

CORPORATE RISK REGISTER

November 2025

Summary Corporate Risk Register November 2025

CRR No.	Nature of Risk	Date added to CRR	Executive Lead	Current Risk Score	Last Reviewed By RMC	Next Review By RMC	Link to LIM Value Stream	Page No.
Workforce Risk								
Workforce Supply Risk <i>Cautious</i>								
CRRW4	Insufficient staff to provide treatment, care and services to patients	May 23	Director of Human Resources, Chief Nurse & Chief Medical Officer	16	Jun 24	Dec 25		5-18
Workforce Deployment Risk <i>Cautious</i>								
-	-	-	-	-	--	-	-	
Operational Risk								
Business Continuity Risk <i>Cautious</i>								
CRRO1	Risk of a viral pandemic	May 18	Chief Operating Officer	15	Apr 25	Oct 25		19-20
CRRO2	Power failure/lack of IPS/UPS resilience due to electrical infrastructure	Aug 15	Director of Estates & Facilities	16	Jul 25	Jan 26		21-24
CRRO13	Brotherton Wing, Blocks 11, 12 and 32 physical condition	Jan 24	Director of Estates & Facilities	16	Jul 25	Jan 26		25-26
Health & Safety Risk <i>Minimal</i>								
CRRO4	Staff absence Health, Safety and Wellbeing	Oct 20	Director of Human Resources	16	Sep 25	Mar 26		27-30
Change Risk <i>Cautious</i>								
CRRO8	Risk of failure to deliver the pathology project – REMOVED FROM CRR FOLLOWING DISCUSSION AT OCTOBER 2025 RMC MEETING	May 20	Director of Finance	16	Sep 25	Oct 25		-
CRRO9	Risk of failure to deliver the LGI Site Development Project – REMOVED FROM CRR FOLLOWING DISCUSSION AT NOVEMBER 2025 RMC MEETING	Nov 21	Director of Finance	16	May 25	Nov 25		-
Information Technology Risk <i>Cautious</i>								
CRRO10	Cyber-attack leading to potential loss of IT systems and/ or data	May 22	Chief Digital & Information Officer	20	Oct 25	Apr 26		31
CRRO11	Insufficient DIT resources to maintain Trust IT estate to minimally supported standard and meet demand for DIT led projects.	Jan 23	Chief Digital & Information Officer	16	Oct 25	Apr 26		32
Clinical Risk								
Infection Prevention & Control Risk <i>Minimal</i>								
CRRC1	Healthcare acquired infection	Mar 19	Chief Medical Officer	16	Oct 25	Apr 26		33-44
Patient Safety & Outcomes Risk <i>Minimal</i>								

CRRC4	Emergency Care 95% Constitutional Standard	May 14	Chief Operating Officer	20	Aug 25	Dec 25	ED LGI	45-48
CRRC5	18-week RTT constitutional standard	May 14	Chief Operating Officer	20	Sep 25	Mar 26	Ophthalmology / Cardiac Surgery	49-54
CRRC6	62-day cancer constitutional standard	May 14	Chief Operating Officer	16	Jul 25	Dec 25	MDT & Pancreatic Breast Only	55-59
CRRC7	Failure to achieve 28 day cancelled operations standard	May 14	Chief Operating Officer	16	Sep 25	Mar 26	Cardiac	60-62
CRRC9	Patients waiting longer than 6 weeks following referral for diagnostics tests	May 14	Chief Operating Officer	16	Aug 25	Jan 26	Breast cancer	63-66
Capacity Planning Risk								<i>Cautious</i>
CRRC10	High occupancy levels and insufficient capacity and flow across the health and Social care system causing impact on patient safety, outcomes and experience.	Sept 15	Chief Operating Officer	16	Sep 25	Mar 26	MMPS	67-70
Financial Risk								
Financial Management & Waste Reduction Risk								<i>Cautious</i>
CRRF1	Failure to deliver the financial plan 2025/26	May 14	Director of Finance	20	Nov 25	Feb 26		71-74
CRRF2	Insufficient operational capital allocations	May 23	Director of Finance	20	Aug 25	Feb 26		75-77
CRRF3	Cash Availability – REMOVED FROM CRR FOLLOWING DISCUSSION AT OCTOBER 2025 RMC MEETING	Nov 24	Director of Finance	16	Apr 25	Oct 25		-
External Risk								
Regulatory Risk								
CRRE1	CQC Registration – breaches of Regulation(s) Maternity and Neonatal Services	Jul 25	Chief Nurse	16	Nov 25	Dec 25		78-83
CRRE2	CQC Registration – breaches of Regulation(s) Well-led	Nov 25	Chief Nurse	16	Nov 25	Dec 25		84-86

Corporate Risk Register - Key

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

Risk Appetite Scale

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

Risk Score

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

CRRW4: Insufficient staff to provide treatment, care and services to patients	C = 4	16	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk				
	L = 4		1	2	3	4	5	6	8	9	10	12	15	16	20	25	
										Target Score					Current Score	Initial Score	
Risk Description: There is a risk that the organisation has insufficient staff numbers or utilises existing staff inefficiently resulting in: <div><div>1. A potential failure to provide safe care and treatment to patients.</div><div>2. Staff suffering psychological and physical harm (burn-out)</div><div>3. Loss of stakeholder confidence and/or material breach of CQC conditions of registration.</div></div> This could be caused by <div><div>1. Inability to recruit to staff vacancies across all professional group and support workers, caused by a local and national shortage of qualified and experienced staff.</div><div>2. Failure to retain existing staff, for example due to early retirement or staff taking on roles elsewhere.</div><div>3. Not utilising staff appropriately due to poor rostering / job planning or staff undertaking duties not appropriate for their role</div></div>													Executive Leads <div><div>• Chief Nurse</div><div>• Chief Medical Officer</div><div>• Director of Human Resources and Organisational Development</div></div>				
													Date Added to CRR: May 2014 Last reviewed: June 2025 (Updated Sept 2025) Next Review: December 2025				
													Committee reviewed at: Resource Management Group Workforce Management Group				
Controls						Gaps in Control						Further Mitigating Actions					
NURSING, MIDWIFERY AND AHPs - Chief Nurse																	
Ongoing Deep dives into Nursing & Midwifery Recruitment and retention.						Significant vacancies nationally for specialist roles.											
Development of new roles and alternative workforce models						Inconsistent vacancy data – data held centrally via finance ledger does not align with CSU local data.											
						For some roles, the private sector offers better pay and incentives (e.g., no on-call).											

