

Winter Planning 2025/2026
Finance and Performance Committee
25th September 2025

Presented for:	Approval/ Information
Presented by:	Clare Smith, Chief Operations Officer and Deputy Chief Executive
Author:	Jo Wood, Director of Operations Adrian Wickham, Service Manager
Previous Committees:	NONE

Our Annual Commitments for 2025/26 are:	
Recognise and act upon moments that matter to our patients	✓
Support our patients to get home a day sooner	
Be in the top 25% for patient experience and efficiency in outpatients	
Support each other to act with kindness and compassion	
Reduce our carbon footprint by creating greener patient pathways	
Support our staff to manage every £ wisely	
Make best use of our estate, equipment, and digital assets	✓

Risk Appetite Framework				
Level 1 Risk	(✓)	Level 2 Risks	(Risk Appetite Scale)	Impact
Workforce Risk	✓	Workforce Retention Risk - We will deliver safe and effective patient care, through providing a supportive culture, training, development, and H&WB to our staff to retain the appropriate level to continue to meet the patient demand for our clinical services	Cautious	Moving Towards
Operational Risk	✓	Business Continuity Risk - We will develop and maintain stable and resilient services, operating to consistently high levels of performance.	Cautious	Moving Towards
Clinical Risk	✓	Capacity Planning Risk - We will ensure that capacity is planned to meet the demand for elective and non-elective (acute) admissions to our hospitals, managing this risk to provide safe treatment and care to our patients.	Cautious	Moving Towards

External Risk	✓	Partnership Working Risk - We will maintain well-established stakeholder partnerships which will mitigate the threats to the achievement of the organisation's strategic goals.	Cautious	Moving Towards
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Key points	
1. A programme of winter planning for LTHT has been undertaken which includes modelling the demand, capacity and agreeing mitigating actions and updating associated resilience documentation	Information
2. There is a separate children's bed model for the winter months with associated mitigations	Information
3. The patients waiting in the Accident and Emergency (A&E) departments and adult critical care for an inpatient bed are included in the winter modelling	Information
4. There is a new winter board assurance template requiring sign off and return to NHSE by 31 st September 2025	Information and assurance

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1. Summary

This paper provides a summary of the Leeds Teaching Hospitals NHS Trust (LTHT) winter planning programme. It summarises changes to demand and capacity modelling and summarises mitigating actions being completed internally by Clinical Service Units (CSUs), together with Trust-wide initiatives and system actions.

This paper intends to provide assurance that work is being undertaken to prepare for the demand on services expected during the winter months.

This year the NHS England (NHSE) Urgent and Emergency Care Plan published in June 2025 requested that all providers plan for winter earlier and submit a signed board assurance statement to the national Urgent and Emergency Care (UEC) team by 30th September 2025. Appendix 1.

There are two sections to the provider board assurance statement. Section A includes the statement that requires board sign-off that assurance has been provided around governance and the content of the winter plan. Section B comprises of a winter checklist that provides much of the assurance for section A. The checklist has been used to structure this paper.

A summary of the relevant resilience documentation, such as the Decision Management Tool (DMT) for adults, children's and infection prevention and control (IPC) is also referenced within this paper.

2. Background

Each summer LTHT undertakes a programme to plan for increasing pressures on inpatient capacity and non-elective services whilst maintaining our commitment to the elective recovery plan. This exercise builds on lessons learnt from previous years' programmes, aligns with national and local briefings, involves modelling the predicted increase in demand for inpatient beds, develops mitigating actions and updates the Trust's resilience documentation and the DMT.

Figure 1: Flow chart demonstrating the sequential stages of the LTHT winter planning programme.



To support the winter planning programme there are a series of Leeds place winter workshops, the third of which was on Tuesday 16th September 2025. There is representation from all key city providers at the workshops to ensure coordination and that plans

compliment and support each other wherever possible. Further to this, a North East and Yorkshire Region winter plan testing event was held on the 3rd September 2025 and intelligence from this event has been included in this paper.

To prepare for winter this year there has been a focus on timeliness of care covered by several workstreams. These complement the winter planning process and include:

- An efficiency programme for reducing length of stay (LoS) – supporting our patients to get home a day sooner – with a focus on specific pathways where significant opportunity has been identified.
- Making Every Day Count – structured Gemba walks are planned for September/October 2025 with a report out scheduled for October 2025.
- The HomeFirst Programme supporting discharges and seeking to reduce the number of patients remaining in hospital with no reason to reside – 20 bed minimum.

During winter, activity is tracked and mapped against the trajectory and this is monitored weekly, with a view taken of the two preceding weeks and a look ahead at the two weeks to follow. This provides continued assurance that the activity is as we expect it to be, and allows us to make changes in advance if significant variations are found. This information is also shared with city partners at the Active System Leadership weekly meetings.

This paper goes on to describe the checklist outlined in section B of the winter board assurance document which enables board assurance completion of section A, outlined in this papers conclusion.

3. Winter planning checklist

The checklist items for the board assurance statement are now described below and the actions taken to mitigate are described. Of note, Leeds place Integrated Care Board (ICB) are also required to complete a board assurance template some of which will be directly referenced as LTHT winter support.

3a. Prevention

There is a plan in place to achieve at least a 5 percentage point improvement on last year's flu vaccination rate for frontline staff by the start of flu season.

Staff

Following recent national guidance, annual COVID-19 vaccination is no longer required for healthcare staff as part of the winter campaign. At LTHT, flu vaccine uptake (43%) continued to exceed COVID-19 vaccine uptake (34%) for the 2024/2025 season, with vaccine fatigue identified as a key barrier. This reflected the regional winter event narrative and picture. The LTHT staff immunisation team expect that focusing solely on the flu vaccine this year will encourage greater participation.

A staff communications strategy is being developed to reflect winter pressures across individual CSUs, supported by data from the 2024/2025 campaign which showed a clear correlation between higher vaccination rates (flu) and lower sickness absence due to respiratory and cold/flu illnesses. This correlation will be central to the 2025/2026 campaign messaging to drive uptake.

Bookable and walk-in sessions will be available throughout the vaccination campaign over all Trust sites with information being provided at CSU level to support CSU delivery of the minimum 5% improvement in vaccination.

Inpatients

The inpatient influenza and COVID-19 vaccination campaign for LTHT is scheduled to commence on Monday 6th October 2025. Vaccinating hospital inpatients is a critical opportunity to protect those at greatest risk of severe illness who may have missed vaccination in the community, while also helping to reduce hospital-acquired infections and winter pressures on the NHS.

Eligible inpatients for the influenza vaccine include adults aged 65 years and over, adults aged 18–64 years in clinical risk groups, and infants aged 6 months to under 2 years who are in clinical risk groups.

The COVID-19 vaccine will be offered to adults aged 75 years and over, immunosuppressed patients, and children aged 6 months and over in clinical risk groups.

A communication plan is in place to support the patient winter vaccine programme.

City population

The 2025/26 vaccination campaign for the city population began on 1st September 2025, prioritising flu vaccines for pregnant women, children, and under-18s in clinical risk groups. The main flu and COVID-19 rollouts begin in October 2025, with the aim of full coverage of eligible groups and improved uptake, especially among vulnerable populations. Efforts include targeted messaging, non-porcine vaccine options, and community engagement through programmes like Community Champions. A system-wide approach will support increased vaccination rates, focusing on disadvantaged areas, those with long-term conditions, frailty, and pregnant women. A communication plan across the GP confederation has been developed to share progress by practice.

3b. Capacity

The profile of likely winter-related patient demand is modelled and understood, and plans are in place to respond to base, moderate, and extreme surges in demand.

The Trust is approaching this winter season with an average bed occupancy of 95.4% in August 2025. As part of a planned length of stay efficiency programme, wards were closed last year and have been closed since last winter and we have been managing our inpatient run rate with 3.5 fewer wards. Despite this, the bed occupancy for 2025 to-date is similar to the same time period in 2024 (January to August). Maintaining the 0.2-day length of stay reduction will support us to absorb some winter pressure. There will be no ward closures planned on the back of this length of stay benefit to enable winter resilience.

Integral to winter planning is the use of the latest available information to support the LTHT predicted prevalence of infectious diseases such as COVID-19, Flu and Respiratory Syncytial Virus (RSV).

