The Leeds Teaching Hospitals NHS Trust

CORPORATE RISK REGISTER

September 2019

Summary Corporate Risk Register September 2019

No.	Former No.	Nature of Risk	Date added to CRR	Executive Lead	Current Risk Score	Last Reviewed By RMC	Link to LIM Value Stream
		Safety and Quality Risk					
CRRS 1	CRR 1	Inadequate nurse staffing levels	May 14	Chief Nurse	16	Aug 19	
CRRS 2	CRR 18	Insufficient Medical Staff to deliver service	May 14	Chief Medical Officer	16	Jun 19	
CRRS 3	CRR 2	Healthcare acquired infection	Mar 19	Chief Medical Officer	16	Apr 19	
CRRS 4	CRR 33	Violence due to organic, mental health or behavioural reasons	May 15	Chief Nurse	16	Apr 19	
CRRS 6	CRR 42	Risk of an Influenza Pandemic	May 18	Chief Operating Officer	15	Aug 19	
CRRS 7	CRR 46	Risk to the delivery of the Aseptic Service	Dec 18	Chief Medical Officer	15	Aug 19	
CRRS 8	CRR 47	Risks arising from Britain's withdrawal from the EU	Mar 19	Chief Operating Officer	16	Aug 19	
CRRS 9	CRR 6	Unserviceable high impact I/T infrastructure and resilience	May 15	Chief Digital and Information Officer	15	May 19	
CRRS 10	CRR 39	Loss of data or system outage as a result of a cyber-attack	Jul 17	Chief Digital and Information Officer	16	May 19	
CRRS 11	CRR 35	Power failure/lack of IPS/UPS resilience due to electrical infrastructure	Aug 15	Director of Strategy and Planning	16	Apr 19	
CRRS 12	-	Pensions Regulations	Jul 19	Director of HR	16	Jul 19	
CRRS 13	-	Inadequate national supply of Total Parenteral Nutrition for home patients	Aug 19	Chief Medical Officer		Aug 19	
		Financial Risk					
CRRF 1	CRR 9	Failure to deliver the financial plan 2019/20	May 14	Director of Finance	20	May 19	
CRRF 2	CRR 40	Insufficient capital resources	Mar 18	Director of Planning and Strategy/Director of Finance	16	Jul 19	
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 Strategy and Planning	15	Jul 19	
		Performance and Regulation Risk					
CRRP 1	CRR 12	Failure to achieve Emergency Care Standard	May 14	Chief Operating Officer	20	Apr 19	ED LGI
CRRP 2	CRR 13	18 week RTT target non-compliance	May 14	Chief Operating Officer	20	Apr 19	Ophthalmology
CRRP 3	CRR 15	62 day cancer target	May 14	Chief Operating Officer	16	Apr 19	MDT & Pancreatic Breast Only
CRRP 4	CRR 23	Failure to achieve 28 day cancelled operations target	May 14	Chief Operating Officer	16	Apr 19	Cardiac
CRRP 5	CRR 31	Patient flow and capacity for emergency admissions (health economy)	Sept 15	Chief Operating Officer	20	Apr 19	
CRRP 6	CRR 32	Unsustainable levels of medical outliers	May 15	Chief Operating Officer	15	Apr 19	
CRRP 7	CRR 45	52 week RTT target non-compliance in spinal injuries and colorectal services	Oct 18	Chief Operating Officer	16	Apr 19	
CRRP 8	CRR 22	Patients waiting longer than 6 weeks following referral for diagnostics tests	May 14	Chief Operating Officer	15	Aug 19	

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 resulting in a potential failure to protect patients or staff from serious harm (including death): loss of stakeholder confidence and/or material breach of CQC conditions of registration.

Executive Lead: Chief Nurse

Date Added to CRR/ Last reviewed date:
August 2019

Committee reviewed at:
Resource Management Group

Controls	Gaps in Control	Further Mitigating Actions
Use of temporary workforce (bank and agency)	Ability to respond to increase in demand e.g as part of silver command	Review of overtime, incentives and bonuses for staff bank and agency. New model of incentivising staff bank for winter pressures to be considered to increase availability of temporary workforce at critical times (Oct 2019)
Roster management and daily Nurse Staffing Status Report (NSSR) to ensure appropriate distribution of resources.	Establishment reviews including using the Safer Nurse Care Tool (SNCT). SNCT is undertaken in line with national guidance twice per year. Currently no live system for monitoring acuity and dependency to provide more consistent evidence based approach for establishment setting and review.	Business Case agreed by Exec Directors for - Nursing Safe Staffing Assurance Project. The aim is to introduce a live system of acuity and dependency reporting to aid decision making. (Proof of concept commenced April 2019). Pilot scheme to be reviewed in Sept 2019 prior to a decision on roll out
Safer staffing guidance and escalation pathway to ensure operational oversight and appropriate mitigation in safe deployment of staff, including out of hours assessment, assurance and escalation for safe nurse staffing guidance document	There are limited periods where wards are reported as 'Blue' and not safe. Some variation in understanding of current and minimum staffing levels at ward level	Workforce team supporting wards in escalation and monitored through weekly quality meeting. Formation of Nursing, Midwifery and AHP workforce group (April 2019)
Review of skill mix and roles - where appropriate balance of registered/unregistered staff can be adjusted to provide	Mixed success with pilots for integrated AHP models of care	Learning from pilot of integrated AHP models of care to be reviewed and recommendations

safe levels of care.		made for wider implementation (Aug 2019)
Introduction of new roles to support registered workforce	Quality Assurance of learning environments to ensure compliance with NMC validated programmes Numbers of Nursing Associate and Nurse Apprentices significantly increased in 2018/19 however benefit to workforce won't be seen until 2021 onwards.	Self-assessment against Health Education Quality Assurance framework (Aug 2019) Introduction of new work-based learning educators (3.0WTE band 5) to support learners in practice (Aug 2019) Review of placement capacity against fair share model (Aug 2019).
Continued focused recruitment of both general and specialist registered nurses.	Inability to reduce percentage of registered nursing staff leaving the Trust.	Development of focused retention initiatives as directed from the clinical resource management group and actioned through the Nursing, midwifery and AHP workforce group (December 2019)

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. Proposed changes in pension taxation have resulted in Consultants reducing their clinical commitments at the Trust (linked to CRRS 12).
This may result in clinical services under pressure; delays in responding to the deteriorating patient; and/or poor experience in training for junior doctors, which could result in training posts being removed – causing further rota gaps.

