1 April 2021, shielding advice was paused nationally. CEV staff have been advised that they should continue to work from home where possible and if this is not possible a risk assessment (RA) must be undertaken. CAG have agreed that the current risk assessment will remain in place until 20 September 2021 The Trust has issued updated guidance and regular coffee mornings are in place for both shielders and managers to assist with the review of RA		Review Government guidance, local prevalence rates and nosocomial transmissions in September 2021 to determine if the existing risk assessment should be updated.
Social Distancing at Work (Lead - Jo Buck)		
A social distancing workstream has been established with several work streams that cover the areas outlined in the national guidance.		
The requirements for social distancing have been proactively communicated to all staff and managers Advice available to managers who are completing the Workplace Assessment Enhanced Risk Assessment now available for non-clinical workplaces for teams to resolve workplace social distancing issues. Enhanced risk assessments identified the need for more space in some CSUs and space has been made available following utilisation of THQ. Processes for auditing and recording compliance issued to all departments.	Continuing evidence that staff not fully complying with social distancing requirements in non-clinical areas leading to increased risk of transmission and or requirement for staff to isolate. As restrictions are lifted in a social setting, staff may find it even harder to comply with IPC requirements, particularly if staff are wanting to return to face to face contact and finding virtual contact increasingly difficult to maintain.	Ongoing and proactive programme to communication to reinforce the need for staff to undertake all necessary precautions in all settings/environments. Health and Wellbeing framework in place to ensure organisational HWB activities are delivered in operational teams which includes local comms plans which promote social distancing and IPC measures.

Staff cohorting guidance has been developed and implemented Communications issued to remind staff that none of the National Guidance has been relaxed and that staff should continue to adhere to appropriate PPE and Social Distancing measures. Monthly social distancing assurance process for non-clinical areas has been launched with compliance reported via CSU governance meetings.		
Social Distancing group is installing physical prompts including signage and screens/barriers. No requests for social distancing prompts (e.g. signage, screens / barriers) are being delayed due to lack of funding.		
Gym continues to be closed due to increasing prevalence rates in Leeds. This decision was taken at CAG. A rolling programme of lateral flow testing is now in place which will help to identify Asymptomatic staff Covid Vaccination centres established and staff vaccines have commenced in accordance with national priorities. As at 16th August 2021, Trust data shows 80.42% of frontline workers have had first vaccination (65.9%% for BME frontline workers). All employees have been written to, asking them to let the Trust know if they have been vaccinated elsewhere. National restrictions on vaccine supply are not impacting	Continuing indications of lower take up from some types of staff, for example BME colleagues. Data gaps in relation LTHT staff vaccinated in other locations	Working with BME staff network and others to ensure communications are appropriate and reach all staff. The new guidance in relation to healthcare workers isolating is being actively reviewed and implemented. The anticipated impact on being able to bring back staff who have had a close or family COVID contact is limited.

vaccination rates for frontline staff. Live Q&A session for all frontline staff on 31st March 2021, designed in partnership with BME Staff Network		
Managing your customers, visitors and contractors (Lead - Helen Christodoulides & Jon Craven)		
Restriction of Visitors to Patients is in place including wearing of face coverings/face masks Visiting guidance is being reviewed every 4 weeks or sooner if national or local restrictions are applied by Director of Nursing (Operations). Screening checklist for visitors completed prior to visit. External professional visitors (e.g trainers/auditors etc) are still unable to visit the Trust unless it is clinically essential and cannot be provided remotely. CAG continue to oversee these decisions on a case by case basis. Maternity have developed a process to ensure all pregnant people can have one visitor for hospital attendances. This includes: the wearing of face coverings/face masks; Screening checklist for visitors completed prior to visit; and negative lateral flow test before visit.		Trial of lateral flow testing for patient visitors took place on J06. The results were shared with CAG. No changes have been made to extend/increase visitors in LTHT currently.
Operational plan for the placement of patients in relation to COVID 19. Signage in place for all clinical areas to ensure staff are aware COVID status of patients.		
Restriction on Visitors to other areas e.g. Sales Reps are in		

place.		
Estates, Facilities, Capital, PFI Providers and Supplies contractors carrying out work on Trust premises have own risk assessments in place. CSUs advised to review the Safe Management of Contractors Procedure and ensure suitable risk assessments are in place prior to any CSU commissioned work commencing on site.		
Cleaning the workplace (Lead – Chris Ayres)		
Staff are encouraged regarding regular hand washing and surface cleaning - Communicated via COVID Bulletin and in local areas. Further advice disseminated from IPC requiring all areas to undertake a cleaning audit.		.
Hand gel and cleaning wipes provided and available in all areas.		
Staff are encouraged to opening windows and doors frequently to encourage ventilation.		
Switched routine cleaning to the use of Chlor-clean for all cleaning with disposable cloths.		
From March 2020 additional staff were deployed to carry out touch point cleaning, concentrating on areas of highest activity. The frequency of cleaning of both the environment and equipment in patient areas has been increased to at least twice daily, in particular, frequency of touched sites/points. Cleaning practices switched to chlorine based products and disposable cloths as standard		