Vacancy gaps monitored monthly and forecasted for the next 12 months. Trajectory for the coming years reported via RMG. Successful recruitment in all safer staffing areas this year		
New entry routes created for those 'new to care' through apprentice CSW and trainee CSW routes. Development of new roles and alternative workforce models.		
Excellence in Practice programme in place for both registered and unregistered workforce		
Learning Practitioner programme		
Focus on 'growing our own' through in-house courses and apprenticeships.		
<p>Safer staffing guidance and escalation pathway to ensure operational oversight and appropriate mitigation in safe deployment of staff. This includes the out of hours, assessment, assurance and escalation for safe nurse staffing guidance.</p> <p>Temporary wards (seasonal and surge capacity) included in external safer staffing return once opened for full roster period of six weeks.</p> <p>All safer staffing documentation reviewed and monitored through the Nursing, Midwifery, AHP Workforce Group (NMAWG)</p> <p>Safer staffing resources, escalations and safer staffing policy available on the Trust intranet.</p>	<p>Variance in practice across CSUs in relation to roster governance and management. Impacts on safer staffing returns (Hard Truths) and timely release of vacant shifts to bank and agency.</p> <p>Available workforce to support opening of surge capacity in response to operational pressure, including ESA escalation.</p> <p>Daily and Weekly management of rosters using workforce production board</p>	
Midwifery	Midwifery Redeployment of non-clinical, specialist and management midwives at times of	Midwifery

<p>Centralised recruitment was launched in April 2024 across West Yorkshire & Harrogate Local Maternity & Neonatal System.</p> <p>The service is recruiting 12.6 WTE band 6 midwives over a phased period concluding in April 2025. The accumulation of these recruitment cycles will facilitate closure of the vacancy gap and alignment with the 2024 clinical Birthrate Plus recommendations.</p> <p>3 Maternity support workers recruited to the Midwifery Apprenticeship scheme at University of Huddersfield</p> <p>LTHT maternity workforce leads participate in the West Yorkshire and Harrogate LMNS workforce steering group. This group has oversight of recruitment and retention across the system and offers mutual learning and support of recruitment and retention strategies.</p> <p>The rolling attrition rate for midwives has fallen from 3.6 in 2021 to 2.1 currently.</p> <p>Exit interviews offered to all staff to identify themes and trends and where possible reverse a decision to leave. Workforce lead within the Women's CSU continues to work collaboratively with the pastoral support lead midwife and clinical educators to operationalise the workforce strategy.</p> <p>Collection and collation of all HR workforce KPI's and triangulation of data to inform improvement strategies. The PMA service is fully established and embedded within the service.</p>	<p>high acuity and increased unavailability of clinical staff due to vacancies, sickness, maternity leave and study leave.</p> <p>Inability of non-clinical, specialist and management midwives to complete their workload due to redeployment to support the clinical service. This directly impacts the Maternity Incentive Scheme compliance.</p> <p>Decrease in the specialist workforce to support timely governance processes and shared learning in a nationally high-profile/risk service.</p> <p>Escalation to support the clinical service includes redeployment from mandatory training. This directly impacts Safety Action 8 of the Maternity Incentive Scheme and if the evidential requirements are not met the service will fail the incentive scheme which is associated with a significant financial cost, safety concerns and reputational harm.</p> <p>Inability at times of high acuity where all mitigating actions have been exhausted to meet national KPI's of 1:1 care during the intrapartum period and</p>	<p>Review of midwife unavailability aligned with the 23% built into the establishment budget under review.</p> <p>Implementation of the staff support framework facilitated by the staff psychologist and staff support leads.</p> <p>Fixed term appointment of a staff psychologist to support work related stress and anxiety and with an ambition to achieve a reduction in sickness and attrition.</p> <p>Appointment of clinical educators to support the community midwifery services.</p> <p>Daily staffing meetings and review of all rosters at a service level to support redeployment to areas of greatest need using workforce production board.</p>
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<p>As per the requirements of the Maternity Incentive Scheme, a Birthrate Plus review was commissioned to identify any changes required to support safe midwifery staffing and the recommendations have been approved by the Trust Board.</p>	<p>supernumerary status of the labour ward coordinator. This directly impacts on safety and achievement of the evidential requirements of the Maternity Incentive Scheme.</p> <p>Increased training requirements aligned with the national core competency 2 guidance.</p> <p>Decrease in the skill mix of midwives due to a disproportionate number of earlier career midwives, impacting on safety and support of earlier career midwives.</p> <p>No available funding to support continued allocation to the midwifery apprenticeship programme.</p>	
<p>Corporate support for areas of concern. Escalation process in place.</p> <p>Programme of Nursing and Quality Framework reviews with CSUs</p>	<p>Variance in results of quality and safety reviews.</p>	<p>Corporate task and finish group established to identify potential impact.</p>
<p>Adult Therapies AHPs DHRBP in post in AT CSU for AHPs to lead on WF plan. Implementation of CSU IAM meeting with all data including WF metrics monthly</p>	<p>Adult Therapies AHPs Variance in understanding of WF issues and available data. No central governance around sign-off and equity in WF issues in CSU</p> <p>Only applicable at CSU not inclusive of other AHP groups</p>	<p>Adult Therapies AHPs Corporate Task and Finish Group established to identify potential impacts.</p> <p>Ongoing work with PPM regarding capability to pull activity in contacts and duration.</p>

<p>ToR drafted for CSU level WF committee for all Professions in CSU to be members of and agree all actions and operational activity.</p> <p>Adult Therapies CSU AHP Specific</p> <p>Development of a capacity and demand tool for AT CSU to understand available resources.</p> <p>Apprentice analyst within CSU supporting data process.</p> <p>Meeting with national C&D team from NHSE September 2023 for support and challenge.</p> <p>Deep dives into AHP groups in AT CSU to support where identified retention or turnover is a concern.</p>	<p>Variance of data relating to activity across each professional group and how captured.</p> <p>Data manually collated no electronic capability.</p> <p>Acuity not part of C&D tool.</p> <p>Lack of technical capability.</p> <p>Lack of national guidance re development of suitable tool.</p>	<p>AHP professions linking with professional bodies for steer on complexity tool.</p> <p>Exit interviews results to be analysed. Rapid improvement time limited projects underway to provide strategy for a profession and light touch approach.</p> <p>Working with regional AHP faculty to implement partner strategies where appropriate.</p>
<p>Therapy Radiographers (Oncology)</p> <p>On-going recruitment.</p> <p>Apprentice programme in place.</p> <p>First international recruitment has been a massive success so may consider more based on UK applicant number.</p> <p>Retention of staff has improved.</p> <p>Education lead in place until Feb 2026. This has had massive impact on staff training and supports the apprentices.</p>	<p>Therapy Radiographers (Oncology)</p> <p>2024 Radiotherapy census data still highlights a shortfall of staff.</p> <p>Annual increase in demand for radiotherapy is 6%.</p> <p>There are not enough students being trained nationally.</p>	<p>Therapy Radiographers (Oncology)</p> <p>Continue to expand the apprenticeship programme. Trust has supported 4 posts for 2025. Support for four more in 2026.</p> <p>The below recruitment and retention initiatives have helped. We have developed some of our band 2 staff into band 3 clinical roles. They may become radiographers possible via apprentice route. This could be a 5-year process.</p> <p>International recruitment may be a longer-term option – National funding of £5000 per recruit has been offered in 2025.</p> <p>We still have 3 x Vacancies at band 5. This increase to 7 as we have 1 going on a career break, 1 on Mat leave and 3 acting up</p>
Radiographers (Radiology)	Radiographers (Radiology)	Radiographers (Radiology)