Executive Lead: Chief Medical Officer

Date added to CRR: May 14
Last reviewed : June 19

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.	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
Excellent rota design and management.		Review of clinical processes using Leeds Improvement Method to reduce inappropriate medical tasks - on-going
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	Lobbying of national bodies for regulation of PAs - on-going
High quality education placements evidenced GMC trainee survey results & Medical Education quality assurance of training programmes	National Workforce plans – provide limited training opportunities	
Guardians of Safe Working, Junior Doctor Forum, Exception Reporting results and subsequent response from specialty.		
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
International Recruitment		Links with College of Pakistan September 2019
Attendance Management and Professional Support		

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

Risk Description:
Effective management systems are not in place or sufficient to protect patients from the risk of hospital acquired C difficile and bloodstream infections caused by multi-resistant organisms. Caused by insufficient compliance with infection prevention procedures, including hand hygiene decontamination, environmental cleaning and insufficient training.

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

Executive Lead: Chief Medical Officer

Date added to CRR: Mar 19
Last reviewed: Apr 19

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	The risk assessment process is partly electronic and partly manual which means that this is not always 100% successful	PPM+ release in September 2019 to include HCAI Alert and automated population of HCAI column on eWhiteboard
Training Policies and Guidelines Mandatory Infection Prevention and Control Training to all staff, with an overarching Infection Prevention and Control Policy and a suite of Guidelines and SOPs	Compliance with policies - Human Factors and Systemic issues	Patient story video created for medical asepsis training to launch October 2019
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	Optimise every available area when a clinical area becomes free
Antimicrobial Stewardship: Policies and Standards, City Wide Group, Ward Rounds and day 3 IV antimicrobial review	Worldwide shortage of antimicrobials.	Combined treatment approach in place
Detection Monthly ward health checks	Surveillance software to identify new cases of infection ceases to be supported from June 2019	IA new national ambition to reduce healthcare Gram - negative blood stream infection by 50% by March 2021 across the whole health and social care sector has

		been launched. - Service to be re-provided within PPM+ - Substitute existing FMA with Next phase rolling out trust wide for 2 interventions during 2019
Recovery and lessons Learned Management of outbreak guidance - ward closures, Outbreak Control Group meetings and city wide response	Compliances policies/guidelines - human factors and system issues	Leeds Improvement Methodology used developed behavioural change questionnaire to ascertain ward culture and develop bespoke education. Reintroduction of detailed hand hygiene audit for all ward areas commencing September 2019
Commenced route cause analysis investigation for all gram negative bloodstream infections to identify contributory factors	It is unclear the proportion of BSIs that are avoidable Need to include tests and interventions specifically identified for CDi	Development of a BSI bundle completed. Pilot wards to test and evaluate the bundle by March 2020.

CRRS 4: Violence due to behaviour disturbance caused by 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:	**Executive Lead:**
There is a risk of violence towards patients, visitors and staff due to behaviour disturbance caused by organic, mental health or other reasons, resulting in the potential for a fatality, serious harm or litigation against the Trust.	Chief Nurse
	Date Added to CRR/ Last reviewed date: August 2019
	Committee reviewed at: Joint LTHT/LYPFT forum

Controls	Gaps in Control	Further Mitigating Actions
Policy for Conflict Resolution (Reducing violence and aggression in the workplace) and establishment of Security Co-ordinators.	Concern that there is a disconnect with the current de-escalation training and the actual incidents staff deal with and the skills taught.	On-going review of the TNA and monitoring of feedback/incidents by Conflict Resolution Trainer Training plan reviewed and paper presented to Quality Management Group in July 2019. Trust wide working group to be established in August 2019 to review arrangements for prevention and management of violence and aggression
Restraint and Restrictive Intervention Policy	No care planning tool that supports the policy	Pilot of new restraint & restrictive intervention care bundle will be complete by end Q1 2019/20 New clinical guideline being developed " Use of Rapid Sedation/Rapid Tranquilisation" by end Q1 2019/20, currently awaiting sign off from Clinical Guidelines Group in August 2019
24/7 service provision from Liaison Psychiatry including	CAMHS do not record their assessments	LYPFT planning to allow LTHT Mental Health

sharing of key risk information for patients in LTHT. Acute Liaison Psychiatry Service (ALPS) response to referral target in ED of 1 hour implemented Q3 2018/19	on LTHT Electronic Patient Record LTHT Mental Health Team cannot access LYPFT electronic patient record systems	Team access to their electronic patient record systems in 2019/20
Enhanced Care risk assessment embedded in LTHT		
Individual patient alerts visible on PPM to indicate potential risks	Alerts are not maintained resulting in potentially inaccurate data	
Security staff regularly patrol within LTHT where repeat incidents are identified by particular patients, heighten patrols will be put in place and responses to incidents prioritised.	LTHT does not have a rigorous stop and search policy	
Mental Health training and education offered for new and existing nursing staff	It may be useful to consider recruiting RMNs or unregistered staff with MH experience into the LTHT workforce	Working group chaired by HoN ESM and Service Manager from LYPFT reviewing current workforce profile, to make recommendations to Senior LTHT/LYPFT Group in Q2 2019/20

CRRS 6: Risk of an influenza 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 Preparedness Plan due to an influenza pandemic which could cause potential multiple fatalities, significant delayed treatment and financial loss.

Executive Lead: Chief Operating Officer

Date added to CRR: May 18
Last reviewed: Aug 19

Committee reviewed at: Emergency Preparedness Group

Controls	Gaps in Control	Further Mitigating Actions:
Pandemic Influenza Plan		
CSU Business Continuity Plans	Not all CSU Business Continuity Plans are up to date	Support CSUs in the completion of Business Continuity Plans, CSU refresh updates throughout 19/20.
Vaccination programme	Not all staff or at risk groups elect to have a flu vaccination	Work with Corp Comms and HR on approach in 2019/20 to further increase staff take up of the Flu Vaccination
Infection Control procedures (including Personal Protective Equipment)	Adherence to procedures	
Leeds Outbreak Plan (operational response guidance)		
Surge and escalation arrangements		Surge and escalation plans to form part of winter planning and preparedness for 2019/20

CRRS 7: Risk to the delivery of the Trust Aseptic Medicines Preparation Service	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 medicines-related errors or denial of Intravenous (IV) additive medicines, notably chemotherapy and parenteral nutrition treatments

Due to shortage of staffing required to prepare products following increased clinical demands and increasing regulatory demands from external auditors

Resulting in unmet clinical need or patient safety risk from product errors or microbiological contamination as well as poor staff experience and working conditions