"Touch Point Clean" documents introduced with effect from 30 November 2020 in line with latest national guidance. Each CSU covid secure risk assessment includes the need for additional touch point cleaning. Additional cleaning staff where required to clean patient toilets after each use, undertake cleaning of high frequency touch points and cubicle curtain changes for each patient (suspected Covid) across around 25 areas in order to reduced nosocomial infection. Started a process of assurance training for the existing 100 Ward Environment Porters regarding patient shared equipment		
In some areas signage is displayed regarding Social distancing for toilet areas.		
Housekeeping staff have ensured enhanced cleaning in Public areas.		
Good Mechanical ventilation is in place in some areas to ensure air flow is changed every hour. New air handing unit installed in Acute Respiratory Care Unit. Working with UoL to trial ventilation in J10 and plan to extend this to ED. Initial results indicate Social Distancing continues to be of utmost importance. 5 portable air purifiers in side rooms trialled in ED. The results were considered at Operational IPC meeting. Criteria for use to be agreed as part of the hierarchy of control assessments by CSUs Informatics have now developed a safe control document for	Despite programme of improvement, the design and construction of some buildings means recommended levels of ventilation are not practicable. Noise and heat in the Emergency Departments and other areas are placing additional pressure on both staff and visitors.	Environmental reviews to be undertaken and consideration given to moving equipment which generate heat and/or noise, where practicable.

the control of contractors.		
PPE and face Coverings (Lead - Gillian Hodgson)		
Risk assessments are in place and national guidance is being followed. Application of the published IPC guidance continues, this is reviewed regularly through the newly formed Trust COVID-19 Operational IPC group and Covid Response Review Group and by the Chief Nurse, Chief Medical Officer and COO. Guidance is disseminated through the tactical structure. A risk assessment has been developed for staff 'pinged' by the NHS Covid 19 App. This will only be used for critical/patient safety issues raised through the Bronze/Silver command structure and all completed risk assessments will be approved by IPC/Director of Nursing.	National guidance can change at short notice.	Guidance regularly reviewed.
Identification and use of Latex products is recorded on each General H&S Risk Assessment for every and ward and dept and Latex products. Usually gloves, are restricted for use in certain areas e.g., Theatres. Robust escalation process in place if supply problems occur resulting in the need to look at latex alternatives.		
Employees are requested to declare any known sensitivity/allergy to Latex upon commencement of employment via Occupational Health processes and are subject to annual health surveillance measures. LTHT adopts a latex free environment where there are alternatives available.		
CSUs have taken responsibility for providing FFP3 mask fit testing locally. Escalation of any gap in the process is raised through the Incident Co-ordination Centre. All CSUs submit a		

weekly return detailing the staff that have been FFP3 fit tested and the masks that they can use. A centralised database is held. CAG decision to allow staff to optionally wear FFP3 masks instead of FRS masks in red pathways.		
Incident Command Structure used to ensure adequate on-going provision of PPE and robust escalation process is in place if supply declines. Areas are supplied with fluid resistant face masks(FRFM) that secure in different ways and mask adjusters, to prevent the frequency of slippage/dislodgement.. New government guidance in relation double vaccinated staff who are 'pinged' by the NHS Covid 19 App being allowed to continue to work is helpful in terms of staff availability, however, data and audits suggest most staff are isolating due to household contact		
Workforce Management and Staff Resilience (Lead - Jo Buck)		
Health and wellbeing Leads in all CSUs to keep in contact with those self-isolating etc and re-purposed staff.		
Mental Health and wellbeing advice available via Intranet, Staff Connect and Facebook Group. Additional link psychologists recruited to provide support to staff. Working with partner organisations in the city and ICS to ensure consistent levels of support are available. Adequate support is now available via staff clinical psychology	Increased risk of staff anxiety and 'burn out', including potential PTSD, due to sustained nature of pandemic, increasing patient numbers, increasing staff absence, staff being repurposed into unfamiliar areas, on-going social isolation due to long term home working and other demands on the workforce (for example, supporting vaccination/immunisation programmes). With the recent increase in the number of	Continuing work to balance integration of service delivery, workforce, financial and quality. Task and Finish group chaired by Director of HR & OD established to look at options for identifying individuals and teams in need of support. We have circa 450 nurses due to be onboarded from September to February – we anticipate this will ease some if the