The NHS England team have provided the information for inclusion in the winter plan:

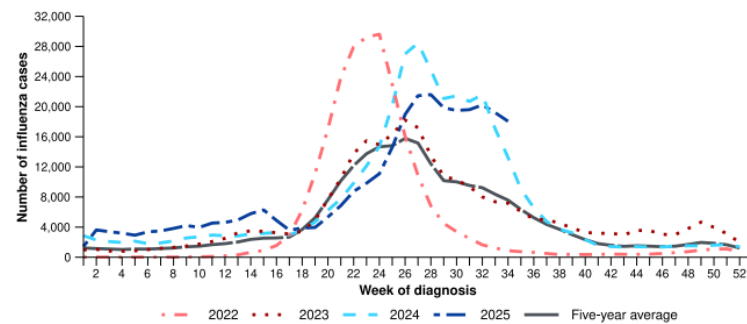
- Covid is not a seasonal virus – reduce to current run rate
- Rise in respiratory admissions through September

- Rise in flu in late December/early January
- Peak RSV in November

Led by NHS England, data from the southern hemisphere has been used annually to predict the impact of seasonal flu on our inpatient bed base. In 2025, the trend is showing nothing unusual, and the peak of flu cases is predicted to be lower than 2024. Everything is pointing to a season with 'normal' levels of flu cases.

Figure 2. [Chart to show the flu cases in the 2025 influenza season in Australia](#)

Figure 6: Notified influenza cases and five-year average* by year and week of diagnosis, Australia, 2022 to 24 August 2025



Source: National Notifiable Diseases Surveillance System (NNDSS)
* The years 2020 and 2021 are excluded when comparing the current season to historical periods when influenza virus has circulated without public health restrictions. As such, the five-year average includes the years 2018 to 2019 and 2022 to 2024. Please refer to the [Technical Supplement](#) for interpretation of the five-year average.

Adults

Using learning from previous years' bed modelling, along with the latest information from the national NHSE team, the summary in Table 1 shows the methodology used in the bed model.

In the North East and Yorkshire Region winter plan testing event in September 2025 a third extreme pressure scenario was tested. This third scenario had scenario 2 plus a business continuity incident. Scenario 3 would require a business continuity response in addition to the additional bed capacity. The business continuity responses are described later in this paper.

Table 1. Summary logic used in the 2025 Adult bed modelling for the two scenarios.

Modelling Category	Flu Scenario	Covid Scenario	Elective Scenario	Non-elective Scenario
Scenario 1 Most likely case	Average of last 2 Baseline years (2023-24, 2024-25)	Current run rate	Elective inpatients match last year + 5%	Match last year's total
Scenario 2 Flu and covid more impactful, demographic growth not mitigated by improvements	Match last year's total	Last year's total	Elective inpatients match last year + 5%	Match last year's total +2%

Using the variables outlined in Table 1, the weekly adult inpatient bed requirements between September 2025 to May 2026 have been modelled using the most likely scenario 1.

As last year, this year's model captures the demand of patients that are within the A&E departments and waiting for an inpatient bed and those awaiting a step down from critical care. This will help summarise total demand and support planning to deliver reduced congestion and overcrowding in the A&E departments alongside capacity for our sickest patients in critical care.

The shortages in beds illustrated by the modelling have been summarised in Table 2, which shows the predicted maximum, minimum and mean bed deficit for scenarios 1 and 2 during the period between 1st September 2025 and 31st March 2026.

As with 2024/25 for the adult bed model, the peak period of pressure is predicted to occur in mid-February 2025 for both scenarios (Appendix 2). National planning guidance recommends 92% bed occupancy. We are currently tracking at 96% occupancy and have modelled winter against this as per previous years, balancing capacity, workforce, and financial availability with demand.

Table 2. Summary of adult bed modelling before any mitigation: Sept 25 - 31st Mar 26

		Maximum deficit	Minimum deficit	Mean deficit
Scenario 1 - Most likely case	100% Occupancy	-123	94	-52
	98% Occupancy	-155	62	-84
	96% Occupancy	-187	30	-116
Scenario 2 - Flu and covid more impactful, demographic growth not mitigated by improvements	100% Occupancy	-126	73	-60
	98% Occupancy	-158	41	-92
	96% Occupancy	-190	9	-124

At SJUH, to mitigate the anticipated increase in demand for adult inpatient beds there will be an additional 15 beds by opening capacity on ward J33 in October 2025 and a further 30 bed benefit from opening a further ward in Beckett Wing in January 2026. J24 (a 5.5-day ward) will be opened 24/7 from November as part of a recurring winter scheme to support patient flow. At the LGI, 27 beds will be available with the opening of L12 from October 2025.

Table 3. Summary of adult bed modelling with LTHT additional capacity: Sept 25 - 31st Mar 26

		Maximum deficit	Minimum deficit	Mean deficit
Scenario 1 - Most likely case	100% Occupancy	-36	151	10
	98% Occupancy	-70	118	-23
	96% Occupancy	-103	85	-56
Scenario 2 - Flu and covid more impactful, demographic growth not mitigated by improvements	100% Occupancy	-54	130	3
	98% Occupancy	-87	97	-30
	96% Occupancy	-121	64	-63

Both sites will be further supplemented with CSU schemes funded through the winter period which will deliver enhanced admission avoidance, length of stay reduction and/or increase capacity to support the winter response. These are currently being assessed for impact and prioritisation. The schemes to be funded will be communicated in the week ending 19th of September 2025.

The delivery of these actions will be monitored regularly in the corporate operations meeting for assurance of delivery, with early escalation for any risks identified which impact on delivery of this capacity benefit. Quality risks will be escalated through the quality and safety assurance group.

The number of patients that do not have a criteria to reside in hospital and are waiting for the next steps to enable them to leave hospital in August 2025 average 241. This is 16 more patients on average each day when compared with the August 2024 figure of 225. There is an upwards trend and the totals in 2025/26 have maintained a higher average than in 2024/25 throughout the year. Appendix 3. There is an agreement with the West Yorkshire Integrated Care Board that from October 2025 the number of patients in the hospital that no longer meet the criteria to reside (NCtR) will be reduced by 20 when compared with the same month in 2024/25. We continue to work with our city partners to support and coproduce actions to support patients with NCtR to leave hospital sooner.

Based on scenario 1, the impact of the additional capacity from opening winter wards and the benefit of further mitigations can be seen in table 4.

Table 4. LTHT remaining adult bed mean deficit over the winter months November 2025-March 2026 at 96% occupancy

Scheme	Nov	Dec	Jan	Feb	Mar
LTHT Adult total bed deficit before mitigations 96% occupancy	-118	-132	-185	-187	-146
J33 additional beds opened	30	30	30	30	30
J30 additional beds opened	0	0	30	30	30
J24 additional 3 beds opened	3	3	3	3	3
L12 additional beds opened	27	27	27	27	27
Admission avoidance at LGI SDEC - through AHP support	8	8	8	8	8
Length of stay productivity improvements (0.2%)	51	51	51	51	51
LTHT Adult total bed benefit of mitigations	119	119	149	149	149
LTHT Adult remaining deficit after LTHT mitigations	1	-13	-36	-38	3
ICB - Reduction in NCtR patients in LTHT	20	20	20	20	20
Remaining adult bed deficit	21	7	-16	-18	23

January and February are still left in a minus position. Further capacity will be provided by city partners during the winter months to support flow out of hospital including additional Social Workers and Short-term assessment services. This further capacity will be monitored via the system visibility dashboard and reported to the Active System Leadership Executive Group (ASLEG).

Children's

Children's bed modelling has been completed in previous years and includes factoring in the number of children in the bed base with Covid, flu and RSV infections to predict the

increase in demand on the children's bed base over winter. The graphs for the Children's CSU bed modelling are available in Appendix 4.

Table 5. Summary logic used in the 2025 Children's CSU bed modelling for the two scenarios.