Executive Lead: Chief Medical Officer

Date added to CRR: Dec 18
Last reviewed: Aug 19

Committee reviewed at: Drugs & Therapeutics Committee

Controls	Gaps in Control	Further Mitigating Actions
Temporary increase in support via use of agency staff and internal redeployment of Pharmacy staff with required skills to assist in the aseptics service	Movement of internal resource results in staff with less expertise becoming involved in validation and preparation of high risk products; the staff re-deployment impacts in other medicines optimisation service areas such as inpatient care with medicines and discharge flow. Locum staff with necessary technical skills are in limited supply. Training in the specialist area of medicines handling occurs over a number of years and cannot be rapidly increased but is in the pharmacy workforce plan. Use of Healthcare Scientists and non-registrant supervisors as different workforce is being pioneered in Leeds.	Staffing resource is continually assessed; this does requires careful balance as many such skilled staff are key to the Oncology inpatient and day case activity Additional activity funding has been agreed with LCC for 2 x 8A pharmacists and 2 x band 5 technicians. In recruitment/training as at February 2019. Locum specialist aseptic technicians recruited x 3WTE since November 2018
Purchase ready to administer products	Greater numbers of commercially prepared ready to	Further expansion in availability of premade

from commercial aseptic medicines units to replace items previously made in LTHT Aseptic facilities LTHT is already acknowledged in the Carter Review (NHS Improvement Model Hospital - reduction in unwarranted variation) as a leading centre for dose standardisation of chemotherapy and has released 24% extra chemotherapy capacity from the aseptic units.	administer products to be purchased when feasible; not all products required are available commercially nor stable enough to be pre-made sometime in advance. Purchase cost is usually increased compared to cost of local production. This specialist medicine supply sector is fragile and becoming increasingly so. The purchase of pre-made products puts additional demand on the Quality Assurance team within the Pharmacy Preparative service. Demand for chemotherapy, immunotherapy and parenteral nutrition continues to grow significantly. The increasing availability and commissioning of immunotherapy treatments in addition to the fragile outsourced supply chains mean that there is a 19% increase in demand for chemotherapy at AP06 18/19.	products is unlikely while the sector is not robust in order to avoid excess exposure to risks associated with a failure in contingency arrangements Robotic compounding systems are now becoming available; LTH has purchased the first system in the UK and is building experience with batch production of lower risk antibiotic products during 19/20.
Work with other LCC and Pathology to refine pathway planning to help smooth chemotherapy and immunotherapy demand and recognise capacity limitations.	Demands are heightened by significant issues with patient pathway planning and a common failure to integrate blood results as a key control step at an appropriate and/or prioritised time. The Chemocare e-scheduler was implemented September 2018 but compliance with prescribing guidance on notice periods is not satisfactory at present (69% prescribed >48hrs before treatment)	Working with Cancer services to explore changes to current pathways that can support pressures in other ways such as demand management. Active Quality Improvement project underway with LCC and Pathology – “Every second counts”. On-going discussions with AMS CSU and Children's Services regarding Parenteral Nutrition demand management. Licensed formulation of neonatal nutrition “Numeta” was launched in January 2019; expansion in access to more neonates & children is

		planned. Discuss and develop an agreed approach to demand management from planned expansion of clinical trials with LCRF/LCC.
External inspection of unlicensed units by National Specialist Pharmacy Services Inspection (NHS-England) under Executive Letter 97(52) External inspection of the licensed Production Unit (Moor House) by MHRA	The two main unlicensed units at SJUH and LGI are both currently rated as "Significant risk" due to increasing demand placing pressure on capacity and the Pharmaceutical Quality System Radio-pharmacy is currently rated "Low risk" MHRA Re-Inspection is now overdue	Completion of all required actions and development of effective capacity assessment and management tools Agreed escalation and mitigation approach across all CSU service users to support management of peak demand and capacity use in planned manner
Temporary reduction (October 2018) in specification of Aseptic Service, resulting in lower risk products being prepared on wards by nursing staff	Increased risk transferred to busy nursing colleagues, preparation occurring in clinical areas.	Continue to review capacity and demand management with a view to changing aseptic service specification again

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

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

Executive Lead: Chief Operating Officer

Date added to CRR: Feb 19
Last reviewed: Aug 19

Committee reviewed at: Emergency Preparedness Group

Controls	Gaps in Control	Further Mitigating Actions
National co-ordination and assurance of suppliers and direction on holding additional (6 weeks) stock of consumables, medical devices and pharmaceuticals	Detail on specific products held in stockpile is unclear Lack of clarity on escalation and co-ordination of issues nationally	LTHT EU exit co-ordination and contingency plan to be produced for the March 2019 Trust Board Clarity from NHSE anticipated in March 2019
CSU risk assessment and information sharing events		
Supplies and procurement processes and plans for product shortages in place		
Action and readiness tracker for LTHT based on Operational Readiness Guidance from DHSC		
Multi-agency and LTHT Incident response plans and business continuity plans in place		
EU exercises to test scenarios and contingencies carried out in February 2019		

CRRS 9: Unserviceable high impact I/T systems	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:
The identified most high impact IT systems and access to archived medical information may fail without warning or suffer performance issues caused by critical systems being held on old platforms and insufficient data storage, system outage or damage, environmental factors, unauthorised access or failed backup arrangements.
This may result in errors or delays in diagnoses, a need to repeat tests, invoice failures, reporting failures and/or unsatisfactory patient experience.

Executive Lead: Interim Chief Information Officer,

Date added to CRR: May 15
Last reviewed: May 19

Committee reviewed at: Digital Hospitals Programme Board

Controls	Gaps in Control	Further Mitigating Actions
Access to server rooms and servers is restricted to authorised personnel only and strictly controlled to eliminate risk of contamination, damage, misuse or sabotage.	Limited access controls in place, no CCTV, no audit logs available from door access systems. Some server rooms still on physical keys.	Room risk assessments completed and a review plan for each room established.
Control of computer room environment (cooling with alarm if control parameters breached, security, UPS backup, fire prevention and detection equipment) in place in main computer rooms. All computer rooms occupied daily to verify the operating environment.		
Back up computer rooms with sufficient redundancy to operate a full service in the event of failure of 2 out of 3 rooms. Routine scheduled maintenance of servers in accordance with manufacturer's specification and relevant guidelines /alerts.		
Nagios System alerts are generated in the event of failure. Out of hours alert notices are escalated to IT personnel or on-call team for immediate action and Senior Management Team notified. Additional monitoring is now being placed on all IT infrastructure and the duty on-call rota is in place.		

Critical IT systems on the old platform are being migrated to new IT platform to reduce exposure and maintaining resilience	There is no strategic replacement plan Due to agreed £10m reduction in capital spend for 2018/2019, several major IT systems (including PAS, Copath and Telepath) will not be upgraded until 2019/2020 with a possible breach of warranty	Trust reviewing capital requirements. Strategic Outline Case to support IT Infrastructure produced and funding targeted for June 2019. Investment in the IT systems upgrade deferred from 2018/19 is a priority in 2019/20
Optimised power, performance and stability of old IT platform following migration of workload to new platform. Expansion of new platform has provided additional stability.		
Centralisation of IT Staff and Systems. Recommendation from the reviews carried out following the Telepath system outage to migrate, where appropriate, department systems, their associated networks and data centres to the central DIT.	Lack of full IT ownership and governance	Implementation of the recommendations from the internal and external reviews carried out following the Telepath system outage. Digital and Information have created the ONE IT to drive this forward. A programme of work has been agreed for delivery by end of March 2019.
Recommendation from Telepath system outage reviews to centrally manage, where possible, system back-ups ensuring regular (daily) checks to confirm that back-ups are intact and complete and are capable of being fully restored.	Identification of key stake holders	Risk Assessment Task and Finish Group established to complete a risk assessment of all key critical systems
Business Continuity Plans in place for all major IT systems		

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

Risk Description:
There is a risk of loss of data or system outage due to a cyber attack resulting in significant service disruption, harm to patients and financial loss.