and the EAP, in addition a senior psychologist has started to manage the staff clinical psychology service and further enhance service provision. Health and wellbeing conversations template now available for all staff to complete. HWB principles agreed and 1 of 4 priorities for HR&OD. HWB principles incorporated into tactical response and HR&OD representation on tactical group. Increased treatment options for staff with serious and / or ongoing mental health concerns established, including dedicated funding for treatment via the EAP and referrals are being sent via the WY & H ICS wellbeing hub. First long covid support session held on 16 July.	cases, it is expected that more staff will have to self-isolate and the pressure of those staff in work will increase. The sustained pressure that staff have been under is of concern and this is beginning to come through in our sickness absence that is higher than usual for this time of year. We took the decision not to cancel A/L but staff shortages are of concern and we hope it will ease in September but may also be offset by increased COVID prevalence and pressures as schools / universities return. Risk to employee HWB linked to resetting the provision of clinical services. Risk that staff will suffer from long Covid. In addition to the risk to the individual worker, this could also adversely impact workforce availability	staff pressures HWB Committee agreed to make improvements to the stress risk assessment process to make it easier to complete. In addition, HRBPs and the HWB team will use information from staff survey to support teams who may be at risk of stress. Following a presentation to Tactical on 21 July 2021 showing the potential impact of transmission rates on the workforce, all tactical workstream leads have been tasked to look at their recovery plans with this in mind. Support from Occupational Health and referral to best available treatment. Further coffee mornings planned over the next three months to support staff with long covid and guidance for managers, helping them to support staff with long covid will be developed. Leading in Leeds programme to be rolled out, commencing October 2021

	Increased risk that staff are subject to challenging behaviour if patients/visitors do not accept the continuing need for higher precautions in a hospital setting, compared to elsewhere. Manager confidence, capacity and capability to create open cultures where health and wellbeing needs can be identified and addressed.	
Advice has been given for staff to be split into teams or groups where practicable.		
Shops within the Trust are using Electronic payment methods.		
Communication/Training materials developed for workers prior to returning to site.		
Advice developed and issued in relation to cohorting of staff in clinical areas.		
Testing in place for symptomatic staff and/or household members. Enough capacity and home testing available. Good levels of performance against turnaround time. This is actively monitored through the Incident Command Structure. CEV staff working remotely		
Staff testing in place for test and trace and comprehensive guidance in place to support Managers Senior Leaders session on 02.09.20 used case studies to reinforce lessons learned for staff test and trace		
A variety of staff Health and Wellbeing offers are available and a dashboard has been developed to monitor staff utilisation.	Take up of Health and Wellbeing Offer unclear and dependent individuals coming forward.	Review exit interview process to determine if insight from leavers can be used to help improve workforce retention, deployment and support –

New exit interview arrangements launched to understand impact of Covid on turnover. Turnover is monitored by Resource Management Group as there is a risk it may increase due to the pandemic. Strengthened workforce planning approach discussed at Board Time Out and being implemented via the Resource Management Group via the Workforce Committee.		October 2021 Working with partners across Leeds to deliver a health and wellbeing champions programme, to commence by Dec 2021. Increased capacity in the HWB team to work on engagement with staff and increase awareness of existing offers. First Quarterly report on plans to be submitted to HWB committee in Oct 2021
Inbound and Outbound Goods (Lead - Chris Slater)		
Maintain consistent pairing where 2-person deliveries are required		
Measures to minimise person to person contact for deliveries in place. There are on-going discussions with suppliers about on-site requirements. Guidance for suppliers has been developed Methods to reduce frequencies of deliveries for example by ordering larger quantities have been undertaken. The Trust has now opened an offsite consolidation centre for inbound deliveries of PPE. This ensures suppliers deliver to one single site and adhere to social distancing measures. Pick up and drop off collection points, procedures, signage	There is less control over 3rd party goods deliveries for retail	

and marking have been devised. Pick pack and dispatch of PPE is now from the consolidation centre and the local stores within the hospital have been closed. No staff are able to drop in for PPE which limits the risk of exposure.		
PPE is now in plentiful supply and stocked at Dolly Lane, this means the inbound deliveries are now kept to a minimum. The Trust now holds a minimum of 30 days stock Dolly Lane signage is now in place with one-way systems in operation. Single working at Dolly Lane is not permitted. All staff have had training and induction on lifting and handling. Where possible single workers unload/load vehicles		