<p>Annual radiography recruitment event for year 3 undergraduates to attract staff prior to qualifying and build early on boarding relationships.</p> <p>Regular recruitment cycle in place for all modalities.</p> <p>Investment in apprentice radiographer roles, apprentice assistant roles and apprentice radiographer practitioner roles.</p> <p>3 x ARPs undertaking the bridging course to enable them to gain a degree in radiography in 2027.</p> <p>Strategic review of the apprentice versus undergraduate radiography programme.</p> <p>New for March 2025, apprentice sonographer training to be undertaken by internal candidates (x2)</p> <p>Undergraduate (non-apprentice) ultrasound course to commence in Sept 2024 at Leeds unit to avoid the need to train as a radiographer first. This will increase the number of trained sonographers in 3 years' time.</p> <p>Staffing the CDC from within, CDC seen as an attractive place to work.</p> <p>CT team manager and X-ray staff appointed.</p>	<p>13-week recruitment pause impacting on some modalities less than others. For cross sectional imaging, the training time from zero experience is 20 weeks. Adding the 13 week pause to this means significant roster gaps and reliance on voluntary overtime.</p> <p>Retention risks due to independent sector offering more attractive salaries (Ultrasound and MRI) with no on-call commitment.</p> <p>On-going engagement with the US staff to review options to support retention.</p>	<p>Tier 2 exemption for all CT/MRI/Nuclear medicine and US posts.</p> <p>Work to modify training pathways in X-ray to improve time to competency once radiographers are qualified is in place. HEE funded clinical educators on 12-month FTC x 3.</p> <p>For 2025 there are 4 x funded ce posts for 1 year to reduce training time in X-ray, IR and Nuclear medicine.</p> <p>Introduction of a band 4 role to undertake more 'simple' scanning procedures is being piloted in MRI – staff member due to qualify in 2025.</p> <p>Working on a plan to offer training in a second modality for interested staff on either a secondment or part time basis.</p>
<p>Theatres</p> <p>20 apprentice ODPs per year by increasing to 10 students per year from Huddersfield University and 10 from Sheffield Hallam University.</p>	<p>Band 6 CT radiographer gaps at CDC</p> <p>Limited number of places available due to back-fill requirements.</p>	

MEDICAL and SCIENTISTS - Chief Medical Officer		
Medical staffing risks – controls and mitigating actions documented on Chief Medical Officer Risk Register		
Utilisation of International Medical Recruitment	Further pastoral support and supervision to be provided to international recruits after 1 years' service – there is a need to increase capacity for educational supervision within consultant job plans	Use of international recruitment agencies. HR/Nursing/Medics working together to develop approach to pastoral support. Job planning process to include time allocation for educational supervision which must be factored into costings
There are several ongoing deep dives into Medical Recruitment and retention		<p>Focus on 'growing our own' through in-house courses and apprenticeships. Development of new roles and alternative workforce models.</p> <p>Working with WYAAT on attraction, recruitment and retention.</p> <p>Discussion with HEE colleagues re impact of LTFT training – length of training to be increased pro rata – which may reduce attractiveness of option to some groups.</p> <p>Work being done on, options for rota management to reduce dependency on bank and agency.</p> <p>Work being done to standardise rates across WYATT.</p> <p>Specific work to reduce bank and agency spend by ensuring effective roster management, collaboration and clear escalation strategies.</p>

		<p>Burnout group has been established – deep dives into areas where burnout risks are high with targeted interventions.</p> <p>Development of wellbeing strategy for senior medical staff</p> <p>Development of a consultant retention strategy to include pension planning, flexible working and other key actions.</p> <p>In terms of retention, considerable on-going work around trainee engagement (greater visibility of the Chief Registrar, Resident Doctor Body, Clinical Leadership Fellowships, routine unannounced ward visits to engage with trainees, and more), Rest facilities improved at the SJUH site, and being reviewed at LGI.</p> <p>Following the publication of 'Improving the Working Lives of Doctors' a task and finish group has been formed to audit current compliance and set in train improvements across a number of workstreams.</p>
Consistent job planning and annual leave management to ensure most effective utilisation of existing medical workforce	<p>A recent audit has identified areas for improvement in the Trust's Job Planning arrangements.</p> <p>Lack of knowledge of demand meaning services cannot plan workforce needs effectively.</p>	<p>A detailed action plan is in place to address these issues.</p> <p>Embedding processes of standard work and financial daily management regarding rota management, cover and leave to ensure workforce responsive to the service demands.</p>

	<p>Rota management for medical workforce has not been linked to changes in service requirements – resulting in high locum and bank spend.</p> <p>Annual leave for consultants is not always transparent, with potential for taking above entitlement.</p>	<p>A task and finish group was established in November 2024 to address job planning along with a number of other issues relating to medical staffing processes.</p> <p>Work being done to look at areas where leave management needs improvement. Move to e-rostering. Paper on rolled up annual leave signed off by Executives in March 2024.</p>
<p>Guardians of Safe Working, Resident Doctor Forum.</p> <p>Exception Reporting results and subsequent response from specialty.</p>		
<p>A global control for Health Care Scientists (HCS) workforce is the new structure for HCS leadership. This has named Leads for each of the main themes, Physical, Physiological and Life sciences as well as Bioinformatics. Under this leadership team is a HCS organisational structure that mirrors the Trusts structures including a Resource management group. This forum helps identify and manage workforce risks through shared experience and provides an escalation route outside of the normal CSU route as needed.</p>	<p>Concerns over staffing levels in audiology esp. paediatric audiology. Raised with clinical effectiveness and outcomes group.</p> <p>Still pressures from AQP competition, national review of audiology. Staffing risk of 50% vacancies.</p> <p>Only have capacity to train 1 paediatric audiologist a year.</p> <p>Annual staff establishment pattern. For several roles in the Trust recruitment is heavily dependent on graduate leavers. As such there is a spike in recruitment from September, spiking in November. But throughout the year these declines. The effect is that for about 2/3s of the year staffing levels are well below the average annual level.</p>	<p>Local audit and external audit completed, and no errors issues identified but national review of paediatric audiology following Lothian review.</p> <p>Using February for setting staffing levels is not the best time as levels are well below the annual level at this time. Better to use the level in September otherwise this introduces another pressure into the workforce. To be discussed within RMG</p> <p>Working with HEE etc for more training across all areas.</p> <p>Apprentice scheme highly successful for engineering, although lag due to training period.</p> <p>Unknown at present as impact still evolving.</p>

	<p>National shortage across Medical Physics.</p> <p>Clinical engineering - have made good progress in filling vacancies but have another group of retirements on the horizon.</p> <p>Difficulty recruiting in haematology, blood transfusion high pressure and are so not attractive job.</p> <p>Genetics shortage. service expansion faster than university trained students. The impact of CDCs on the workforce is unknown. The teams are actively working with colleagues in the Trusts and ICS to gain better understanding through the Operational team.</p> <p>Hyper specialist services with half of the 52 specialisms with only 5 or less staff creating sustainability risk.</p>	
GENERAL WORKFORCE ISSUES – Director of HR and OD		
There is a Trustwide affordable workforce plan and progress against the plan is presented to the Workforce Management Group and Workforce Committee	<p>Workforce (including temporary staffing) is currently higher than the affordable plan.</p> <p>It is estimated that the total WTE will need to reduce next year. Specific information has been provided to each CSU.</p>	

Each CSU has an Operational Workforce Action Plan (OWAP). HRBPs and working with CSUs to deliver action plans.		.
Mandatory training for all staff to ensure competent and skilled workforce.	Lack of assurance that all resident doctors have completed mandatory training, caused by ineffective systems and reporting, resulting in failure to protect patients from harm.	Review of systems and processed to be led by the medical directorate.
Specific service level staff shortages for hard to recruit staff are captured in the OWAP and the CSU risk registers, with escalation of significant CSU risks to RMC.	<p>Significant risks captured include:</p> <ul style="list-style-type: none"> • Gaps in the Stroke service • Fragile Epilepsy service • Ongoing recruitment difficulties for Genetics Clinical Scientists, mortuary staff and BMS in Blood Sciences. • Gaps in resident doctor and nursing rotas in Urgent Care • Consultant workforce gaps in Women's and unavailability in Maternity Workforce. • Consultant Gaps in Paediatric Hepatology and Congenital Cardiac Surgery • Nursing gaps in Neonates, Haematology and Oncology • Retention of staff due to competition from private sector, for example paediatric audiologists • On-going gaps in radiotherapy prior to annual cohort joining in September. • Gaps in Medical Physics Clinical Scientists 	Specific mitigation plans and actions for each of these are detailed in CSU OWAPs