Executive Lead: Interim Chief Information Officer

Date added to CRR: July 17
Last reviewed date: May 19

Committee reviewed at: Digital Hospitals Programme Board

Controls	Gaps in Control	Further Mitigating Actions
The NHS N3 Network - N3 is a private ring fenced network with protection /security at all entry and exit points. There is no direct access into the network from the wider world, however it does provide outbound access for NHS organisation.		
External penetration testing - a penetration test is proactive and authorised attempt to evaluate the security of an IT infrastructure by safely attempting to exploit system vulnerabilities. The Trust undertakes annual penetration testing to identify weaknesses within the Network perimeter in a controlled way to safely exploit any system vulnerabilities.		
Firewalls - The N3 Network is protected from individual end users and vice-versa by firewalls which only allow certain types of data to pass through.		
Anti-virus/anti-worm/denial of service attack measures - N33P monitors the network for unusual activity which may indicate virus or denial of service activity.	No identifiable Cyber Response Team No capacity to monitor detections within existing teams in a timely manner. The Trust requires a dedicated expert	SBAR on the approach to cyber security issued May 2017, incorporating recommendations and potential costs. Cyber response function and governance

	resource in the field of security, cyber security is constantly evolving and current staff members are not dedicated to the task as it requires greater attention. This resource should reside outside of the operation teams, with the ability to block insecure solutions, make recommendations, audit systems, and constantly monitor potential risks	being designed - implementation Spring 2019. Mersey Internal Audit Agency has carried out system resilience reviews of cyber security. LTHT was one of the National Cyber Response Pilots in 2018. The Trust is working with NHD Digital to secure plans and manage the impact of this
Web filtering - Communication with the internet is further protected through the use of web filtering. All web traffic is passed through a web filter system which checks both the source and destination.		
Password Management - All those granted authorised access to the Trust's computer system are issued with a personal password. Access to the network (desktop) is only permitted to authorised staff who have completed the registration process and obtained their own personal user name and password.	There is a delay in being informed that a staff member has left the Trust / no longer requires access to Trust computer systems and no automatic process of being able to disable user accounts in a timely manner.	Workflow linked with ESR processes and management tools are being evaluated to allow the line management function to inform the Account Management Service to deactivate staff access.

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 Strategy & Planning

Date added to CRR: Aug 15
Last reviewed: Apr 19

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 5 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 a replacement for systems that should be installed as per HTM 06-01 (UPS/IPS) to maintain critical supplies in the event of mains failure. The fitting of batteries is not consistent in all Medical Physics equipment across the Trust which could result in confusion when power supplies are disrupted.	Theatre upgrade programme - £1.5 million a year built in to capital programme 2019/20 to bring theatres up to modern HTM standards. Decant theatres at St James are under construction and will be completed summer 2019, this will provide decant facilities to enable theatres at St James to be brought up to compliant standards.
Complete assessment of telephony switchboard resilience in	Not all Information Technology systems are	

terms of UPS protection and autonomy (up to 4 hours)	supported by UPS with the required autonomy to maintain a service upon loss of supplies.	
Estates Handbook updated for emergency plans with detailed processes and regular review.	This handbook provides the Estates on-call team with information of what can be done when power interruptions occur but does not assist with the shortcomings of the installed systems.	The handbook is reviewed annually.
Increased interleaving of circuits on 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.	Increased Capital availability in 2019/20 for B&E will provide the opportunity to focus on backlog and resilience improvements. Decant theatres at St James are under construction and will be completed summer 2019, this will provide decant facilities to enable theatres at St James to be brought up to compliant standards.
A UPS/IPS infrastructure has been installed to support Geoffrey Giles Theatres 1 to 8 and Recovery	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 the Theatres is still required. If there is a power failure within these theatres the only system with inbuilt battery back-up are the	Infrastructure to support Geoffrey Giles theatre 1 to 8 and Recovery was installed in March 2017 and final UPS connections to J54 were completed (not IPS), further capital investment is required to connect the infrastructure to Giles Theatres once the decant theatres are completed in summer

	Operating Light's.	2019. Money is available in the B&E Capital Theatre Upgrade rolling programme in 2019/20 however access is required to each Theatre in turn to carry out the work.
Some areas (e.g. J1, J54) are fitted with the required UPS provision but not fitted with Isolated Power Supplies (IPS).	A number of clinical category 5 areas as required by HTM 06-01 are not fitted with IPS to safeguard the patient from the risk of electric shock and provide increased local electrical resilience.	IPS should be installed to all clinical category 5 areas in-line with HTM 06-01 when areas are refurbished. Awareness of the electrical shortfalls in UPS and IPS provision in clinical category 5 areas is required. Electrical Action cards for all category 5 areas are being developed by Estates and will be passed to the relevant clinical triumvirate teams for review and explanation as required. Once agreed these should be situated at the entrance to all Clinical Category 5 areas detailing the expected impacts of electrical failure and the actions required by staff. Completion summer 2019.

Risk CRRS 12: Pensions Regulations	C = 4	16	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
	L = 4								Target score					Initial & Current Score		

Risk Description:
Risk that the income tax associated with membership of the NHS Pension scheme will reduce the availability of medical staff to deliver clinical services (linked to CRRS 2).
This is because high earning medical staff are more likely to not agree to undertaken voluntary additional work or exercise their contractual right to reduce Additional Programmed Activities or submit flexible working requests to reduce their job plan commitments.

Executive Lead: Director of Human Resources

Date added to CRR: July 19
Last reviewed: Jul 19

Committee reviewed at:
Risk Management Committee

Controls	Gaps in Control	Further Mitigating Actions
Consultants and other high earners can undertake additional Programmed Activities (PAs) and review this through the job planning processes.:	There are no controls requiring consultants to undertake prolonged and voluntary additional work over and above their job plan.	Nationally there is a consultation in relation to allowing consultants to reduce their pension contributions by 50% (in exchange for 50% of pension benefits). This will allow consultants to reduce tax liability whilst retaining the benefits of scheme membership.
Consultants undertaking private practice are contractually required to provide 11 PAs to the NHS.		A Detailed CSU level analysis has been undertaken to identify those specialties which are most likely to be affected.
Formal arrangements for reviewing and amending job plans.		Collaborative working with WYAAT colleagues to agree consistent approach.