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

Risk Description:
There is a risk of failure or complete outage of the Patient Administration System which is running on legacy hardware which is outside of live support and is running on an unsupported version of the software (Patient Centre)

The operational and financial risk to the Trust would be significant in the event of a hardware failure or PAS malfunction which left the Trust unable to recover the PAS and running on Business Continuity Plans indefinitely

Executive Lead: Chief Digital Information Officer

Date Added to CRR: Aug 2020
Last reviewed: Feb 2021

Committee reviewed at: Digital Hospitals Programme Board

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

CRRS 20: Delivery of the Leeds & West Yorkshire Vaccination programme	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: The Trust may not be able to meet the requirements relating to its role as lead provider for the West Yorkshire ICS and the accountable organisation for the Leeds place vaccination programme, due to

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

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

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

Executive Lead: Chief Medical Officer

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

Committee reviewed at:
Quality, Safety and Assurance Group

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

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

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

Lead provider contractual arrangements with NHSE and subcontracting arrangements with place-based lead provider in place.	Contractual arrangements between LTHT and place-based lead providers not fully in place.	Full reporting of financial actions at place reported to LTHT. Plan for clinical and quality responsibilities previously held by Leeds providers to be moved to vaccine programme reporting into LTHT board structures.
Vaccine procurement, delivery and storage arrangements set out in clinical and operating model (December 2020). Statement of Purpose (LTHT) updated and submitted to CQC to meet Regulatory requirements (January 2021). Pfizer vaccine available (December 2020) AstraZeneca vaccine available (January 2021). Moderna vaccine available (April 2021). Monthly report to Quality and Safety Assurance Group, setting out progress, reported patient safety incidents, risks and mitigation. Vaccination centres can now hold three Vaccines on site. However, can only use two on site in any one day.	Regulations re vaccine storage limiting options (Pfizer BioNTech), including local peer vaccination. Vaccine supply to WY ICS controlled centrally and subject to short-term change. Handling two vaccines in one site requires careful segregation of storage and administration and consenting processes All vaccine is allocated at national level and only within the gift of place teams when it arrives.	Place-based flexibility of delivery capacity in place. National SOP describes segregation arrangements when handling more than one vaccine per site. Training and handling arrangements under development (March 2021) Advice provided to people attending for vaccination Booking, access and administration processes to be implemented in April 2021 to reduce risk and enhance control of the distribution of multiple vaccines. SRO Leeds place currently working with national colleagues to close the shortfall. Moderna is currently being used at Elland Road for adult 1st and 2nd doses with Pfizer administered to 16-18 year olds. • Queue management provided by professional security team • Separate entrances for different vaccines + expected dose. • Update training for all staff

		• Briefings at the start of every shift • Dedicated pods for different vaccines with clear signage Where it is unclear which vaccine a patient has received as a first dose, administration staff check on NIVS history page.

CRRS 21: Patient harm – falls and hospital acquired pressure ulcers (COVID-19)	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 of hospital-acquired harm to patients related to pressure ulcers and falls due to repurposing of staff, reconfiguration of clinical services and restrictions re hospital visitors and volunteer support, as a result of the on-going coronavirus (COVID-19) pandemic.
Cross-reference CRRS16: risk of re-commencing normal activity levels due to reduced capacity (COVID-19)

Executive Lead: Chief Nurse

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

Committee reviewed at:
Quality and Safety Assurance Group

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

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

CRRF 1: Failure to deliver the financial plan for 2021/22	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 planned control total in 2021/22. This would have the following impacts:

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

Executive Lead: Director of Finance

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

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

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

year		
Quarterly Fundamental Review of the Trusts Financial Position to Finance and Performance Committee setting out the risk range of the in year financial position and executive owned mitigations	Changing financial regime and as yet unknown income level for Q3 and Q4 2021/22	Regular updates to the Executive Team and Finance and Performance Committee including Exec lead financial mitigations
Weekly reporting of the Waste Reduction position CSU to the Director and Deputy Director of Finance which in turn feed into Finance Performance Framework CSU meetings	None	Regular meetings with the PMO to assess risks to the programme
CSU ownership of realistic control targets and run rate based forecasts linked to the Integrated Accountability Framework.	Changing financial regime and as yet unknown income level for Q3 and Q4 2021/22	Regular updates to the Executive Team and Finance and Performance Committee including Exec lead financial mitigations
Operation of the financial performance framework with: • Monthly Clinical Director signed off forecasts and a RAG rating against CSU agreed Control Totals • Escalation meetings with Director of Finance for RED rated CSUs and with the Deputy Director of Finance for AMBER CSUs • Financial sustainability board, including the Chief Executive and other Executive Directors, for those CSUs on Amber and Red for multiple months	Changing financial regime and as yet unknown income level for Q3 and Q4 2021/22	Regular updates to the Executive Team and Finance and Performance Committee including Exec lead financial mitigations
Fixed Income allocations through the negotiation of Aligned incentive contracts with Leeds CCG and NHSE	Changing financial regime and as yet unknown income level for Q3 and Q4 2021/22	• Regular meetings with commissioners and attendance at all ICS finance forums • Regular communication with NHSE/I to identify and adapt to changes
Implementation of Finance the Leeds Way Improvement Plan	None	None
Emergency cash funding available to meet payment obligations or unforeseen capital emergencies through NHSE/I bidding process	This is a bidding process and not all requests will be supported	Estates and Facilities Risk Review Group required to prioritise schemes for any funding that is made available
Progress against the five year capital plan is overseen by the Capital Planning Group including specific prioritisation for the MSE, BME and DIT programmes.	Requirement for additional capital expenditure due to Covid-19/activity recovery may restrict spend in 2021/22	CPG puts increasing focus through the year on strength of programme managers forecasts and ability to complete. Confidence levels and

		risks are specifically addressed
Capital programme - priority bidding process for clinical services/specialty teams overseen by Head of Medical Physics & Engineering and Deputy Chief Medical Officer/Medical Director (Operations).	There is no contingency in the Capital plan for 2021/22 for any emergency failures.	Any unforeseen equipment failure would lead to immediate re-assessment of current year spending priorities with a view to substitution

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

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

Executive Lead: Director of Estates & Facilities

Date added to CRR: Oct 2018
Last reviewed: Sept 2021

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

Controls	Gaps in Control	Further Mitigating Actions

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

Risk Description:

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

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

Executive Lead:
Simon Worthington

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

Committee reviewed at:
Building Development Committee

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

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

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

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

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

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

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

Risk Description:

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

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

Executive Lead:
Simon Worthington

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

Committee reviewed at:
Building Development Committee

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

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

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

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

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

Risk Description:
Failure to achieve the 95% compliance threshold against the 4-hour Emergency Care Standard, caused by sustained adult main department attendances and insufficient patient flow. This can lead to a congested department impacting on patient outcomes, patient experience, increased infection risk, staff morale, non-compliance with required national standards and financial penalties. Risk has increased In light of COVID19 presentations and admissions through wave 2 and 3 response. Challenges with flow continue due to the required changes in patient placement pathways both within and out with the hospital. Hospital occupancy levels have risen reflecting change in patient demand.

Executive Lead: Chief Operating Officer

Date Added to CRR May 2014
Last reviewed: June 2021

Committee reviewed at:
Finance & Performance Committee

Controls	Gaps in Control	Further Mitigating Actions:
CSM status reports, daily silver meeting and operational response guidance in place - Bronze and Silver command escalation process both within LTHT and across city system.	Community / partner provider new process requires embedding and capacity e.g. Package of Care, delays in accessing Community Care Beds which is being affected by COVID19.	Early identification of patients without a reason to reside in hospital and referral to SPUR for community services, placement CCB/ discharge to assess community beds. Escalation process being updated to ensure senior leadership input earlier into the patient pathway to resolve issues.
Daily monitoring and reporting of 4 hour performance	Timeliness of bed allocation by CSUs to ED Absence of real time electronic bed state and real time beds overview.	Revised focus through the ECS accountability weekly meeting. Plan to re-focus on bed back within 1 hour via the delivery contracts. Unplanned Care programme with oversight and governance regarding non elective flow and discharge to be re-established as an integral reset and recovery phase. CSU operational response is focused on improvement in Non-admitted performance SJUH and LGI site. Centralised bed allocation operational model currently being tested at LGI and forms part of a PDSA to be reviewed.