Modelling Category	Flu Scenario	Covid Scenario	RSV Scenario	Elective Scenario	Non-elective Scenario
Scenario 1 Most likely case	Average of last 2 Baseline years (2023-24, 2024-25)	Match last year's totals	Average of last 2 Baseline years (2023-24, 2024-25)	Elective activity in line with elective recovery plan. (105% of activity)	Average of last 2 Baseline years (2023-24, 2024-25)
Scenario 2 Increased Flu and RSV (+20%)	Last year's totals plus 20%	Match last year's totals	Last year's totals plus 20%	Elective activity in line with elective recovery plan. (105% of activity)	Average of last 2 Baseline years (2023-24, 2024-25)

Table 6. Summary of Children's bed modelling before any mitigations October 25 - 31st March 26

		Maximum deficit	Minimum deficit	Mean deficit
Scenario 1 Covid peak before and after flu peak in January	100% Occupancy	6	29	17
	98% Occupancy	4	26	15
	96% Occupancy	1	24	12
Scenario 2- Increased Covid and RSV (+20%)	100% Occupancy	2	29	16
	98% Occupancy	-1	27	13
	96% Occupancy	-3	25	11

The winter funding schemes are still being reviewed and will be shared by week commencing 22nd September 2025. The response is expected to be the same as last year and, whilst draft, the below mitigations can be expected to support the children's CSU during periods of increased demand and pressure in winter. These predicted mitigations do give a positive bed capacity figure which supports fluctuations to mean capacity and a greater response to peaks in demand.

Table 7. LTHT remaining children's bed deficit over the winter months October 25 - March 26 at 96% occupancy

Scheme	Nov	Dec	Jan	Feb	Mar
LTHT Children's Hospital bed deficit before mitigations	1	6	11	7	12
Children's – Additional beds L38, L40, L51, L52	15	15	15	15	15
Children's – Additional beds CAT, L31, L50	10	10	10	10	10
Children's – Virtual Ward (Resp. & Onc. pathways)	2	4	6	6	6
Total Children's Hospital bed benefit of response	27	29	31	31	31
LTHT Children's Hospital remaining deficit after mitigations	28	35	42	38	43

In comparison with last year's modelling, the maximum deficit at 96% occupancy is a similar figure for children's services, and a slightly improved position for adults.

3c. Infection Prevention and Control (IPC)

IPC colleagues have been engaged in the development of the plan and are confident in the planned actions.

LTHT have an Operational IPC group chaired by the medical director for operations that meets fortnightly. In September 2025, a meeting of this group has been dedicated for the winter plan to be presented and discussed. The attendees will be briefed on the plan and are active partners in development of both an adult and children's decision management tool, and there is a separate infection and prevention decision management tool for periods of extreme pressure.

A plan to cohort a ward for flu patients will need to be flexible and adaptable around where the pressures in the hospital are felt at the time. For this reason, this will continue to be a multi-disciplinary team decision.

3d. Fit testing

Fit testing has taken place for all relevant staff groups with the outcome recorded on ESR, and all relevant PPE stock and flow is in place for periods of high demand.

Fit testing

Fortnightly Operational IPC meeting discusses key operational risks and mitigations for peak pressures.

For our A&E departments, clinical educators and CSU trainers support this programme. Weekly fit testing sessions are stepped down in spring and summer and restart in September to support autumn and winter. The nursing staff in our paediatrics, LGI adult and SJUH A&Es are priority areas and are achieving the target of staff tested. Fit testing is included as part of new starter weeks which supports high compliance.

Medical testing for key areas is in progress. The rotation of resident doctors requires continual training offers which are in place. There are reasons why some people cannot be fit tested, for example those people with beards, and for these instances, respirator hoods can be provided and are in stock within the Trust.

PPE Stock

Clinical areas maintain agreed stock levels of all items. If increased stock is required, this is either requested via the Materials Management Team who raise orders to NHS Supply Chain (NHSSC), or clinical areas can raise orders directly. Orders to NHSSC are normally delivered in 48 hours but can, if urgently required, be sent within 24 hours and we are able to hold and move stock around in large quantities thanks to the Trust's size.

NHSSC have a Resilience Team and are currently planning their winter response and increase stock levels accordingly. To ensure accurate forecasting to ensure stock availability, LTHT IPC and procurement teams will liaise when any changes are made to policy or procedure that will have an impact on the use of PPE.

3e. Patient Cohorting Plan

A patient cohorting plan including risk-based escalation is in place and understood by site management teams, ready to be activated as needed.

LTHT ward teams work with the IPC team in real time 7 days per week over the winter period to respond to the peaks in demand and the need to cohort wards. There are specific triggers associated with acuity, specialty, type and strain of virus, and the duration of the impact expected on capacity that supports the coproduction of any required cohort wards. There is a daily report of flu and COVID19 confirmed positive inpatients which enables monitoring and a twice daily report from the IPC team shared with bed holding CSU's describing ward restrictions.

Thanks to ever-improving infection prevention and control measures, the Trust continues to close fewer beds (123 in June 2025 compared with 454 in June 2024, 114 in July 2025 compared with 953 in July 2024). Of the closed beds, fewer are unoccupied resulting in a lower detrimental impact on capacity and patient flow. A side room utilisation form is in use on LTHT's digital electronic health record, PPM+, and compliance with this is monitored by the Operations Centre weekly and shared with CSU heads of nursing. The use of this form supports the flexibility of moving patients if required to ensure the side rooms that we have available can be optimised to support patient placement and that those that need them have access to them.

The Operations Centre host a weekend briefing meeting to on-call teams on a Friday afternoon, and anticipated cohorting plans are described here by a member of the IPC team, allowing for questions to be asked and responded to prior to the out of hours and weekend period.

3f. Rota reviews

Rotas have been reviewed to ensure there is maximum decision-making capacity at times of peak pressure, including weekends.

An A&E workforce winter uplift to support increased acuity and admission avoidance will be supported through winter funds. A&E medical rota reviews have taken place supported by human resource colleagues to offer more resilience and continuity, reducing short notice changes of shifts and to maximise workforce availability at key points.

The winter surge areas will be supported by our increased registered nurse (RN/RM) levels. Our registered nurse vacancies have significantly improved, with an 8.2% vacancy gap (down from 13.2% in 2024/25 and 19.2% in 2025/26) and we have a strong newly qualified pipeline of nurse/midwives who will be out of their supernumerary period and within our workforce by December 2025. The supernumerary period will be longer in some specialist areas.

Our clinical support worker (CSW) vacancy level had also significantly improved to 206 WTE in July 2024 from 800 in 2022. In 2025, we have seen a slight increase again in this gap to 319 due to a short pause in training and recruitment, but monthly cohorts of 33 candidates have been reinstated for the remainder of 2025 and through 2026 to continue to reduce this vacancy gap.

To support teams at times of significant pressure, we will need to ensure strong, visible leadership across the Trust through the use of Gemba walks, and signpost to the health and wellbeing resources available.

Infection Prevention Control senior nurse weekend cover will commence in November 2025 to support expected winter peak pressures.

3g. Discharge Profiles

Seven-day discharge profiles have been reviewed, and, where relevant, standards set and agreed with local authorities for the number of P0, P1, P2 and P3 discharges

We have both admission and discharge profiles at Trust, site, service, and ward level available for staff to see through PPM+. The Operation Centre uses this information to map likely pressure points and monitor by site and speciality where pressure points are likely to occur to support early intervention and potential mutual aid across specialities.

Patients who have ongoing care requirements but do not meet the CtR are evident on a system visibility dashboard. There is daily and trend data and patient level data dependent on role within the Leeds system. We have agreed through the ICB, LTHT contract a reduction of 10 pathway one and 10 pathway three inpatients that do not meet the CtR, compared to the same winter month last year.

Referrals for ongoing care needs across the city are mapped each day, and we are working with the transfer of care hub on how to promote and increase the weekend referrals out of LTHT, particularly for pathway 1 patients.

3h. Elective and Cancer Delivery

Elective and cancer delivery plans create sufficient headroom in Quarters 2 and 3 to mitigate the impacts of likely winter demand – including on diagnostic services.

Elective delivery plans are phased to account for seasonal variation as part of the annual planning cycle. Services have been set utilisation and productivity targets which account for delivery across the full year including the impact of winter. Collectively services have delivered 104.6% of activity compared to 2024/25 year to date. Specialities challenged with long waiting times for elective and cancer care have been set improvement trajectories to reduce this as much as possible.