CRRS 13: Risk that LTHT cannot support the provision of on-going specialised care for Home Parenteral Nutrition Patients	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
							TS								CS	IS

Risk Description:
A failure in the ability of one of the nationally contracted outsourced home parenteral nutrition (HPN) suppliers to meet the needs of all LTHT patients registered with them who had been receiving the highly specialised parenteral nutrition products required for their ongoing care

Caused by
a reduction in the suppliers capacity to prepare and supply Home PN products with no additional national compensating capacity being available

Resulting in
Patients suffering inconvenience and disruption(s) to their HPN supplies; increased level of monitoring, increased risk of infection and deterioration which may require admission to hospital ; increased demand on the specialised intestinal failure services (AMS, Children's Services, MMPS & Adult Therapies) and Hospital Pharmacy aseptics and specialist medicine preparation services. This may in turn impact on available inpatient service capacity; parenteral nutrition care to inpatients (adult and paediatric); nursing medicines preparative activity on wards and to the volume of other Hospital Pharmacy prepared items such as intravenous ready to administer medicinal products, chemotherapy or clinical trials with medicines.

Executive Lead:
Chief Medical Officer

Date Added to CRS/ Last reviewed date:
August 2019

LINKS to
CRS7 (MMPS 8762)Risk of delivery of Trust Aseptic Medicines Preparation Services CS=15(C5xL3)

AMS Risk 9903 Risk of harm from missing PN CS=15(C5xL3)

Adult Therapies Risk 9887 Delivery Issues with provider CS=15 (C5xL3)

Committee reviewed at:
Drugs and Therapeutics Group

Controls	Gaps in Control	Further Actions Planned:
• Purchase and supply of an increased range of premade standard PN products to try to meet the clinical needs of displaced patients	• Commercial availability of suitable PN products • Volume of available PN products due to unanticipated spike in requirement following provider capacity reduction and impact across all PN providers	• Contribution and influence to the national clinical team developing standardised approach for all NHS E patients • Location of alternative non-UK licensed products in use in Europe
• Increase LTHT aseptics service capacity by a. increasing the speed and volume of the available workforce with skills required to prepare the highly specialised PN products b. re-provide suitable products -of all product categories CIVA, ready to administer infusions, dose banded chemotherapy, through purchasing from the commercial open market c. identify and utilise any previously skilled employee who can be redeployed and backfilled d. redeploy employees to non-specific skilled roles to release more time from skilled employees and use different skill mix to support appropriate activities	• LTHT Aseptics are mid plan to increase skilled workforce plan as agreed re CRS7 in 2018 • Highly specialised skills required to prepare PN not readily available at short notice • Limited open market provision of ready to use products • Limited capacity in other aseptics services commercial and NHS • Limited available workforce in other Trust providers • Medicinal product stability - some products must be prepared within the day of intended use	• Further procurement scoping of ready to use purchasable product • Highlight capacity limitations and flex in unexpected circumstances to the WYATT and NHSI Aseptics Service Review and Management of Variation and Capability work streams • Host National Webinar though NHS E/I Emergency preparedness, resilience and response team (EPRR) to encourage sharing of good practice • Support HPN patient risk assessment to maximise standard product use options
• Utilise other outsourced provider capacity	• Limited numbers have been allocated to Trusts nationally and all have been made use of • Impact on ward based staff and waiting times due to loss of overall capacity to respond as previously to increasing volumes of ready to	• Support HPN patient risk assessment to maximise standard product use options • Identify other means of obtaining suitable products

	administer intravenous medicines and chemotherapy products	
• Critically manage inpatient demand for parenteral nutrition products	• AMS Gastroenterology Team required to allocate available inpatient resource daily whilst also managing the daily HPN provider failures	• All referring specialties have been informed of requirement to control requests to most clinically urgent - AMS, Oncology and Critical Care
• Respond to rapidly updated information about individual patient status and PN requirements	• AMS Gastroenterology Team required to allocate available inpatient resource daily whilst also managing the daily HPN provider failures	• Lack of reliable and accurate information in a timely manner from HPN provider
• National NHSI/E Emergency preparedness, resilience and response	• Communication and information flow	• To continue to influence the National Commercial Medicines Unit and National EPRR for improved solutions
• Total patient pathway Service demand management in medicines preparation services	• Overall aseptics preparation capacity interdependencies and flex capacity management and prioritisation in a daily changing situation	• Jointly with other main aseptic user CSUs present case of need to Operational Performance Management Team w/c 19.08.19
• Leeds Improvement Method and Efficiencies Continue to develop Paperlite, Every Second Counts, Chemocare eScheduling, stricter adherence to order placement time lines and Automation activities	• Speed of impact and system efficiency realisation • Same personnel involved as required to deliver the increased capacity	• Support of improvement work through broader MMPS team structures and encourage other team participation and support

CRRF 1: Failure to deliver the financial plan for 2019/20	C = 5	20	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
	L = 4								Target Score						Current Score	Initial Score

Risk Description:
There is a risk that the Trust does not achieve its financial targets in 2019/20
Due to the inability to deliver the Waste Reduction Programme and planned activity levels due to delayed discharges, the impact of urgent care pressures on patient flow and changes to secondary care provision in other, local trusts.
May result in the possible loss of PSF funding from the DH.

Executive Lead: Director of Finance

Date added to CRR: May 14
Last reviewed: May 19

Committee reviewed at: Finance & Performance Committee

Controls	Gaps in Control	Further Mitigating Actions
Board owned financial plans	Implementation risks for Waste Reduction Programmes Although support from the PSF is protected, this does not help the Trust's overall cash position	Implementing the other centrally managed projects as per the plan **(March 2020)** Work with the Trust's partners Asset sales
CSU ownership of realistic budgets and run rate based forecasts linked to the Integrated Accountability Framework launched in 2017.		
Operation of the financial performance framework		Transacting the performance management framework to ensure that CSU's fully identify and deliver their waste reduction targets and manage any pressures within the resources available **(March 2020)**
Agreement with Leeds CCG and Specialist Commissioners for Aligned Incentive based contracts for 2019/20.	Impact of Leeds partners response to urgent care pressures	Work with the Leeds health economy to find a solution to the severe urgent care pressures facing the Trust within the

		resources available to the economy Effective implementation of the Aligned incentive contract with Leeds CCG and NHSE Specialised Commissioning including effective mechanisms to re-patriate NHS work currently done in the private sector
Implementation of Finance the Leeds Way Improvement Plan		
Integrated Care System (ICS) Financial Plan and Control Target	In 2019/20 the Trust will be monitored as part of the Integrated Care System (STP) control target which will need to establish an effective financial framework to ensure delivery of the target. Receipt of at least 15% of the Trust's Provider Sustainability Funding (PSF) will be reliant on delivery of the overall ICS control target	Work with the ICS to agree a framework and attempt to over-achieve the Trust control target to provide additional flexibility to the ICS **(March 2020)**

CRRF 2: Insufficient Capital Resource	C = 4	16	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
	L = 4		1	2	3	4	5	6	8	9	10	12	15	16	20	25
						Target Score								Current Score	Initial Score	

Risk Description:
There is a risk to the continuity of clinical services due to the Trust having insufficient capital resources in the current and future financial years to replace ageing equipment and maintain the estate building and engineering infrastructure across clinical and support departments and to support the initial stages of Building the Leeds Way, resulting in potential significant harm to patients and unsafe conditions for staff, visitors and residents.