Patient streaming in place to most appropriate route e.g. GP, Minors, Frailty, JAMAA SAU.	Under developed SDEC model Estate and footprint constraints Medicine Consultant workforce constraints Access to SDEC model via 111First	Continued monitoring of 95% compliance and breach analysis for patients streamed away from ED. NHS -elect analysis and 6 month programme to identify maximum opportunity for SDEC pathways and admission avoidance for all adults with an implementation plan. Model currently being developed which identifies other estates options for LGI & SJUH. Forms part of the overall estates strategy.
Creation of space to support social distancing requirements and internal A&E flows.	Estate footprint constraints Requirement to return footprint to previous activity	St James's A&E footprint has increased into eye casualty and ultra sound following re-provision of those services to enable A&E internal flow. LGI A&E now has a modular build to support internal A&E flow. Minor Injury services remain centralised at LGI out with the A&E footprint.
System Gold action plan being implemented and monitored through SROG / STaR.	Community capacity to support timely transfer of patients from acute bed base. Complexity of discharge pathways. Impact of Long COVID.	Implement work plan and monitor against the key objectives through twice weekly SROG which acts as city bronze and reports into STaR. "Cracking Discharge" working group to support timely care chaired by COO Unplanned Care Board established with agreed programmes of work across system chaired by Medical Director for unplanned care.
System level mutual aid actions (system wide agreed tactical options to be considered during periods of escalating pressures)	Ability of system partners to respond in a timely fashion.	Monitoring of Mutual Aid actions through System Resilience Operational Group and STaR.
Winter and COVID planning with CSU's and system partners for 2021/22	Unpredictable activity levels	Operational response guidance developed and monitored through daily operational processes developed and refined in time for winter 21/22

		CSU owned winter schemes monitored for implementation and impact
COVID19 modelling in place for wave 4 response in order to proactively manage and support flow and admissions across LTHT.	Novel modelling with a 7day forward view only. Unknown impact of potential variants	Further modelling in progress to enable responsive configuration of services, state of readiness and red/amber/green beds by site.

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

Risk Description:
There is a risk that the Trust will not recover 18-week RTT performance as a result of reduced levels of activity during periods of COVID19 admissions. Increased COVID-19 activity resulted in a reduction in non-urgent face to face outpatient clinic activity and the majority of elective surgical activity to allow staff to be released to support additional critical care and inpatient capacity. This was required to support increased COVID19 admissions. As a result of suspending this activity, the number of patients waiting over 18 weeks increased significantly.

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

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

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

Executive Lead: Chief Operating Officer

Date Added to CRR: May 2014
Last reviewed date: June 2021

Committee reviewed at: Finance & Performance Committee

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

		also included as part of our activity planning submission.
Delivery contracts with CSUs will enable improved management of recovery trajectories - these will be agreed and implemented during April / May 2021.	Prolonged social distancing restrictions will limit activity and may result in continuing growth in waiting lists.	Re-establishment of social distancing group reporting into tactical recovery group will assist with guidance on social distancing measures and link with operational IPC group.
Single points of access in some specialties will allow onward referral of routine activity to AQP's spreading burden across providers	AQPs will be subject to same restrictions on activity as LTHT.	
Effective advice and guidance can support primary care decision making and reduce unnecessary referrals	Absence of system to support capture of advice into EPR prevents roll-out to all specialties.	System requirements being scoped as part of business case development.
Development of guidance and offer of support in development of patient initiated follow up (PIFU) pathways helps reduce unnecessary appts in outpatients releasing capacity for other patients.	Some pathways require remote monitoring or use of apps - no current portal link to EPR	Work underway with DIT colleagues to explore potential for implementation of patient portal.
Recovery plans to allocate available theatre, critical care, ward and staff capacity to areas of greatest clinical risk will be required during the recovery phase.	Prioritises clinically more urgent patients and so does not improve RTT position.	
Use of Royal College guidance to prioritise elective activity to improve planning for capacity allocation to patients with greatest clinical need.	Prioritises clinically more urgent patients and so does not improve RTT position.	
Established arrangements are in place to allow additional outpatient and inpatient activity to be scheduled outside normal working hours - will be required during recovery phase	Pension taxes had reduced number of additional sessions provided by consultant staff	

Independent sector capacity likely to be available to support during recovery phase.	Capacity available for higher volume outpatient activity is limited. Contract change means IS only accepting IPT of low complexity high tariff patients in a limited number of specialties.	
Use of external theatre resource to staff LTHT theatre capacity to 100% of pre-covid	Activity still likely to be reduced due to inefficiencies associated with social distancing and patient isolation in the pre and post operation pathway	
ICS Elective coordination group established to support regional recovery of admitted waiting list through a collaborative approach to increase elective capacity in low complexity / high volume specialties	Providers at different stages of recovery RE internal capacity and management of P2 patients. Payment mechanism is a barrier to shared working approaches	LTHT to create a tactical proposal for a specialty to work with a partner Trust to demonstrate proof of concept.