During winter, greatest emphasis will be placed on delivery of elective care in the elective hubs of David Beevers Day Unit, Wharfedale Hospital, Gilbert Scott Operating Theatre and the Hand Unit at LGI, and Chapel Allerton Hospital. These units are least affected by winter pressures. We are currently working on maximising our long wait and routine elective waits as per our trajectories. We are currently ahead of plan with this.

Maintaining elective activity during periods of acute pressure is important to reducing waits for our elective patients.

We continue to deliver elective activity at SJUH and LGI during winter pressures by:

- a. Increasing the number of day case and outpatient procedures, reducing demand for beds.
- b. Effective scheduling, reducing the amount and impact of last-minute cancellations on day of surgery for non-clinical reasons.
- c. Earlier optimisation of patients waiting for surgery, reducing risk of clinical cancellation on the day, and reducing length of stay.
- d. Increase in the number of cases performed with our surgical robots, resulting in reductions in post-operative length of stay.

- e. Maximising the case opportunity and touch time utilisation of theatres to ensure these are used as productively as possible.

3i. On Call Arrangements

On-call arrangements are in place, including medical and nurse leaders, and have been tested.

7 days on call cover arrangements for out of hours includes Head of Nursing, General Manager and Director on call. In addition, there is a senior clinical site manager (CSM), one based at SJUH, and one based at LGI for all out of hour periods. Additional support for maternity services out of hours is planned, which will release the CSM to focus on timely patient placement. Medical leadership at consultant level is within speciality services.

Digital Informatics and Estates and Facilities teams also provide on-call support to the Trust, and there is an out of hours contact for any communications and press enquiries.

This information is available to the on-call team, collated in a folder in the Emergency Preparedness SharePoint and therefore accessible from mobile phones.

3j. OPEL Framework

Plans are in place to monitor and report real-time pressures utilising the OPEL framework.

The national OPEL Framework for 2024–2026 was published by NHS England in December 2024 and updated in May 2025 and now applies to acute, community health services and mental health providers. The definitions, scoring criteria, and weightings of acute metrics were updated to better reflect current operational challenges, and each OPEL level now includes revised actions for providers and NHS England regional teams.

LTHT OPEL Metrics

Leeds Teaching Hospitals NHS Trust (LTHT) continues to use a standardised set of 9 acute metrics to assess operational pressure and calculate OPEL scores at both site and Trust level. These metrics align with the national framework and support consistent reporting across providers:

1. Mean ambulance handover time
2. ED all-type 4-hour performance
3. ED all-type attendances
4. Majors and resuscitation occupancy (adult)
5. Time to treatment (TTT)
6. % of patients spending >12 hours in ED
7. % general & acute (G&A) bed occupancy
8. % open beds that are escalation beds
9. % of beds occupied by patients no longer meeting the criteria to reside (NCtR)

The data for LTHT OPEL metrics is automatically sent every two hours through the system, Rapid Actionable Insight Driving Reform (RAIDR). On this RAIDR system we can also view other acute Trusts position, ambulance handover position (newly updated to report the 45-minute metric) and the ICB position as a whole.

A key line of enquiry (KLOE) report is sent twice daily to System Co-ordination Centre (SCC)

to provide additional context of the operational position and to confirm that the required OPEL actions have been enacted, and this information shared with WYAAT operational colleagues. The SCC is responsible for supporting interventions on key issues that influence patient flow. The LTHT operational centre is contacted by the SCC at additional points during the day with any further queries, and we utilise the contacts and support from the SCC to escalate where necessary any repatriations to out-of-area destinations and mental health patients in our emergency departments or bed base.

There is an agreed process of escalation for a system call to mobilise city partners to support in times of extreme pressure. Appendix 5.

Through the weekly city partners meeting we will hold each other to account for the delivery of agreed schemes and monitor the impact. Fluctuations in demand across different pathways mean that the specific capacity offered may not be suitable for the patients in bed base at that time.

To further augment the OPEL actions, Decision Management Tools (DMT) have been in use for a number of years and are undergoing review for both adults and children's services to align them to changes in national standards and terminology as well as changes to LTHT estate. This is to further support the winter response and to provide operational teams and on-call teams out of hours a suite of options to temporarily support the release of capacity in times of exceptional operational pressure. The actions on the DMTs have a Quality & Equality Impact Assessment (QEIA) reviewed by senior medical, nursing, and operational managers as part of the winter preparedness.

The DMT for the adult bed base (Appendix 6), has been reviewed and refreshed to support the operational response and the Children's hospital DMT (Appendix 7) has also been refreshed to ensure greater resilience in preparation for surges in patient demand. The IPC DMT has been reviewed as part of the annual review process and out to OIPC group for comment, with the last date for feedback being the 24th September 2025.

The Operational Response Guidance (ORG) is also being reviewed in preparation for winter. The ORG includes surge plans for extreme pressures with a planned and considered approach to balancing risk across site if the A&E departments become overcrowded to a point of patient safety concern. The surge areas and temporary escalation spaces included in the ORG and the full capacity plan are described in Appendix 8.

The QEIA impact for the winter plan is summarized in Appendix 9.

4. Conclusion

We understand the likely pressures from two scenarios and have tools and responses to a third scenario. We have mitigations for some of these pressures and business continuity plans and tools for extremis. Our system partners have provided actions as described that will increase capacity for specific patient cohorts. Discussions will continue through the remaining ICB-led winter workshops to build upon the city programme of additional capacity to support flow out of the hospital.

Elevated levels of pressure are still expected, but the measures in place feel sufficient for the winter predicted.

However, normal variation in patient arrivals means that even if capacity is sufficient on average throughout the winter season, there will inevitably be peaks and troughs in demand. At these peak periods demand will outstrip our bed capacity, and we will see periods where our services are under considerable pressure. As in all times of pressure, we may have beds available in these instances, but they may not be for the correct specialty, gender, enhanced level of care needs, or a side room may be required for reasons of infection prevention or control or for behavioural reasons.

5. Board assurance statement Section A

Section A of the board assurance document requires sign-off on the below statements, with reference to the checklist detailed in sections 3-5 of this paper:

Table 8. Section A requirements of the board assurance statement

Governance	Comments in draft
The Board has assured the Trust Winter Plan for 2025/26.	<i>Confirmed based on Finance and Performance winter plan paper acceptance</i>
A robust quality and equality impact assessment (QEIA) informed development of the Trust's plan and has been reviewed by the Board.	<i>There is a quality and equality impact assessment for the overarching winter plan.</i>
The Trust's plan was developed with appropriate input from and engagement with all system partners.	<i>Third Leeds place winter planning event took place on 16th September 2025</i>
The Board has tested the plan during a regionally led winter exercise, reviewed the outcome, and incorporated lessons learned.	<i>North East & Yorkshire Winter Event took place on the 3rd September 2025 attended by the LHTT winter Director of Operations</i>
The Board has identified an Executive accountable for the winter period, and ensured mechanisms are in place to keep the Board informed on the response to pressures.	<i>Chief Operating Officer (COO)</i>
Plan content and delivery	
The Board is assured that the Trust's plan addresses the key actions outlined in Section B.	<i>As described at the Finance and Performance Committee on 25th September 2025</i>
The Board has considered key risks to quality and is assured that appropriate mitigations are in place for base, moderate, and extreme escalations of winter pressures.	<i>Operational response guidance, internal professional standards, Temporary Escalation Spaces, key system winter actions and impacts have all been reviewed and updated. Their impact will continue to be monitored throughout winter reporting through corporate operations and weekly quality meeting with potential escalation to the Quality and Safety Assurance Group as triggered.</i>
The Board has reviewed its 4 and 12 hour, and RTT, trajectories, and is assured the Winter Plan will mitigate any risks to ensure delivery against the trajectories already signed off and returned to NHS England in April 2025.	<i>ECS and occupancy Finance and Performance Committee paper submitted and accepted in August 2025</i> <i>Winter model will include elective bed requirements at a 5% uplift from 2024/25 as an elective buffer and is monitored through the Trust accountability structure, including IAM, Service delivery meeting and escalation to COO.</i>

6. Risk

The areas covered in this paper sit within the existing risk appetite and actions planned are to support the defined risk appetite.