Executive Lead: Director of Planning and Strategy/Director of Finance

Date added to CRR; May 18
Last reviewed: Jul 19

Committee reviewed at: Finance & Performance Committee

Controls	Gaps in Control	Further Mitigating Actions
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).	Although spend in 2018/19 was £62m this is £10m less than had been planned. Up to £20m may be available for B&E in 2019/20 for which there is currently no business case or alternative finance.	Should BTLW take place this will remove circa £41M from the Trust backlog figure of £110M. Development of a long-term Capital and Estate plan. Work with national bodies and the Integrated care System to secure funding (e.g. loan or PFI)
Estate risk adjusted backlog register updated annually to assist prioritisation of annual investment.	2018 Estates backlog review identifies a backlog figure of £110m to bring the estate to condition 'B' standard. Note that this excludes additional costs that are dependent upon the project solution chosen (for example fees, VAT, decanting and temporary services to other areas)	Continued funding to complete annual external backlog reviews (Statutory and Physical condition) as per DOH guidance.
Contingency in the capital programme for emergency situations.	Limited contingency available to fund emergency situations e.g. lift failures.	If emergency funding exceeding the contingency amount is required a cost pressure would be raised with the senior finance team to ascertain if reserve funding is available.
Agreed Estates and Facilities B&E Capital Allocation		

Procedure in place to ensure available Capital is spent on the correct priorities		
Trust Capital spent on backlog/risk is increasing year on year.	Available B&E Capital still insufficient to make a significant reduction in the backlog figure.	As risks increase due to the lack of available Capital they would be added to the Estates risk register and escalated to the CRR if required.
Estates and Facilities Risk Review Group meet every 2 months to ensure focus on reducing risk and backlog with available Capital.		Robust oversight of the capital programme to ensure the capital allocation is spent in year.

Risk CRRF 3: Risk of further delays in delivering the refurbishment of the Generating Station Complex (GSC) at LGI	C = 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 further delays in delivering the refurbishment of the Generating Station Complex at LGI due to the poor performance of the contractor which could result in commercial pressure, financial loss and damaged relationship/disputes with the contractor over the remaining period of the 25 year partnership.

Executive Lead: Director of Planning and Strategy

Date added to CRR: Oct 18
Last reviewed: Jul 19

Committee reviewed at: Finance and Performance Committee

Controls	Gaps in Control	Further Mitigating Actions
Director level meetings with contractor	These meetings/correspondence and on-going technical discussions provide the Trust with progress updates, however progress continues to be behind agreed targets.	Complete the construction phase of the contract by 25 October 2019, potentially this could be further delayed.
Monthly liaison meetings attended by technical and contract managers		Legal advice is being taken re issuing dispute notice to contractor
Joint Project Board with University		
External legal and technical advice		
Maintain current level of correspondence with Contractor regarding any claim in line with contract procedure		
Provide regular updates to Finance & Performance Committee		
Provide a central financial provision in 2018/19 Annual Accounts for a bad debt in relation to the guaranteed energy savings in 2018/19	Communication received from Contractor for delay claim. Trust has responded and is considering, along with the University, taking the matter through the formal dispute process.	Discussions with the Trust and University are on-going; aim to be settled Autumn 2019 (Q3).

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

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

Executive Lead: Chief Operating Officer

Date Added to CRR May 2014
Last reviewed date:
April 2019

Committee reviewed at:
Finance & Performance Committee

Controls	Gaps in Control	Further Mitigating Actions:
CSM status reports and operational response guidance in place - Bronze, Silver and command escalation process.	Community / partner provider capacity e.g. Package of Care, delays in accessing Community Care Beds.	
Daily monitoring and reporting of 4 hour performance	Timeliness of bed allocation by CSUs to ED	Revised focus of Unplanned Care Programme to include Leeds Improvement methodology (A3) for: Improvement in Non-admitted performance SJUH site Improvement in overall compliance with the 95% standard at LGI
Patient streaming in place to most appropriate route e.g. GP, Minors, Frailty, Jamma.		Continued monitoring of 95% compliance and breach analysis for patients streamed away from ED.
Creation of space for a Rapid Assessment Unit at SJUH as a result of the transfer of Jamma, Frailty and Minors.		St James's RAU model currently in pilot phase. LGI to develop RAU model based on learning from SJUH.
System level action plan including Newton Europe recommendations being implemented and monitored through SRAB / A&E Delivery Board.	Community capacity to support timely transfer of patients from acute bed base. Complexity of discharge pathways.	Decision making work stream to continue to implement work plan and wider actions/recommendations to be monitored

		through SRAB. Newton Europe to re-audit discharge pathway **June 2019**
Weekly Operational Winter Group (partner meeting) in place to review themes and actions required to help facilitate improved patient flow.	Continue with high numbers of Super stranded / MOFD patients within a hospital setting.	System level trajectory for reduction in numbers of Super stranded patients agreed with partners **May 2019** Actions to deliver trajectory by **March 2020** Implementation / progress SRAB action plan **ongoing**

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

Risk Description:
There is a risk that the Trust will not deliver 18-week RTT performance either because of demand / capacity mismatch or an inability to clear waiting list backlog and a further risk that total waiting list size will not be delivered at the same level as March 2018. These targets are related as reducing total waiting list size is likely to add pressure to admitted pathways requiring theatre and inpatient bed capacity.
This may result in a poor experience for our patients, reputational damage and increased scrutiny. There is also a financial risk from the imposition of breach sanctions and additional capacity being required at increased cost.

Executive Lead: Chief Operating Officer

Date Added to CRR:
Last reviewed date: Apr 19

Committee reviewed at: Finance & Performance Committee

Controls	Gaps in Control	Further Actions Planned:
Delivery contracts with CSUs will include waiting list size and RTT as key contracted deliverables.	Inconsistent use of production boards/daily managment to assess demand, activity and capacity data and manage risks. Processes to review demand and capacity and react to fluctuations in demand are not robust across the organisation.	Co-production of production boards with CSUs to monitor demand and manage risks, **July 2019** Promotion of improved capacity and demand modelling by CSUs and specialty services to monitor performance in-year, **Sept 2019**
Accountability process will ensure greater focus is given to CSUs performing against plan.	Inconsistent sharing of successfully implemented schemes to deliver additional capacity or reduce demand.	Sharing of new ways of working across the organisation to promote best practice or most efficient use of capacity through the Planned Care Board, **May 2019**
Greater seasonal delivery of routine inpatient activity in a number of specialties	Processes to review demand and capacity and react to fluctuations in demand are not robust across the organisation.	Promotion of improved capacity and demand modelling by CSUs and specialty services to monitor performance in-year, **Sept 2019** Reviewed through winter planning preparations.