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 patients in line with the 62 day referral to treatment standard.

This is due to the risk of late referral from other providers, an imbalance between capacity and demand, for key pathways/ at key pathway points, variable waiting list management, insufficient control over pathways of care or higher than expected demand (for acute and urgent care).

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

Executive Lead: Chief Operating Officer

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

Committee reviewed at: Finance and Performance Committee

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

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

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

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

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

Executive Lead: Chief Operating Officer

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

Committee reviewed at:
Finance and Performance Committee

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

The programme reports monthly to the Tactical Sponsorship group chaired by the COO		
Daily management Daily 8am capacity planning meeting to prioritise admissions, including patients who have had operations cancelled and to allocate demand for critical care capacity. Prompt starts for all elective theatre lists to automatically send for patients who don't require a critical care bed	Co-ordination of theatre/ ward and critical care capacity does not always align leading to greater risk of cancellations Patients requiring critical care are unable to automatically proceed to theatre	
Daily/weekly Trust / CSU planning All CSUs have weekly access meetings to identify available theatre capacity for additional sessions, manage risks and review cancellations and discharge and theatres KPI's using the LTHT scheduling tool. The scheduling project Collaborative CSU process to 'book' patients into an admission area by appointment and lock down of list order to improve patient flow and reduce risk of late starts and subsequent on day patient cancellations Daily email prompt to CSUs highlighting their 28 day breach risks Weekly collaborative critical care clinical prioritisation review by LGI and SJUH CSUs to support listing of clinically urgent patients and to match listed activity to anticipated capacity Daily critical care review by Medical Director for	Critical Care capacity can change overnight due to staffing absence or high numbers of unplanned admissions and result in on day cancellations	Ongoing work to enhance the scheduling tool with the 'Monte-Carlo simulation' which will support scheduling and utilisation.

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

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 admission, caused by demand outstripping capacity and complexity of patient flow associated with the COVID19 pandemic. This has led to high bed occupancy levels impacting on our ability to maintain elective operating as per the activity plan, non-compliance with national standards, poor patient outcomes and patient experience.

Executive Lead: Chief Operating Officer

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

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. Use of Virtual wards for Frailty and Respiratory to prevent admission and/or support early discharge.	Use of SDEC not fully utilised across all services as yet	Implemented further Ambulatory Surgical pathways in LTHT utilising newly recruiting Emergency General Surgeons to reduce pressure on SAU and provide urgent surgical review and intervention for patients. Medical SDEC model scoped and delivered in August 2021 to deliver admission avoidance and same day care on the St James's site. LGI SDEC model also being scoped to identify missed opportunity.
LTHT escalation process and full capacity plans by CSU - bronze, silver and gold command in place. Decision management tool updated with risk assessed actions listed for consideration.		
DOP / CSM in and out of hours support and co-ordination.	Live information to enable real time oversight	Embedding daily management within the Operational Centre. Daily data suite to enable

		expected demand, capacity and opportunity by CSU and site.
Robust bed modelling analysis to identify known activity surges. Operational Response Guidance in place. Seasonal planning sessions have been initiated to mitigate anticipated spikes in patient demand. Detailed inpatient bed modelling has been undertaken in conjunction with the University of Leeds, which incorporates the city COVID19 prevalence rate and children's RSV.	Physical capacity. COVID19 surge planning with certainty.	Internal bed modelling has also been used at LTHT on a daily basis to assess current demand against current capacity. Covid ward escalation and de-escalation plans agreed and in place. The COVID19 modelling forecasts inpatient numbers one week ahead in advance for LTHT to plan and manage capacity to the expected requirement for inpatient beds throughout the surge in COVID19 admissions. LTHT inpatient bed modelling has been combined with SAGE models for COVID19 prevalence to forecast COVID19 admission numbers. The Children's Hospital is developing a regional RSV surge plan for potential surge in under 2 year olds with RSV potentially in Summer 2021,
Management of Long Length of Stay patients (Stranded patients)	Rise in number of patients that do not meet the Reason to Reside within the Hospital 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	The Leeds Improvement Method value stream with an RIPW will now focus on Home First to support earlier discharge in a patient's pathway. Reason to Reside project commenced in April 2021 with the aim of ensuring patients receive a daily review and to understanding why patients are in hospital. Process now embedded. LTHT daily data collected and submitted Nationally. Data is themed to understand pathway opportunities. First week of July 2021 the reason to reside quality improvement programme was further supported by a 48 hour review which was