	<ul style="list-style-type: none"> • Gaps in ultrasound • Paediatric general anaesthetics • Gaps at WGH • Senior clinical capacity in T&O • Gaps in resident doctors in ACC • Respiratory Consultants • Entry level gaps in decontamination, security and nursery 	
Vacancy control panels operating in all CSUs with oversight of CSU vacancy trackers through Trust Expenditure Review Group (TERG). Multidisciplinary, executive led weekly workforce meeting in place to oversee vacancy controls, variable pay (including non-clinical and clinical agency) and FTE reduction.	Recently announced changes to immigration and visa legislation will significantly impact on the Trust's ability to recruit and retain overseas nationals in Band 2 and Band 3 positions.	Work is on-going to assess the impact of these changes.
In year commitment on retention for 2024/25 has now closed but maintaining current levels of turnover remains as part of the People Priorities.		
Resource Management Group meets bi-monthly to lead, support and report on activities related to resource management. Workforce Management Group receives monthly Workforce Metrics to ensure alignment to Finance. Workforce Committee receives a deep dive into workforce issues 3 times per year. Weekly HRBP huddle with Centres of Excellence and Director of HR to discuss workforce issues		
The organisation has a Structured Approach to Winter Planning.		
The organisation has a structured approach to managing the risk of staff retiring early due to risk of high pension		

tax liability. Pension Guidance has been developed for all staff.		
There is a Structured approach to Exit interviews across the Trust. Exit Interview results and analysis forms reviewed by Workforce Management Group and Workforce Committee.		
Optimal Attendance Management, including resident doctors, is now embedded as business as usual. Further detail is contained within CRR04. Regular review of absence management data with Tri team / HRBPs / Operational HR /CSUs with actions agreed.		
Roster management tools in place to support staff groups. New Roster metrics developed and these are reviewed through HONS meetings and also through RMG. Roster management metrics in relation to adherence to best practice and safer staffing guidance shared with CSU and presented to WMG and WFC.	Roster management not embedded consistently across all clinical staff groups.	Levels of attainment steering group reviews progress and further roll out plan.
Continued support for the development of new roles for example: <ul style="list-style-type: none"> • Apprentice programme. • Advanced Practitioners • Physician Assistants • Volunteer programme. Nursing Associate deployment reference group commenced to support governance and assurance of new role. Future You programme implemented to create workforce plan, recruitment and retention strategy for the Nursing		

Associate role. Progress reviewed through NMAWG and RMG		
Deputy DME overseeing PA undergraduate placement program at LTHT.		
Use of temporary workforce (bank and agency), including specialist agencies to provide observation, supervision and safe care to patients.		
Monitoring of staffing requirements through daily staffing meeting, weekly variable pay submissions, and weekly reports to Director of Finance.		
Locally agreed payment rates for staff, process for escalation, review and approval (Executive Director)		
A gap analysis has been undertaken against the National long term workforce plan.		
Leeds Health and Care Academy Talent Hub connecting with diverse talent pools and working across the City on advertising, screening candidates and supplying a pipeline to support workforce capacity.		
Artificial intelligence (AI) has the potential to reduce workforce requirements for some tasks.	The impact of AI on our workforce is not fully understood.	On going work to understand the impact and opportunities of AI.
Risk of staff absence due to potential Industrial Action Currently none of the unions have a mandate for industrial action, however, we have received a notification of a ballot of resident doctors from the BMA. Standard work is in place for the deployment of staff and staff mitigations to support essential services in the event of industrial action as follows:		

CRRO1: Risk of a viral pandemic	C = 5	15	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
	L = 3		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 Trust services being overwhelmed (either in part or as a whole) caused by a viral pandemic resulting in significant patient and staff harm, impacting on quality, delivery of constitutional standards (performance) and finance.													Executive Lead: Chief Operating Officer Date added to CRR: May 2018 Last reviewed: October 2025 Next Review: April 2026 Committee reviewed at: High Consequence Infectious Disease Group Emergency Preparedness Coordinating Group			
Controls			Gaps in Control						Further Mitigating Actions:							
Pandemic Plan in line with NHS framework for managing the response to pandemic diseases.			<ul style="list-style-type: none">There has been no update to either the national pandemic plan nor the Leeds outbreak plan post covid-19Some specific recommendations from the 2023 EPRR core standards review in relation to PPE training and resources have not been implementedExercise to validate plan neededCurrent workload in relation to HCID (mpox in particular) impacting on updating of pandemic plan						<ul style="list-style-type: none">Plan has been updated internally based on covid-19 experience and other relevant guidanceNew framework for response being developed; due for completion November 2025Oversight of plan and preparedness at High Consequent Infectious Diseases groupDiscussion exercise held in September 2024 and plan will be updated to reflect learning. A table top exercise will be scheduled. The Trust will participate in a national exercise in Autumn 2025 (Exercise Pegasus) and any learning will be further incorporated							
CSU Business Continuity Plans			<ul style="list-style-type: none">Assurance that up to date business continuity plans are in place for all services within the trust.						<ul style="list-style-type: none">CSU business continuity plans are performance managed through the business continuity sub-group to EPCG.							

		<ul style="list-style-type: none">• Support is provided to help CSU business continuity leads.
Infection Control procedures (including Personal Protective Equipment) Training for 'donning' and 'doffing'	<ul style="list-style-type: none">• Mask fit testing training levels• PPE training levels	<ul style="list-style-type: none">• Challenges in relation to training have been escalated through Operational IPC and more is being made available through a train the trainer programme targeted specifically on those areas most likely to be impacted(ED, J20, SIM, children's, critical care (adults and paediatrics) and women's).
Surge and Escalation Arrangements (OPEL) LTHT Incident Response Plan which would be activated in case of a pandemic.	<ul style="list-style-type: none">• Assurance that all CSU surge and escalation plans are up to date	<ul style="list-style-type: none">• Surge and escalation plans form part of winter planning and preparedness.• Incident Response Plan has been completely re-written and is regularly being tested and exercised.