Work with commissioners to control growth in referral rates where appropriate alternate pathways exist.	Inconsistent use of production boards to assess demand, activity and capacity data and manage risks and foresee any growth quickly (is it true growth of a blip)	Expedite discussions with Commissioners when required to manage any growth through alternate pathways where possible.
Theatre scheduling tool rolled out to daycase areas and some inpatient specialties to maximise use of theatre time AIC incentivises specialties to develop new ways of working that control demand.		
Established arrangements are in place to allow additional outpatient and inpatient activity to be scheduled outside normal working hours	Key staff are not always available to undertake additional activity in response to peaks in demand.	
2019/20 contract requires choice to be offered to patients once they have waited over 26 weeks from referral.	No established process for offering choice. Lack of capacity within external providers.	Work with commissioners to establish process for offering choice on or before 26 weeks. July 2019

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

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

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

Executive Lead: Chief Operating Officer

Date added to CRR: May 14
Last reviewed: Apr 19

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	None
The Trust maintains and publishes a timed pathways, agreed with the local commissioners and any other Providers involved in the pathway, taking advice from the Cancer Alliance for the following cancer sites: lung, colorectal, prostate and breast	Referrals from other providers do not always occur in a timely manner to support delivery of 62 performance	WY Alliance supporting work re late referrals/ Inter Provider Transfer (IPT) to LTHT. Criteria for an effective IPT have been developed by pathway and will be implemented from April 2019 under new breach allocation rules. Working in partnership with the IST to undertake detailed pathway analysis in key pathways such as Prostate, Lung, Lower GI

		and Breast. As part of this work informatics will auto-populate the ISTAnalyser Tool these 3 pathways and embed in those teams it's use to track patients actively - **end June 2019**
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	Introduction of a daily review of Production Boards by CSUs containing cancellation data and forward booking profile to manage risks coupled with the introduction of Service delivery contracts with CSUs to include cancelled ops and 28 day re-booking data - **end June 2019**
Root cause breach analysis is carried out for each pathway not meeting current standard.	Root cause analysis is not always carried out for the 10 previous breeches.	This will be incorporated into the work using the IST analyser tool to provide CSUs with a clear understanding of where the pathway blocks are and which patients are at risk of breaching - **end of June 2019**
Capacity and demand analysis for key elements of some but not all of the pathways not meeting the standard (1st outpatient appointment; treatment by modality) is carried out systematically and routinely.	Capacity & demand modelling is not routinely completed for all elements of every pathway	Engagement with NHSI on the use of their Capacity & Demand modelling tool in key pathways initially through 19/20 - **end of June 2019**
An Improvement Plan is prepared for each pathway not meeting the standard, based on breach analysis, and capacity and demand modelling.	The use of the IST analyser tool is not yet embedded routinely in the key pathways to review breaches and track patients more effectively	This will be incorporated into the work using the IST analyser tool to provide CSUs with a clear understanding of where the pathway blocks are and which patients are at risk of breaching - **end of June 2019** WY Alliance supporting work re late referrals/ Inter Provider Transfer (IPT) to LTHT. Criteria for an effective IPT have been developed by pathway and will be

		implemented from April 2019 under new breach allocation rules. Developing streamlined diagnostic processes through LICS/early diagnostic programme to get to diagnostics earlier and reduce diagnostic demand. - **end Dec 2019**
The national guidance on reporting methodology being consistently applied.	None	None
A clinical review of 104 day patients undertaken.	None	None

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

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

Executive Lead: Chief Operating Officer

Date added to CRR: May 14
Last reviewed: Apr 19

Committee reviewed at:
Finance and Performance Committee

Controls	Gaps in Control	Further Actions Planned:
Daily 8am capacity planning meeting to prioritise admissions, including patients who have had operations cancelled and to allocate demand for critical care capacity.	Co-ordination of theatre/ ward and critical care capacity does not always align leading to greater risk of cancellations	Roll out the systematic use of the Electronic theatre scheduling tool, coupled with an increased emphasis on improving step downs from Critical Care in 4 hrs to ensure all available capacity is utilised to ensure as many patients are treated as is possible - **end June 2019**
All CSUs have weekly access meetings to identify available theatre capacity for additional sessions, manage risks and review cancellations and discharge and theatres KPI's using the PA consultant scheduling tool	Awareness of the cancellation and 28 day rebooking risks are not always visible to CSU management teams	Introduction of a daily review of Production Boards by CSUs containing cancellation data and forward booking profile to manage risks coupled with the introduction of Service delivery contracts with CSUs to include cancelled ops and 28 day re-booking data - **end June 2019**
CSUs to systematically engage in process to identify procedures and patients who could have their procedure as day case to reduce risk of cancellation Proactive reduction in normal operating levels during Jan, Feb and March which should reduce the cancellation numbers	Theatre staff and surgeons are not always available to undertake additional activity in response to peaks in demand	Review current Demand & Capacity tools and processes employed within LTHT to improve planning and flow in this area. This will involve visits to review best practice in other centres who perform well in this area - **end Sept 2019**

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

Risk Description:
Failure to maintain adequate capacity to meet the needs of patients requiring emergency admissions, caused by increasing demand and insufficient patient flow. This can lead to high bed occupancy levels impacting on our ability to maintain elective operating, non-compliance with national standards, poor patient outcomes and patient experience.

Executive Lead: Chief Operating Officer

Date Added to CRR: Sept 15
Last reviewed date: Apr 19

Committee reviewed at: Finance & Performance Committee

Controls	Gaps in Control	Further Mitigating Actions:
Continued focus on ambulatory models of care to ensure admission avoidance wherever safe and possible to do so Daily consultant ward rounds across all CSUs.	Continue with high numbers of Super stranded / MOFD patients within hospital bed base.	Unplanned Care work stream focus on further reduction in super-stranded patients. **Work scoped and implementation from May 2019 onwards**
Escalation process and full capacity plans by CSU - bronze, silver and gold command in place.		
DOP / CSM out of hours support and co-ordination.		
Robust bed modelling analysis to identify known activity surges		Operational Response Guidance to be reviewed and in place by November 2019.
Management of Long Length of Stay patients (Stranded patients)	Ageing population 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)	Roll out of the Discharge collaborative across LTHT wards **Ongoing** Complete (system level) all actions outlined within Newton Europe recommendations. **Monthly monitoring through SRAB**
City wide OPEL escalation and mutual aid actions.		Feed into System level Winter Review meeting

Maximum utilisation of community care beds and Early Supported Discharge models.		Commission Newton Europe to undertake Hospital avoidance review. **Diagnostic Work scheduled May/June 2019.**
Additional capacity in partnership with Villa care to provide a ward on Beckett Wing in times of extreme demand	Ability of private providers to deliver the required care packages to enable early transfer for patients from a hospital setting.	Escalate patient flow concerns through weekly ODG / Operational Winter Group. **Weekly**