	leads to increase length of stay.	undertaken in light of the very significant and sustained operational pressures that were being experienced in our hospitals. No Reason to Reside information now shared with city bronze group weekly and discussed in system daily huddle. Home First model being scoped with system partners to ensure patient assessments take place in their usual place of residence to identify additional needs. "Spot purchase" of beds or services to support discharge.
Maximum utilisation of community care beds and Early Supported Discharge models.	Patients under 60 years old are currently unable to access current CCB and D2A community beds.	Patients requiring a temporary community bed placement under the age of 60 will be able to access the Villa Care beds once the clinical responsibility is transferred from LTHT to Primary Care. Decision making workstream to continue to implement work plan and wider actions/recommendations to be monitored through Systems Resilience Assurance Board. Hospital discharge service policy and operating model issued on 21st August 2020, clear "must do's" for all providers in a Health & Social Care system. Streamlined electronic referral mechanism was

		implemented on 2nd November 2020 for patients requiring Community services for discharge. Discharge to Assess bed capacity has been introduced to support patients requiring rehabilitation or convalescence following a hospital admission.
Additional capacity in partnership with CCG and Villa care to provide ward capacity on Beckett Wing in times of extreme demand.	Ability of private providers to deliver the required care packages to enable early transfer for patients from a hospital setting.	Escalate patient flow concerns through weekly System Resilience Operational Group (SROG).

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

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

Executive Lead: Chief Operating Officer

Date added to CRR: May 2015
Last reviewed: April 2021

Committee reviewed at: Finance & Performance Committee

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

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

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

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

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

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

Executive Lead: Chief Operating Officer

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

Committee reviewed at:
Finance and Performance

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

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

CRRP8: Patients waiting longer than 6 weeks following referral for diagnostics tests	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 has more than 1% of patients waiting more than 6 weeks at month end following referral for the defined basket of 15 tests against this standard.
During wave 1 of COVID-19, there was a significant growth is diagnostic backlog as all routine work, other than urgent, was suspended. This backlog has been significantly reduced since the recovery restart in June 2020, however capacity remains at approximately 85-90% of normal levels and is expected to remain at this level throughout the remainder of 2021/22.
Performance will therefore remain challenging due to reduced levels of activity and increased demand as cancer, IP and OP elective activity recovery is undertaken with the on-going risk of COVID-19 admissions requiring higher levels of IP diagnostic provision than previously seen.

Executive Lead: Chief Operating Officer

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

Committee reviewed at:
Finance & Performance

Controls	Gaps in Control	Further Actions Planned:
Weekly review of current diagnostic operational pressures alongside daily COVID19 status - providing the ability to review current position and inform decision making processes on levels of activity that continue to be delivered.	Unexpected levels of demand (resulting in cancellations of routine diagnostic activity)	Continuation of weekly review of operational status - staff will be reallocated as necessary.
To support operational pressures across the organisation, diagnostic inpatient activity will continue to be prioritised.	Unexpected levels of demand . Outpatient activity may be reduced or cancelled if required which may impact on diagnostic backlog position	Weekly review of operational status will be continued.
Weekly Tactical meetings now moved to monthly Diagnostic Tactical workstream, chaired by Radiology CD as position is stable, and supported by	Data available to all diagnostics teams is not the same, with limitations in data from some clinical systems (e.g. CRIS and Cardiobase) to	Will review options available as part of Endoscopy and PAS system upgrades.

ADOP with input from all relevant CSUs . Processes in place to support recovery and any additional COVID requirements.	support management and recovery planning. Support from IT is constrained to support better data production.	
Weekly Diagnostic month end breach prediction process continues to be in place.	Unexpected levels of demand may result in activity being reduced or cancelled to support increased in COVID-19 admissions and reallocate resource.	Weekly monitoring of position and supporting actions re- instated.
Equipment replacement programmes agreed for MRI, CT and Cath Laboratories during 2020/21. 1st phase commenced for MRI and CT.	Impact of plans being progressed on Diagnostic recovery if mitigating action plans do not align.	Cath Laboratory and MRI replacement plans progressing during 2020/21. 1st 2 new labs in now in place. Final additional MRI scanner in operation from mid/end of May 2021. Mobile remaining in place to end of August 2021 to further support recovery. Mitigation plans for capacity lost in place with other providers/ extended hours.