CRRO2: Power Failure due to Electrical Infrastructure/lack of IPS/UPS resilience	C = 4	16	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
	L = 4		1	2	3	4	5	6	8	9	10	12	15	16	20	25
						Target Score									Current Score	Initial Score
Risk Description: There is a risk of power failure at a Trust site (ward or clinical area) Due to failure to comply with HTM 06 01 caused by outdated electrical infrastructure and the absence of complete IPS/UPS resilience in Clinical Category Grade A: Life support/complex surgery (Risk to patient due to loss of supply) or Grade 1: Medical support services (Risk to business continuity due to loss of supply) locations. May result in a poor patient experience; a failure to protect patients or staff from serious harm or fatality; loss of stakeholder confidence; and/or a material breach of CQC conditions of registration or HSE prosecution												Executive Lead: Director of Estates & Facilities Date added to CRR: August 2015 Last Reviewed: July 2025 Next Review: January 2026 Committee reviewed at: Electrical Safety Group				
Controls			Gaps in Control						Further Mitigating Actions							
Emergency generator power provision across all sites. Dual electrical supplies to most clinical areas.			Emergency Generators take on average 20 to 30 seconds to start and supply power, clinical areas without UPS provision will be without power for this period . Not all patient bedheads have interleaved electrical supplies which is an HTM requirement. This could result in the loss of electrical supplies to individual bed heads upon a local electrical failure.						When wards and clinical areas are refurbished in the future interleaved electrical supplies should be installed to each bedhead and all clinical category Grade A areas should have full UPS/IPS support fitted in-line with HTM 06-01.							
Medical Physics has fitted independent battery back-up to some life support equipment in clinical areas.			This is not consistent across all areas of the Trust resulting in confusion when power supplies are disrupted						Theatre upgrade programme - no capital funding available specifically identified in 5-year capital plan; if specific theatre risk items are identified they would need to be prioritised from our backlog investment profile.							
Complete assessment of telephony switchboard resilience in terms of UPS protection and autonomy (up to 4 hours).			Not all Information Technology systems are supported by UPS with the required autonomy to maintain a service upon loss of supplies.													
Estates Handbook updated for emergency plans with detailed processes and regular review.			This handbook provides the Estates on-call team with information of what can be done when						The handbook is reviewed annually.							

	power interruptions occur but does not assist with the shortcomings of the installed systems.	
Increased interleaving of circuits in Clarendon Wing i.e., there is now more flexibility as to where power to wards/departments is directed from, increasing resilience.	This interleaving work has improved the resilience in Clarendon Wing 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.
HTMs are not retrospective, and areas were designed to comply with best guidance at the time of design and construction.	Although HTMs are not applied retrospectively, HTM 06-01 was introduced in 2007 (current version 2021) so many areas remain non-compliant to current guidance but and 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.	<p>The Electrical Safety Group has updated/ approved the UPS/ IPS live compliance tracker for each site which will inform the capital investment prioritisation list, following engagement with an independent Electrical Engineering Consultant (technical audit assessment/ report, for the Medical Location Risk Grading accordance with HTM 06-01 clinical risk grading & BS 7671 Section 710 group locations). This has been undertaken across the organisation's critical medical (patient safety) & critical equipment (business continuity) locations to get a firm position on compliance & a gap analysis, with a technical solution to inform/ develop a multi-year business case, to secure the required investment.</p> <p>This will formalise the E&F risk management process to assess/ address the susceptibility to risk from total (or partial) loss of the electrical supply with the consequence of a power failure assessed and graded against a wide range of</p>

		<p>departments with complex requirements and potential risks.</p> <p>Medical grade A locations requiring investment have now been independently assessed to understand the level of funding required & timeframes (impacted by available capital/ access to areas) to inform the business case/ become fully compliant with HTM 06-01.</p>
A UPS/IPS infrastructure was installed to support Geoffrey Giles Theatres 1 to 8 and Recovery in 2017. Theatres 1-8 connected to the system in 2020/21. Theatre 9 connected to the system in 2023/24. Recovery connected to the system in 2024/25.		
Some areas (e.g., J54) are fitted with the required UPS provision but not fitted with Isolated Power Supplies (IPS).	Several clinical category Grade A areas are not fitted with IPS as required by HTM 06-01 to safeguard the patient from the risk of electric shock and provide increased local electrical resilience.	IPS should be installed to all clinical category A areas in-line with HTM 06-01 when areas are refurbished. Awareness of the electrical shortfalls in UPS and IPS provision in clinical category Grade A areas is required. Electrical action cards have been provided by Estates to Clinical, this will be reviewed 6-monthly.
UPS/IPS systems have been installed in a number of clinical category A locations including those detailed above in Geoffrey Giles (theatres 1-9 and recovery); Cath Labs 1, 2, 3, 4, 5 & 6; LGI - Jubilee Wing MRI; 2no. Clarendon Wing B Floor NHS MRIs; Theatre 17 Jubilee Wing; Theatres 1 & 2 CAH. L43 Neonates (Clarendon Wing); Maternity Theatres & Recovery (Gledhow Wing) and ARCU (Gledhow Wing) were upgraded and fitted with compliant UPS/IPS systems in 2021.	There are still a number of Clinical category A areas without UPS/IPS systems.	<p>Feasibility studies suggest that around £10m will be required to install UPS/IPS systems in Grade A locations (typically, those supporting life support or complex surgery).</p> <p>The previously approved 5-year capital plan included £6.4m for electrical backlog and compliance priorities. However, in May 2025 the Building & Engineering operational capital plan for 2025/26 was cut from £21m to £11m because of reduced capital availability.</p>

<p>IPS was installed in J1 (Neonates SJUH) in 21/22.</p>		<p>The overall Trust 5-year capital programme is under review based on the Trust Risk Appetite Framework. The funding request for this investment will form part of this prioritisation review and will form part of the revised draft capital plan to be submitted to Finance & Performance Committee in Q3 2025/26.</p> <p>UPS has been installed to J54 on the central system, phasing option/s for IPS connections under review, with a view to completing in 2025/26 (subject to access and funding).</p>
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CRRO13: Brotherton Wing, Blocks 11, 12 and 32 physical condition	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: <ul style="list-style-type: none">There is a risk of Brotherton Wing becoming unsafe for occupying patients, staff and visitors.Due to a failed roof covering, deteriorating building fabric and aged engineering services (impacting statutory compliance requirements).Resulting in a risk to patient safety and quality of care, poor working environment for LTHT staff and a negative impact on LTHT reputation from patients, staff and visitors.													Executive Lead: Director of Estates & Facilities			
													Date added to CRR: Jan 2024			
													Last reviewed: July 2025			
													Next Review: January 2026			
													Committee reviewed at: Building Safety Group			
Controls			Gaps in Control						Further Mitigating Actions							
Estates Staff working to control flow of water by collecting in receptacles.			Water is being managed once within the building structure, due to total failure of Block 11 roof covering, cannot capture/control all flowing water.						Receptacles sited at known spots for flowing water, daily monitoring of collection spots by shift team.							
Disconnected electrical services on Floors D-F to separate supplies in non-occupied areas from impacting occupied clinical areas. A Specialist Contractor has carried out Fixed Wire Installation Testing in Blocks 11,12 and 32.			Rising mains now between A and C Floors only are non IP65.						Replaced local equipment for IP65 equivalents where possible.							
Trust Building Team working to replace failed suspended ceilings in clinical areas where patient care and access to WC availability has been restricted.			As no control of flow of water there is no guarantee that the ceilings will not collapse again.						Attempts to divert flow in unoccupied areas above via drain/pumping system and sealing gaps in penetrations.							
Capital Scheme in progress to remove F Floor extension and install new roof covering. Business case approved and application submitted to the Building Safety Regulator (BSR).. BSR application has been approved today, works can now proceed, target completion Q1 2026/27.									Controls 1-3 will continue until roof covering is replaced.							