The key risks and considerations are reflected within the Corporate Risk Register under CRRC4 Failure to deliver the Emergency Care Standard and CRRC10 Patient flow and capacity for emergency admissions.

7. Communication and Involvement

The winter plan will be communicated to all tri teams and service leads at a winter event in October 2025 and has been co-produced with system colleagues at Leeds place, West Yorkshire and region through winter workshops hosted by the ICB. Our updated internal resilience documentation will be shared with all colleagues involved in the daily flow of the hospitals and will also always be available in the on-call folders for easy access.

8. Equality Analysis

A demographic equality analysis has been completed for urgent and emergency care relating to how age, ethnicity, deprivation, and home address and how these affect attendance rates using an A&E dashboard.

9. Improving Health Equity

The proportion of patients who attend an A&E who live in areas recorded as being in the IMD (Index of multiple deprivation) profile 1 was recorded as approximately 40% for SJUH and 33% for LGI for the quarter up to May 2025, higher than the mean for England which is approximately 15%. Increasing attendance rates in this group are attributed to chronic health conditions that worsen over the winter months and require more intensive management compounded by damp housing and lack of heating.

Whilst LTHT has a higher-than-average deprivation group who attend A&E, in order to maintain equity at the point of attendance, we would prioritise based on clinical urgency and are also committed to work across system boundaries to reduce health inequalities.

The winter plan intends to mitigate against increased demand during winter and maintain care quality and safety for all our patients by reducing waits in A&E and for those attending to get access to the care they need as soon as possible. The city vaccination programme is aimed at those with higher chronic disease and deprivation, and we continue to work with city partners on their targeted health inequality initiatives.

10. Publication Under Freedom of Information Act

This paper is exempt from publication under Section 22 of the Freedom of Information Act 2000, as it contains information which is in draft format and may not reflect the organisation's final decision.

11.Recommendation

The Finance and Performance Committee acknowledge the 2025/2026 winter plan in this paper and accept it as assurance that the Trust is well prepared for the demand and pressures predicted to come this winter.

To note there will be periods of pressure where an operational response and decision management tool will be evoked to support patient timeliness, safety and quality.

To acknowledge the winter predictions will be under continual review and schemes will pivot should respiratory virus pressures peak earlier or later than expected.

This committee consider the questions in section A of the board assurance statement outlined in section 6 of this paper and confirm assurance.

12.Supporting Information

The following information makes up this report:

Appendices

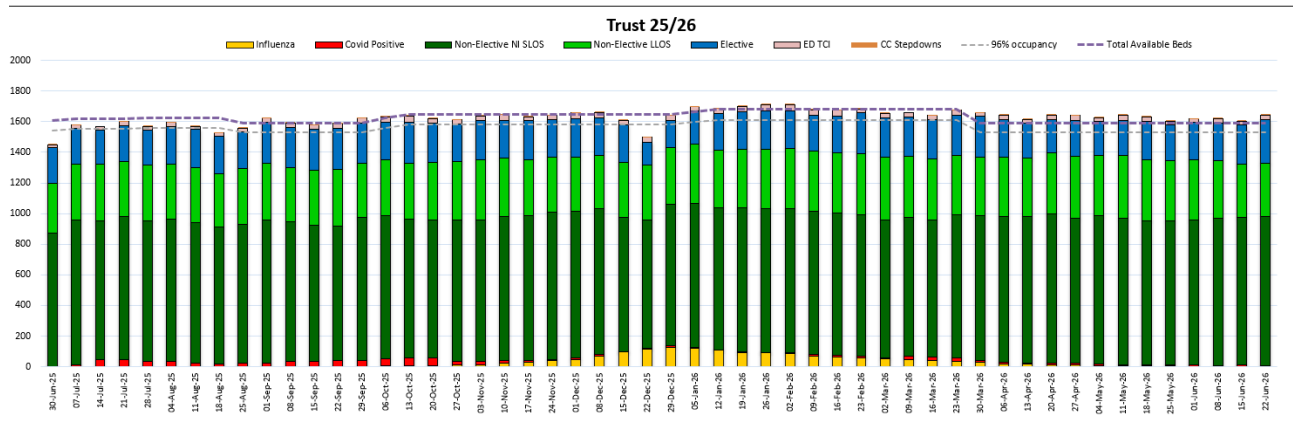
Appendix 1 – Board assurance statement



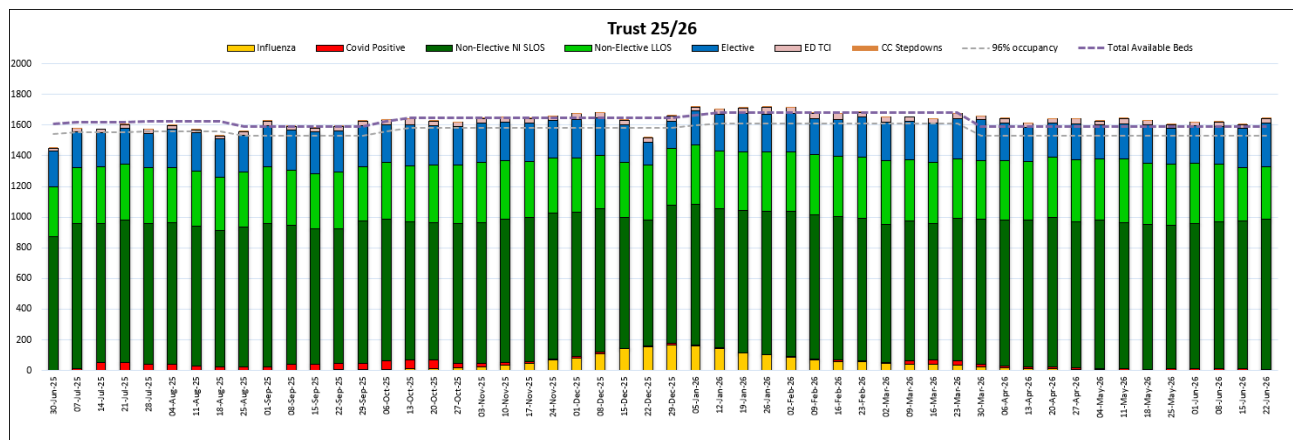
Board Assurance
Statement - NHS Tru

Appendix 2 – Adult bed modelling

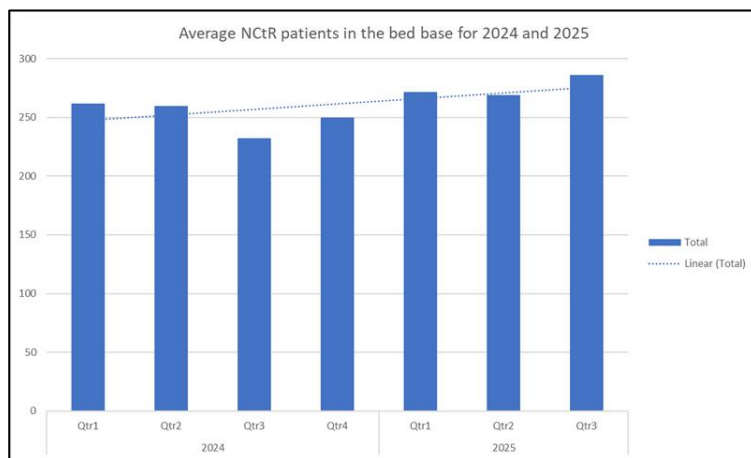
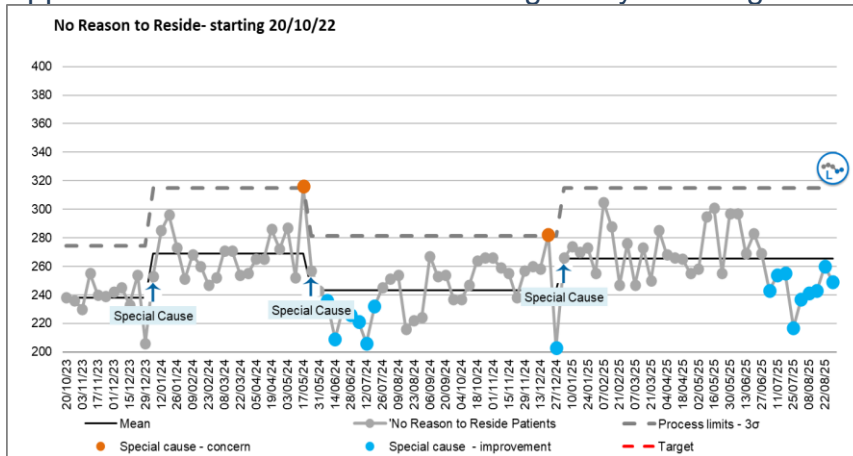
Scenario 1