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

Risk Description: Risk of patients being cared for in non-designated areas and high outlier numbers, caused by demand outstripping available capacity and reduced outflow from the acute bed base. This can lead to poor patient outcomes, poor patient experience increased out of hours transfers and a failure to comply with national performance standards (E.g. ECS compliance and Last Minute Cancelled Operations).	**Executive Lead:** Chief Operating Officer **Date added to CRR:** May 15 **Last reviewed:** Apr 19 **Committee reviewed at:** Finance & Performance Committee

Controls	Gaps in Control	Further Mitigating Actions:
Continued roll out of the SAFER bundle.	Continued increase in patient demand upon the acute bed base.	Commission further work to strengthen hospital avoidance models of work. **SRAB by End Q1 19/20** Roll out of the Discharge collaborative across LTHT wards **Ongoing**
Demand prediction model established and winter plan matched against key pressure points.		Revised bed model to be in place for Winter 2019/20. Actions to be updated within Operational Response Guidance following Winter Workshops **November 2019**
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.	
Continued work to strengthen ambulatory care models to avoid hospital admissions.		Newton Europe Hospital avoidance diagnostic commencing **May/June 2019**. Summit planned for July 2019 actions to be implemented as per recommendations.
CSU surge plans in place.		
Dedicated outlier team to provide consistency of cover to patients being cared for outside of ESM bed base.	Winter pressures / Nurse staffing pressures resulting in loss of bed capacity and high bed occupancy rate.	Discharge collaborative to be rolled out across trust **Work commenced and rollout on-going** Risk Assessment Decision Management Tool

		developed for 'in extremis' decision support. Operational response guidance to be refined to reflect learning from previous winters. **Refreshed Operational Response by Nov 2019**
Additional bed capacity in place with private provider.	Ability of private provider to sufficiently staff capacity.	System level super stranded patient reduction required in order to reduce reliance upon bed capacity within acute trust. Improvement trajectory in place **March 2020**
Continued system level work to strengthen community models and allow maximum utilisation of Community Care Beds.		Review as part of system wide winter review meetings admission protocol/criteria to be reviewed, **Winter 2019**

Risk CRRP7: Patients waiting over 52 weeks for treatment in Spinal Surgery, and other 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 historic or current mismatches of capacity with demand. This is the result of staffing, theatre or inpatient bed capacity not being sufficient to meet referral numbers into these services.

This may result in a poor experience for patients, significant external scrutiny, reputational harm through media coverage. There is also significant financial risk in 2019/20 either through the imposition of fines or payments required to release additional capacity either internally or from other providers.

Executive Lead: Chief Operating Officer

Date Added to CRR May 15
Last reviewed date: Apr 19

Committee reviewed at:
Finance and Performance

Controls	Gaps in Control	Further Actions Planned:
Review of progress against recovery plans with CSUs on a weekly basis with corporate support in resolving developing issues.	None	CSUs to develop plans to reduce maximum waits to under 45 weeks in all other specialties. Promotion of improved capacity and demand modelling by CSUs and specialty services to monitor performance in-year **July 2019**
Performance team monitoring of breach risks in other specialties to prompt early actions to avoid breaches.	None	Continued weekly escalation of any breach risks without a TCI.
Additional theatre and inpatient bed capacity provided by CHFT and independent sector providers for Spinal Surgery.	CHFT reliant on LTHT surgeons to deliver activity. Capacity shortfall in spinal surgery not yet resolved.	Development of a business case to develop a 'hub and spoke model' across WYATT. Project Manager for Spinal Services in post. July 2019.

	Capacity at CHFT currently available only for minor cases.	
Support being provided by Intensive Support Team to model capacity and demand.	Capacity shortfall in spinal surgery not yet resolved.	Development of a business case to develop a 'hub and spoke model' across WYATT. This will outline demand and capacity requirements. July 2019.
Diversion of demand to alternative providers.	Limited criteria of patients can be sent to other providers, resulting in the most complex longest waiters remaining on the PTL at LTHT for treatment.	Continue to explore other in wider region providers with support from commissioners June 2019
Capacity provided at Chapel Allerton Hospital or through enhancing Gilbert Scott Theatres for spinal surgery cases. This delivers capacity for cases and can be used for cases not suitable to be transferred to CHFT or independent sector providers.	Limitations on cases suitable to Gilbert Scott and CAH. Workforce challenges to deliver any additional capacity.	Continue to progress Gilbert Scott (and agreeing suitable cases between surgeons and anaesthetics). June 19 Locum consultants commence from August 19.
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.	Locum consultants commence from August 19.

Risk CRRP8: Patients waiting longer than 6 weeks following referral for diagnostics tests	C = 3 L = 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
								Target					Initial & 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. This is due to demand outstripping capacity in key. This may result in delays to patient treatment, achievement of the Cancer or RTT standards and possible harm, as well as financial penalties.

Executive Lead: Chief Operating Officer

Date Added to CRR: May 2014
Last reviewed date: August 2019

Committee reviewed at: Finance & Performance
Frequency of review at RMC:

Controls	Gaps in Control	Further Actions Planned:
Weekly Diagnostic month end breach prediction process, with follow-up action from performance team with those CSUs not performing/ where Trust position looks at risk All CSUs have weekly access meetings to review their diagnostic performance position and identify additional actions required to manage risks Clear booking processes defined in the Trust Elective Access Treatment Policy Proactive actions with outsourcing, use of other providers, use of overtime/ Bank/ Locum/ Agency and Variation Orders in place for pressured areas (MRI, Ultrasound and Endoscopy). Monthly Performance Escalation process for those CSUs where risks persist or achievement of the 99% performance standard for their specialty is not achieved	Key constraints are currently within the MRI and Paediatric diagnostic surgical services capacity. Data available to all diagnostics teams is not the same, with limitations with data from some clinical systems (eg CRIS) to support the daily management approach Oversight tools of booking processes (such as those available for RTT) not in place for all Diagnostic areas Support from IT is constrained to support better data production Key staff are not always available to undertake additional activity in response to peaks in demand There have been persistent gaps in the Radiology administrative booking team.	MRI expansion with new Paediatric Hybrid scanner at LGI - April 2019 Work with theatres and Children's to establish additional theatre provision required. Aligning with PA consulting work - **starting April 2019** **I**ntroduction of a Diagnostics Improvement Programme Board to provide additional oversight and a defined annual improvement plan. Using a 10 high impact changes approach, this will have 2 main aims i. supporting the sustainable delivery of 6ww, 62 day cancer, RTT standards and ii. IP flow through timely diagnostics - **Inaugural meeting April 2019** Recruitment to and consolidation of the Radiology administrative booing team- **Q1 2019.** CSU performance contract covering key areas not achieving for 2019/20.