Asbestos inspection surveys have been undertaken; removals have taken place in Clinical/ occupied locations to reduce risk.	There are remaining asbestos containing materials throughout the blocks.	The condition of the known asbestos containing materials is regularly audited.
Operational Fire Strategy in place for blocks 11 & 12.	Complex construction works are planned to repair the roof, this doesn't affect access, or the staff evacuation procedures.	The fire service will be informed and are invited to do site familiarisations and staff will be notified of the works and any potential issues as they occur. The Fire Team will continually review and monitor the works

CRRO4: Staff absence Health, Safety and Wellbeing	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 staff are less effective at work or absent from the workplace due to high levels of burnout and or sickness absence which will impact on operational delivery, financial sustainability and staff engagement. Our staff survey data tells us that staff who completed the survey report that they feel burnt out because of work, which can lead to lowered staff resilience and presenteeism.													Executive Lead: Director of Human Resources				
													Date added to CRR: June 2020 Last reviewed: September 2025 Next Review: March 2026				
													Committee reviewed at: Health and Wellbeing Group Workforce Management Group				
Controls Note the key controls listed are based on the workstreams within the Optimal Attendance Management project, led by HR on behalf of the whole organisation						Gaps in Control						Further Mitigating Actions					
Health and Wellbeing Strategy including core metrics in place to ensure robust governance of health and wellbeing activity across the Trust.						Confirmation of Executive responsibilities for overarching staff health and safety strategy.						CMO to be Executive Sponsor.					
Annual staff survey to measure staff views in relation to the People Promise: We are safe and healthy. The overall 2024 results for the Trust showed that for each of the three sub-themes, including burnout, showed the Trust scored around the average or slightly better than average.																	
Health and Wellbeing Committee and working group in place to assure progress against the organisational health and wellbeing strategy and core metrics.																	
Supporting Attendance Policy and Guidance agreed with staff side and in place within the organisation. This details the processes around absence management to enable line managers to take local action to address sickness absence.						Differential application of the Supporting Attendance policy across CSUs.						Scheduled review of Supporting Attendance Policy and Guidance is awaiting agreement from staffside, however,					

Assurance processes are rolled out to all CSUs and is supported by the Operational HR team.		improvements to operational processes incorporated into standard work.
Medical and Dental template process for managing medical and dental sickness absence has been rolled out including where appropriate warranted variation for CSU specific arrangements.	Unclear management arrangements for Junior Doctors due to their short-term employment leading to lack of proactive sickness management for this group. Not all CSUs are at 100% maturity of implementation yet.	Further action by all CSUs to achieve full compliance with the new standard.
Support for managers to enable them to compassionately and consistently manage sickness absence, work related stress and presenteeism including: HR training on application of HR policies Health and wellbeing training for managers Leading Leeds way toolkit Support from HR Operational team, Occupational Health and HWB team. Review of burnout response, stress risk assessment and guidance completed. Action plan agreed.	Line manager capability and capacity to apply the Supporting Attendance policy and wellbeing conversations.	Scheduled review of Supporting Attendance policy and guidance is awaiting agreement with staffside, however, improvements to operational processes have already been incorporated into standard work. Additional targeted HR support is being provided to assist with line management in identified areas, for example, Pathology. Implementation of agreed action plan is being monitored by the Health and Wellbeing Group and Workforce Management Group
Monthly review of absence management data with Tri team /Heads of Departments / HRBPs / Operational HR / CSUs and Corporate areas with actions agreed.		
Range of initiatives to support staff to manage their HWB, including MHFA, Money Buddies, Chaplaincy, clinical psychology supported by a proactive communications plan. The usage is reviewed through HWB Committee who identify gaps and appropriate new interventions.	The internal staff clinical psychology team have identified that most support services are reactive, providing interventions to address established issues. A gap in provision of therapeutic preventative work has therefore been identified, with limited organisational resources to address this.	Work on going to develop a Post Incident Support Pathway, there are ongoing discussions about the funding provision for this work.. Review of provision and funding model by Adult Therapies to be completed.

	The staff clinical psychology team do not have a robust system to record interventions and manage appointments, taking considerable clinical time to complete this work.	Review of provision and funding model by Adult Therapies to be completed.
Occupational Health provide advice to managers on fitness to work and reasonable adjustments to support managers in effectively managing sickness absence.	OH, have insufficient clinical space after having vacated LGI to accommodate BtLW and planned capital funding is now no longer available as linked to BtLW funding.	Discussions underway with Capital Planning, subject to funding, to assess available space and develop alternative plans by December 2025..
Organisational immunisation programme, including on-employment vaccination and Winter vaccinations are available is delivered in accordance with the UKHSA schedule for occupational vaccination for all new starters. The Trust is now compliant with new guidance issued from UKHSA recommending organisations to vaccinate staff in high risk areas for pertussis transmission.		.
	Vaccination numbers for both flu and covid are lower than in previous years but in line with the national uptake.	A roving vaccinator model is being utilised on request, to vaccinate staff in their place of work in order to increase uptake.
Suicide Prevention strategy has been updated and a post-vention guidance in place to Managers and Staff affected.		
Stress Risk assessment process in place to support management of work-related stress.		
Moving and handling policy in place to ensure adequate training of staff to prevent MSK related sickness absence.	Do not currently have assurance that up to date and appropriate moving handling training and competency assessment to prevent Musculo-Skeletal related absence is being undertaken across the organisation in compliance with legislative requirements.	Review of moving and handling training underway to establish legislative and organisational requirements and develop long term solution. Long term solution to be delivered when competent person in post (see below).

	Do not have permanent training facility to deliver moving and handling training to key trainers.	Meet with capital planning to review options. Engage with organisational review of training spaces.
	Do not have a competent person in post to ensure compliance with legislative requirements.	Recruitment to competent person agreed and will commence by November 2025.

CRRO10: Cyber-attack leading to potential loss of IT systems and/or data	C = 4	20	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
	L = 5		1	2	3	4	5	6	8	9	10	12	15	16	20	25
Risk Description: The management of this risk is commercially sensitive information which has been removed from the public version of the Corporate Risk Register.													Executive Lead: Chief Digital & Information Officer			
													Date added to CRR: May 2022			
													Last Reviewed: October 2025			
													Next Review: April 2026			
													Committee reviewed at: DIT Committee			
Controls			Gaps in Control						Further Mitigating Actions							

CRRO11: Insufficient DIT resources to update the Trust IT estate to a minimally supported standard, maintain it, and meet demand for DIT led projects.	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
Risk Description: The management of this risk is commercially sensitive information which has been removed from the public version of the Corporate Risk Register.													Executive Lead: Chief Digital & Information Officer			
													Date added to CRR: January 2023			
													Last reviewed: October 2025			
													Next Review: April 2026			
													Committee reviewed at: DIT Committee			
Controls			Gaps in Control						Further Mitigating Actions							
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CRRC1: 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: There is a risk of patients developing hospital-acquired <i>Clostridioides difficile</i> infection, Methicillin Sensitive <i>staphylococcus aureus</i> (MSSA)bloodstream infection(BSI), respiratory infections and bloodstream infections caused by multi-resistant organisms , additionally there is a risk to staff and patient of being exposed to an infectious disease, due to a reliable and effective management system not being in place to protect patients and staff from infection due to estate constraints, compliance with infection prevention procedures, including hand hygiene, decontamination, environmental cleaning and training. There is a risk of hospital-acquired respiratory infections, including Covid-19 as a consequence of staff not following the guidance consistently. This may result in serious harm or death to a patient, prolonged length of stay, unsatisfactory patient experience, significant financial loss, loss of stakeholder confidence, and/or a material breach of CQC conditions of registration.													Executive Lead: Chief Medical Officer Date added to CRR: March 19 Last reviewed: October 2025 Next Review: April 2026 Committee reviewed at: Risk Committee Quality Assurance Committee Infection Prevention and Control Sub-Committee Risk committee 3.4.25 IPCSC 20.8.25 QAC 21.8.25			
Controls			Gaps in Control						Further Mitigating Actions							
Risk Assessment: Patient level assessment of risk on administration/arrival/transfer (filled in patient care record) IPC/Microbiology risk assessment completed electronically in PPM. IPC alert mechanism incorporated into electronic patient record (PPM+). Staff level assessment of risk at induction Staff vaccinations offered on employment. A comprehensive mechanism for recording staff immunisation assessment for childhood infectious diseases, such as measles and pertussis commenced in November 2024 for all new starters.			Documentation of staff immunisation assessment for childhood infectious diseases, such as measles and pertussis, is not comprehensively recorded for all existing staff. This means if there is an outbreak we do not have the information						Occupational health is working to close the gap in information about immunisations for the highest risk areas i.e. ED and PED. To be completed by March 2026.							