Scenario 2

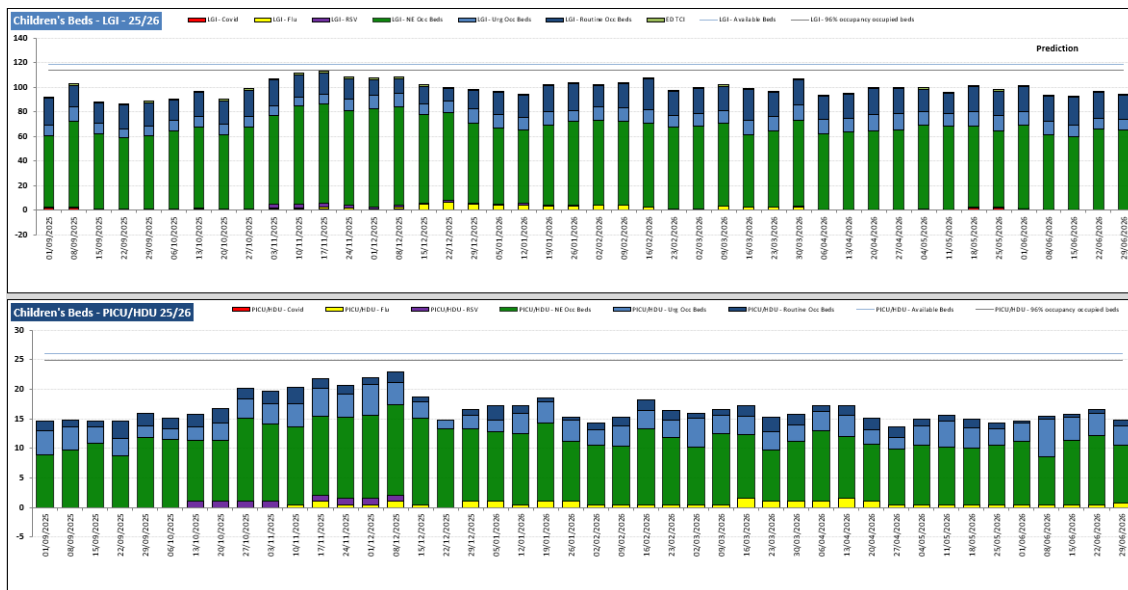


Appendix 3: Chart to show the average daily NCtR figures for 2023 to 2025

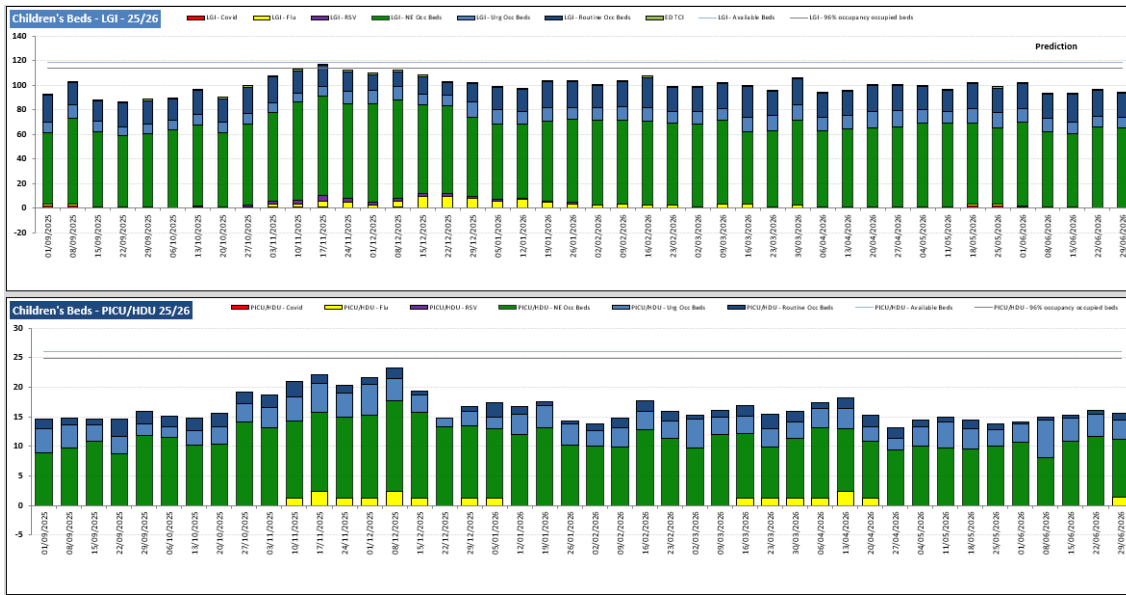


Appendix 4: Children's Hospital bed modelling

Scenario 1



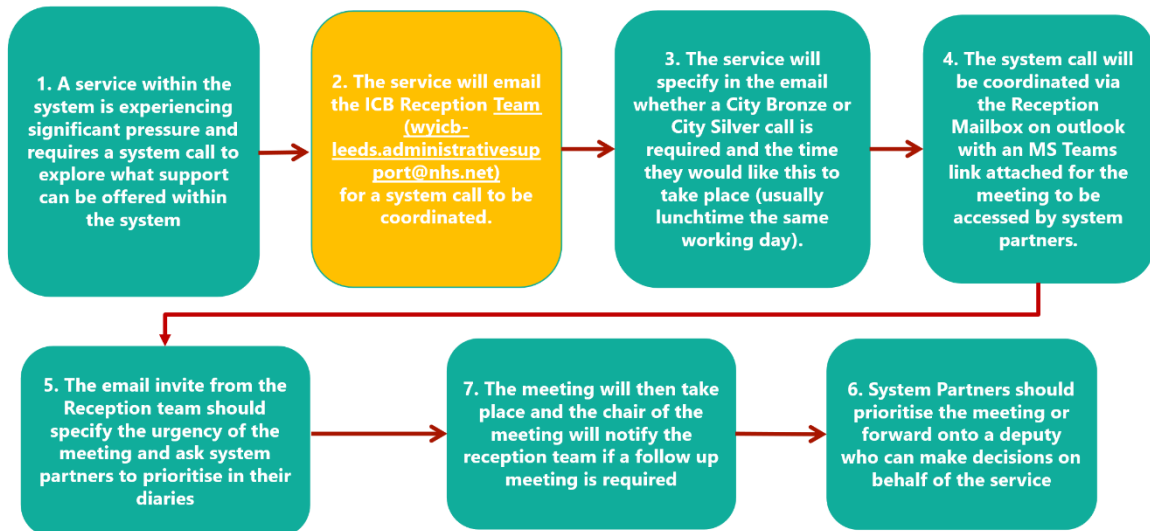
Scenario 2



Appendix 5: Flowchart for the request of a system call

Requests for City call (Bronze, Silver, Gold)