<p>All new starters are now offered the full range of UKHSA recommended vaccinations.</p> <p>Specific communications have been sent to Urgent Care, Children's and Women's CSU's explaining how staff can find out about their current vaccination status and where to go for immunisation. Specific communications have been sent to Urgent Care, Children's and Women's CSU's explaining how staff can find out about their current vaccination status and where to go for immunisation.</p> <p>Measles Outbreak: Measles outbreak closed on 7 March 2025 Local and City measles debrief completed. Findings presented at OIPC August 2025. National Measles incident stood down August 2025.</p> <p>Communication about the current increase in the circulation of measles and pertussis within the community has been briefed national regionally and locally. Close surveillance of the current number of community cases is provided by our Virologists with an escalation plan to the Medical IPC Lead should there be a sudden rise in cases.</p> <p>Staff on the infectious Disease ward are trained and a process for providing mutual aid established.</p> <p>A process for Mpox clade 1 single adult case care pathway for assessment, testing and care awaiting result, has been established in infectious diseases at SJUH.</p>	<p>available to identify unvaccinated staff who may be at risk.</p> <p>When validation of the data from ED was reviewed a 15% gap in information about immunisation status was identified.</p>	<p>To develop a plan for closing the gap for information about immunisations in other areas of the Trust guided by IPC by March 2026.</p>
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<p>Derogation of Mpox clade 1 on 1 March 2025 – no longer classed as a HCID</p> <p>Clinical teams have established the minimum number of staff to be trained in an outbreak response for HCID patient pathways</p> <p>New Laboratory Information System (LIMS) 'WinPath' for Microbiology and IPC implemented June 2025</p> <p>Carbapenemase producing Enterobacterales (CPE) national framework adopted at LTHT. Centre For Laboratory medicine established on St James's site to serve West Yorkshire incorporating new technologies</p> <p>Updated surveillance software installed. ICNET Phase 3 Surgical Module delivery. LIM and ICNET integrated to support Surgical site infection surveillance module</p> <p>HCAI reports generated weekly and circulated to clinical service units to monitor performance.</p> <p>IPC lead for surgery/anaesthesia appointed Dec 2023- this role to lead on improving infection prevention in pathways involving surgery and invasive devices.</p>	<p>Current number of staff trained in High Consequence Infectious Diseases (HCID) PPE would not support an outbreak response for mpox clade 1</p> <p>Reconfiguration of ICNET, required as part of WinPath implementation, resulted in a two-week period where the patient entry on PPM did not include a familiar IPC ICNET advice note for the clinical teams therefore they were unable to search for IPC entries.</p> <p>LTHT does not have a process for trust wide surgical site infection surveillance. Recent review of HCAI's in August indicates the requirement to have oversight and monitor SSI in LTHT will provide essential information to support clinical improvements.</p>	<p>CSU HCID staff training compliance is presented at OIPC gaps in training compliance still exist predominantly in E/D medical workforce. Escalation to DIPC, Medical IPC lead and chair of EPRR mutual aid to support a medical model of delivery being discussed with clinical director.</p> <p>IPC team phoned results and completed a direct advice note into PPM but it is likely that there were gaps. Ongoing review of admissions will monitor if there were any gaps during this period.</p> <p>Surgical site infection surveillance ICNET module went live in TRS (pilot area) In May 2025. TRS to present an update on mandatory surveillance at OIPC 8 October 2025</p>
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<p>Laboratory based ward surveillance process monitored by IPCT. Incident /Outbreak response triggered by surveillance process. Local outbreak management escalated to a Major Outbreak Control Group (MOCG) following further clinical case in January. Point prevalence screening completed; Ward closure, education campaign, peer daily ward assurance checks implemented as part of routine control measures.</p> <p>MOCG Stood down to local outbreak meeting on 5 March 2025. Admission, 10 day and discharge screening commenced on L35. Ongoing low-level transmission occurring</p> <p>Covid -19 testing and management incorporated into national respiratory guidance and National Infection Prevention and control manual (NIPCM)</p> <p>External audit of the HCAI performance data processes completed all recommendations adopted quarterly audit data compliant.</p>	<p>Transmission of vancomycin resistant enterococci within Trauma Related Services.</p> <p>Transmission of <i>Pseudomonas</i> in Adult Haematology</p>	<p>New cases of VRE screen positive patients identified on L34/35. L34 and L35 underwent full ward decant and HPV August 2025. Admission and discharge screening commenced on L34 to continue monitoring and oversight. Work is underway for TRS to lead a sustained AMS programme to reduce the risk of future antibiotic resistance.</p> <p>Rise in bloodstream infections among haematology and some oncology patients since April 2025. In response, an investigative outbreak control group was formed, leading to strengthened training on water-safe care, patient pathway assessments, and water testing. Despite extensive efforts, persistent infections continued, causing severe complications, extended hospital stays, and increased antibiotic use. A fatal case at Easter heightened concerns and led to the elevation of the outbreak to a major control level in June 2025. An external review has been commissioned commencing 17.10.25</p>
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<p>Training, Policies and Guidelines: Essential and Mandatory infection prevention and control training to all staff, with an overarching Infection Prevention and Control Policy and a suite of Guidelines and SOPs.</p> <p>Current national CPE guidance Implemented within Adults New National Carbapenemase Producing Enterobacteriaceae (CPE) guidance implemented in Leeds Children’s hospital</p> <p>Quality Improvement methodology adopted with a Trust wide HCAI collaborative and LIM.</p> <p>LTHT has implemented the National Infection Prevention and Control Manual (NIPCM) for England. National IPC Manual implemented plan re-aligned with HCAI Annual Commitment.</p>	<p>Current offer for Aseptic non touch technique (ANTT) training does not meet Trust requirements</p> <p>LTHT implemented the National Framework of Actions to contain CPE, but not in its entirety due to the significant financial and operational implications to the Trust. There is no formal mechanism for CPE surveillance.</p> <p>Gaps in Learning from HCAI Patient Safety Incident Response Framework</p> <p>Gaps in National Infection Prevention and Control Manual (NIPCM) for England understanding identified during HCAI PSIRF process</p>	<p>Trust review of Aseptic Non-Touch Technique training and implementation underway. Proposal presented at IPCSC in August- request for revision following consultation, paper to be presented at October IPCSC.</p> <p>Review of local and national learning completed August 2025 resulting in revision of CPE risk assessment - test of concept in 3 CSUs to commence W/C 29 September to understand the implications of the new changes on sampling and who we test. Further scoping is required to understand how CPE surveillance can be established.</p> <p>Dyad medical and nursing/AHP leadership model to be implemented in all CSU’s Relaunch of roles, responsibilities and process in autumn.</p> <p>Integration of NIPCM compliance into the new Trust Recognition of Innovation, Safe Care and Excellence (RISE) clinical accreditation programme for wards.</p>
<p>Environmental Controls: Environmental decontamination programme and standards, segregation and safe disposal of waste process, programme of water safety, ventilation safety and IPC design incorporated into refurbishments and new builds.</p> <p>NNU Major Outbreak Control closed. Oversight and scrutiny of interventions required to sustain control provided by CSU. Robust action plan implemented including programme</p>	<p>LGI NNU has experienced new outbreaks of infection related to practice and environment.</p>	<p>Water safe workstreams led by CSU in progress. Executive meeting on water safety held to agree immediate recommendations</p>