Flowchart of process



Appendix 6: Decision management tool – Adults

Adult Beds Decision Management Tool: Approved June 2025

A	B	C	D	E	F	G	H
Reverse board inpatients for a maximum of 4 hours as per surge plan to decongest ED / Assessment Areas	Reduce non-clinical Consultant, AHP and Senior Decision Manager sessions and revert to clinical sessions in day as per CSU agreements	Bed into med/elderly SDEC Has 24 cubicle spaces 3 stage plan beds up to 18 patients overnight	Utilise beds closed due to IPC reasons using the IPC DMT (Utilising 7 day IPC cover)	Bed into MSAA up to 9 patients, with a return to assessment function possible with 8 bedded patients	Request on-call Consultant team to attend site as per specialty pressures medical escalation plan	Enact the Full Capacity Plan and use of Temporary Escalation Spaces (TES) This will be completed in order: Surge spaces, TES	Open additional unstaffed inpatient capacity: Plan and use of 2 beds on J23 (current office) Up to 14 beds on L14 Up to 18 beds on X37 Ensure 4 bed spaces on J82 Discharge lounge late/overnight
Release bed capacity earlier to decongest the ED / assessment areas	Additional SDM support to provide review of patients and support decision making	Additional Bed capacity Supports patient flow Release ward staff to cover other areas	Additional Bed capacity Supports patient flow Maintain Cancer / Tertiary activity Release ward staff to cover other areas	Additional bed capacity to reduce congestion within the EDs	Additional SDM support to provide review of patients and support decision making	Additional bed capacity to reduce congestion within the EDs	Acute Bed capacity Supports patient flow Maintain cancer / tertiary activity
Potential for patients to be boarded over the 4 hour maximum if issues arise.	Impact on non-clinical activity which may have longer term impacts, e.g. teaching, development etc.	Existing staffing levels deteriorate further Increase in sickness levels Inability to deliver safe patient care Increased patient and staff complaints Increased turnover of staff Inability to staff all wards safely	Risk associated with actions are outlined within the IPC DMT	Risk of reduced capacity available for the assessment function of MSAA the following day, which could result in patients remaining in the ED to await assessment and treatment.	Impact on other planned activity for the following day which could impact on Outpatient / elective delivery.	Please see the ESA SOP for further details	Existing staffing levels deteriorate further Increase in sickness levels Inability to deliver safe patient care Increase patient and staff complaints Increased turnover of staff Inability to staff all wards safely
I	J	K	L	M	N	O	P
David Beevers 24/7. Extension of 6 day facility Bed surgical planned or acutes up to 9	Open additional ward capacity to support site pressures: J30 (29 beds) J31 (28 beds) J32 (30 beds) L12 (27 beds)	Reconfigure JAL for surgical step & 23 hour day case patients (7 beds) (Consider in conjunction with CC expansion plan) Please note: 6 staff members are required in the unit to support the fire evacuation due to the stairs at the fire exit.	Open J25 as a 12 bedded short stay area	Use all bed capacity even if it results in mixed sex breaches	Surge into an additional 3 spaces within Green area within the SJUH ED	Double up in SJUH ED cubicles	Cancel elective inpatients in clinical priority order: 1. Routine Electives - P5/P4/P3 2. Urgent Electives - P2
Increased bed capacity Supports patients flow Maintain cancer / tertiary activity	Acute Bed capacity Supports patient flow Maintain cancer / tertiary activity	Maximise elective productivity whilst releasing acute beds Potential to protect some cancer & urgent capacity Improved flow due to easier cases election as on main Increased patient harm & clinical risk Patient status changes from curative to palliative Deterioration in RTT & impact on recovery plan & cancer performance Increased waiting time Risk of routine electives becoming urgent / acute Increase in patient complaints Damage to Trust reputation Professionally unacceptable	Additional bed capacity to reduce congestion within the EDs	Supports patient flow from A&E Potential to prevent temporary YAS diversion	Acute Bed capacity Supports release of ED assessment capacity and supports ambulance handover cubicles	Acute Bed capacity Supports release of ED assessment capacity and supports ambulance handover cubicles	Preserve as much elective cancer work as possible but considers urgent cases of equal priority
Not line with CQC recommendations Privacy and dignity issues Poor patient experience Increase in patient complaints Damage to Trust reputation	Existing staffing levels deteriorate further Increase in sickness levels Inability to deliver safe patient care Increase patient and staff complaints Increased turnover of staff Inability to staff all wards safely		Risk to existing activity through J25 which will include a large number of patients who would need to be cancelled at short notice and rearranged.	Poor patient experience Privacy and dignity issues Damage to Trust reputation Professionally unacceptable	Existing staffing levels deteriorate further Increase in sickness levels Inability to deliver safe patient care Increase patient and staff complaints Increased turnover of staff Inability to staff all wards safely	Existing staffing levels deteriorate further Increase in sickness levels Inability to deliver safe patient care Increase patient and staff complaints Increased turnover of staff Inability to staff all wards safely	Deterioration in RTT & impact on recovery plan Increased waiting times for patients Increase in patient complaints Increased risk of 52 week breaches Primary care referral impact Risk of routine elective patients becoming urgent/acute Deterioration in patient condition

Appendix 7: Decision management tool – Children's

A	B	C	D	E	F	G	H
All District General Hospital / Repatriation patients returned to base hospitals	Discharges - Escalate delayed discharges Review of Virtual Ward Capacity *Consider increasing discharge hub capacity and staffing if hub approved*	PCAL Divert North Leeds Patients to Harrogate General	Consider use of specialty paediatricians to review medical patients by reducing / stopping clinics	Increased deployment of non ward based nurses on wards (Educators and CNS) cancel all study leave and ask nurses to work clinically, include nurse in charge into the numbers	Increase AHP deployment to ward areas to facilitate discharge	Utilise surge beds on L40 PANDA (5), L40 Increase bays 4 to 5 = (3) L51 (3), L52(2), L58 (2) Total increase of 15 beds - to red staffing levels in first instance	Utilise 8 short stay beds as inpatient beds (1 bay of 4, 2 cubicles) on CAT Utilise augmented care surge beds for any eligible non-infectious patients L51 (2), L50 (2)
Maintain tertiary and specialist regional service capability Creates acute bed capacity	Additional Bed capacity Supports patient flow	Admission avoidance	Supports timely discharge	Releases CNS, education and research workforce to increase nursing workforce on wards Enables opening of surge beds Is the nurse in charge included in numbers?	Supports timely discharge	Maximise elective productivity whilst releasing acute beds Potential to protect cancer & urgent capacity Improved flow due to additional medical beds	Provides temporary relief of acute pressure Already staffed
No suitable patients/pressure on receiving hospitals	Increased clinical risk/clinical reluctance	Small impact/pressure on other units	Impact on OPD waiting times	Helps with day time staffing only	Help only available 9-5pm	Surge wards on STL	Detrimental to patient flow
I	J	K	L	M	N		
Cancel routine elective in-patient operating requiring overnight stay (excluding over 65 weeks, P2 and cancer surgery)	Staff all beds, including surge to STL staffing levels	Consider converting L41 to medical beds (no increase in overall bed capacity however provides a further medical ward)	EXTREMIS - Cancel all elective in-patient operating requiring overnight stay including P2 and oncology patients	EXTREMIS - Temporary diversion of activity including x&s from L50 paediatric ED	EXTREMIS - Convert as many day-case beds on L49 and consider staffing L48 as inpatient as staffing allows		
Protect P2 surgical capacity Release theatre staff for acute list / theatre demand	Maximise elective productivity whilst releasing acute beds Potential to protect cancer & urgent capacity Improved flow due to additional medical beds	Supports patient flow	Releases acute bed capacity Reduce number of patients in non-designated areas Release of theatre staff to support ward areas	Provides temporary relief of acute pressure	Additional Bed capacity Supports patient flow		
Poor patient experience/impact on inpatient waiting lists	Risk to patient care - requires Director Approval	Will reduce elective operating	Risk to patient safety	Reputational harm/requires Director sign off	Inadequate staffing		

Appendix 8: Current surge and TES provision

Leeds General Infirmary

CSU	Surge (1) Beds	Surge (1) total	Surge (2)	Surge 2 total	TES	TES total	Reverse Boarding
Cardiology	L14 x 4 beds (up to 12)	4	L14 x 2 beds (Chaired area)	2	L16 x 1 (day room) L19 x 1 bed (day room)	2	L18 x 1 bed (Nurses Station)
Head & Neck	Nil	0	Nil	0	L23 x 1 bed (consultation room)	1	
Neurosciences	Nil	0	L12 x 1 bed treatment room L25 x 1 bed dayroom L24 x 1 bed (dayroom) L12 x 1 bed (therapy room)	4	L12 x 1 additional bed in a bay L24 x 1 beds L25 x 1 bed	3	L17 x 1 Chair
TRS	L34 x 1 bed L10 x 2 beds - surge	3	L35 x 2 bed (day room) L10 x 1 bed (day room)	3	MSAA x 6 (must be single sex)	6	
Children's	L40 x 6 beds (to be used first) L52 x 4 beds L49 x 6 beds L49 x 13 beds	29	Nil	0	Nil	0	
CAH		0	3 beds C2 bay	3			

Total Adults		7		12		12	
Total Children's		29		0		0	
Total		36		12		12	

St James's University Hospital

CSU	Surge (1) Beds	Surge 1 total	Surge (2)	Surge total	TES	TES total	Reverse Boarding
SIM	J20 x 2 closed ID rooms J32 x 3 beds	5	J30 x 1 bed J31 x 1 bed	12	1 x bed J07 (additional bed in a bay) 1 x bed J26 (rm 30/03/50) 1 x bed J29 (rm next to nurse station, when no mental health patients need room)	3	1 x bed J08 (corridor) 1 x bed J15 (corridor) 1 x bed J16 (corridor) 1 x bed J17 (corridor) 1 x bed J19 (corridor) 1 x bed J21 (corridor) Beckett Wing ward (1 bed in each day room on which ever ward is open, contingent on a definite discharge that same day)
Respiratory	Nil	0	RSU increase beds from 12 to 16	4	J11 day room x 1	1	1 x bed J12 (corridor) 1 x bed J09 (corridor)
AMS		0			1 x J91 (middle of a bay) 1 x J92 (middle of a bay) 1 x J48 (dialysis bed space)*	5	

					1 x J82 (middle of a bay) would require an additional RN to support		
Oncology	JONA side rooms	4	1 x bed J93 1 x bed J98	2	1 x bed J97 (in sensory room) 1 x bed J93 (middle of a bay) 1 x bed J98 (middle of a bay) 1 x J94 (day case room) Additional patients may be placed on wards J93, J97 & J98 in bays a maximum of 2 on each ward, but wards would need an additional RN	7	
Women's	GATU x 4 beds	4	nil	0	Nil	0	
Urgent Care	2 x beds J27	2			1 x bed J28 (Meeting/relatives room behind Nurses station) 1 x J27 (HOBs Surge Area)	2	1 x bed J28 (Nurses Station) 1 x bed J27 (Nurses Station)
Total		15		8		18	

Emergency Department Full Capacity Plan

ED	Surge Beds	(1) Surge total	1 Surge (2)	Surge total	2 TES	TES total
LGI Adults Only	Nil	Nil	4 bedded spaces (x-ray waiting room)	4	5 trollies (ambulance assessment) 5 trollies (blue corridor) 2 trollies RAU	12
SJUH	8 trollies (1-8 in blue area) 3 (ED cubicles A, B, C doubling)	11	9 (J22 yellow area)	9	10 (corridor spaces) 10 (chairs)	20
SDEC SJs	13 pts (mix of stay and TCI)	13	15 pts (mix of stay and TCI) Surge 3 silver decision - 18pts (mix of stay and TCIs pts – will impact on SDEC flow)	2 - 5		0
Total		24		15-18		32

Agenda Item 14.1(iii) (Blue Box)

Quality and Equality Impact Assessment (QIA)														
Scheme Title: Winter Plan														
Scheme Value: 4.2 million					Scheme Implementation Date: October 2025									
Scheme Description: The Winter Planning 2025/26 proposal presents a multifaceted strategy designed to safeguard operational quality, patient and staff safety, and system responsiveness amid anticipated seasonal pressures. Failure to implement the recommended mitigations and monitoring as outlined poses significant risks to patient safety, service quality, and equity. This assessment details the potential adverse impacts, identifies vulnerable areas, and offers narrative on the ramifications of inaction.														
Corporate Operations					Scheme Lead:Jo Wood, Director of Operations supported by Deputy Chief Nurse Jo Regan and Deputy Chief Medical Officer Liz Garthwaite									
					Monthly monitoring measures only be complete once QIA is signed off and implementation has commenced									
Risk to	Description of risk	Likelihood	Impact (severity)	Risk Rating	Mitigating actions/controls	Residual Risk Rating	Escalate to Corporate Operational Risk Registers	Quality Indicators ("QIs") (Include Target and Baseline)	Rationale for QIs chosen	Trigger(s) for escalation	Current Month achievement (measures)	Current Month actions to be taken upon breaching trigger level	Responsible person	Current month risk rating RAG
Patient Safety	Without approval of the Winter Plan, there is an increased risk of patient harm due to delayed emergency responses, prolonged ambulance handover times, and overcrowding in clinical areas and non-clinical areas resulting in increased patient harm.	4	4	16	Opening of additional inpatient capacity, additional Emergency medicine clinicians and implement or surge and escalation plans including using temporary escalation spaces; proactive monitoring of high-risk patients; prioritise ambulance offload and high-risk patients; strengthening of actions and escalation triggers	Green	Yes	Reduction in avoidable harm incidents; A&E wait time <4 hours; ambulance handover delays >45 mins	These QIs reflect the timeliness and safety of urgent care delivery, which are most at risk without the Winter Plan.	A&E breaches increase >20%; ambulance delays >45 mins exceed threshold	To be monitored weekly, and month end positions	Activate operational response and surge response; redeploy staff; open escalation areas.	Chief Operating Officer	
Patient Experience	Service disruption, long waiting times and poor communication could cause delays in treatment, increased anxiety and dissatisfaction, particularly among vulnerable patients.	3	4	12	Increased wards supported by staffing and use of surge/TES, provide multi-format and multilingual regular communication to patients; proactive outreach to vulnerable groups; patient advise services (PALS). Monitor quality and safety data, mortality and morbidity data. Request system support when there is increased demand for services	Amber	yes	Friends & Family Test score; number of patient complaints/PALS contacts, Mortality and morbidity data, UEC metrics	Measures capture the patient's perception of care and responsiveness and outcomes	>10% increase in complaints or PALS contacts. Above 10% increase in mortality/morbidity	To be monitored	Additional staff, system support, priorities based on acuity.	Deputy Chief Nurse	
Clinical Effectiveness	Inability to maintain timely elective and urgent care pathways may lead to poorer outcomes and widening health inequalities	3	4	12	Prioritise urgent cases; staffing redeployment; Additional staffing, System support. Planning assumptions based on 5% uplift in elective bed utilisation	Amber	yes	Cancer 2-week wait compliance; elective RTT targets, increased readmissions	Key indicators for timely and effective care delivery.	Breaches exceed agreed trajectory by >5%	To be monitored	Reallocate resources; postpone non-urgent elective work.	Medical Director	
Staff Experience	Increased burnout, sickness absence, and reduced morale due to workload pressures and lack of coordinated support during winter surges.	4	4	16	Offer flexible working; enhanced occupational health support; staff wellbeing hubs; Staff flu vaccination; staff transport during severe weather.	Amber	Yes	Staff sickness rates; NHS Staff Survey report, retention rates	Indicators reflect workforce wellbeing and retention.	Sickness rates exceed seasonal average by >2%	To be monitored	Increase health and wellbeing support; provide wellbeing sessions.	Director of Human Resources	
Equality and Diversity	Vulnerable groups and those with protected characteristics disproportionately impacted by service disruption without equality-focused planning.	3	4	12	Director triumvirate review all contingency actions; targeted outreach; monitor equality impacts in real-time.	Amber	yes	Number of equality-related complaints; service access rates by protected characteristic	Measures assess fairness and accessibility of care.	Access disparity exceeds baseline by >5%	To be monitored	Implement targeted interventions; strengthen liaison with community partners at place and across WYAAT.	Director of Operations	
Operational Performance	Increased waiting times, missed performance targets, strain on partner services, and reputational damage. Failure to achieve operational plan and escalation through National Oversight Framework.	4	4	16	Interim escalation triggers; strengthen organisational response guidance; daily operational huddles; system support and additional elective bed planning	Amber	Yes	A&E 4-hour target; elective backlog size	Key measures of operational flow and performance.	A&E performance falls >10% below target; elective backlog increases by >5%	To be monitored	Trigger silver command response; reprioritise elective activity.	Chief operating officer	
EQIA reviewed by Deputy Chief Medical Officer/Director of Nursing confirmed on 18 th September 2025					Role: Deputy Chief nurse Name: Jo Regan Role: Deputy Chief Medical Officer Name Liz Garthwaite									