<p>of education completed, and routine monitoring of compliance is providing assurance.</p> <p>Refurbishment of NNU ahead of the planned BTLW agreed.</p> <p>Rapid action tender to scope building work commenced October 2023</p> <p>Formalised cot numbers produced.</p> <p>L43 Ventilation plant requires replacement as part of asset management. Progressing with capital funding assessment. March 2024.</p> <p>L43 NNU external visit by NHSE and UKHSA occurred 5 June 2024. Awaiting evaluation report.</p> <p>Trust Water Safety Plan</p> <p>Rolling programme of HPV decontamination instigated in response to the CPE outbreak in SIM. Outbreak is now closed, and a review is being undertaken to identify ways to support other CSU'S with a proactive HPV resource and incident response service.</p> <p>Continue to HPV infections of CDI & CPE, taking the opportunity to HPV all patient shared equipment where possible. HPV ongoing in Oncology CSU admissions ward.</p> <p>Rolling programme of HPV decontamination commenced where temporary access to vacant areas occurs.</p> <p>Hierarchy of controls completed by clinical teams which details controls, risks, and mitigations for Covid-19.</p> <p>All adult haematology en suite side rooms redesigned to reduce risk from water borne infection.</p>	<p>Trust wide roll out of water safety plan requires infrastructure investment</p> <p>Rolling programme of whole ward HPV decontamination paused as current decant facility is providing winter bed capacity.</p>	<p>following the national hospital build announcement. Clinical brief for water lite building work underway.</p> <p>A design pack being worked through with planning team to establish cost, completion date end of September with an onsite start date mid-October. Proposed date of early December for completion of works</p> <p>Resource provided for two High risk areas, LGI NNU, and Adult Critical care J53/54</p> <p>Trust wide rolling programme of HPV in response to incident management underway. Currently deployed in AMS and TRS. SIM funding a rolling HPV programme for CSU</p>
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<p>All patients in adult haematology receive written information about reducing risk of infection related to water hygiene and safety.</p> <p>Antimicrobial stewardship in adult haematology including weekly patient screening</p> <p>Active <i>Pseudomonas aeruginosa</i> surveillance in all augmented care is in place, and regular multi-disciplinary <i>Pseudomonas aeruginosa</i> risk assessments and evaluation of probable water-borne infection is occurring in all augmented care units at LTHT.</p> <p>A multidisciplinary task and finish group has been formed to deliver an assurance programme for the trust based on the learning in haematology.</p> <p>IPC involvement in design, refurbishment, and new builds. Live bed state test phase completed</p> <p>Side Room Management eForm designed to facilitate oversight and optimise isolation of infectious patients and clinically appropriate stepdown of side-room available Side room Management Eform report being generated to support CSU's to understand utilisation, compliance and improve patient flow.</p> <p>Side room capacity increased in ED, ARCU and Critical Care, with additional 12 side rooms across LGI, SJUH and CAH Feasibility study completed on the ability for 3 extra side rooms in Gledhow wing, namely J15,16 and J17 A further increase of 3 side rooms have been provided on J33 in December 2022.</p>	<p>Limited side room capacity in the unplanned pathway.</p>	<p>Live bed state side room delivery currently paused</p>
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<p>Capital planning programme for 2024/25 includes the redevelopment on J42/43. this would increase the number of side rooms within the Trust. Corporate planning review supports increasing side room capacity in Beckett Wing.</p> <p>Respiratory patient pathway areas reviewed to understand where further mechanical ventilation or increased side room capacity is required. Four working groups established, 1. Tactical operational response group, 2. Beckett Wing patient placements and Environment, 3. Multi Occupancy rooms for infections 4. Business Case development. Monitoring and oversight will occur through the OIPC group. Working group to review the estate, clinical requirements and ventilation capital investment formed. First meeting held September 8 2023. Risk matrix under development.</p> <p>A monthly Trust-wide ventilation safety group has been established from September 2021 to provide monitoring, oversight and assurance around our current ventilation and enhance the use of new technologies.</p> <p>Options appraisal identified opportunities to provide two Redi-rooms in Becket Wing to provide isolation with inbuilt mechanical ventilation.</p> <p>Portable air scrubbers provided following impact assessment by the clinical team and ventilation group.</p> <p>CSUs have completed a review of the hierarchy of control risk assessments to identify any gaps and mitigations, all</p>	<p>Large parts of the estate have natural ventilation only.</p>	<p>Newly developed clinical ventilation safety group where risk assessment occurs.</p>
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<p>estates gaps will be reviewed through the ventilation safety group.</p>		
<p>Detection: Monthly surveillance monitoring and assurance through monthly Perfect Ward meetings and additional hand hygiene audits and ward assurance visits.</p> <p>IPC Leadership team continued to review the HCAI performance at Trust CSU and ward level.</p> <p>Consultant Microbiologists provided ward and CSU level review and feedback.</p> <p>HCAI assurance monitoring through the Perfect Ward expanded to include all national HCAI objectives by January 2022.</p> <p>IQPR expanded to include all national HCAI objectives by January 2022.</p> <p>Infection reporting has now been amended so all Klebsiella species are reported.</p>	<p>NHS oversight framework has been released and LTHT is red for MRSA and amber for CDI and E. coli</p>	<p>Quarter 1 performance and July/ August position statement presented at QAC 21 August 2025, due to escalating position key areas supported:</p> <p>A strategic multi-disciplinary HCAI model to provide the architecture for teams to deliver the essentials of IPC and provide focus, oversight and assurance of HCAI through local governance structures.</p> <p>Further development of the Dyad model of IPC leadership at CSU level. CSUs accountability for HCAI PSIRF process to move to co-production of CSU-level action plans following identification of meaningful learning. (see training, policy and guideline section)</p> <p>Relaunch of the Essentials of IPC with oversight and monitoring through the Trust quality processes incorporating Harm Free Care dashboard and RISE ward accreditation process (see training, policy and guideline section)</p>
<p>Recovery and lessons Learned: Outbreak Management. Incident investigations. City wide Outbreak response group.</p> <p>CSUs manage individual HCAI case reviews, incidents, and Outbreak Meetings with support from Consultant Microbiologists, IPCT, Antimicrobial Pharmacists and DIPC/DDIPC.</p> <p>Successful recruitment to Microbiologist role. post holder commenced January 24</p>	<p>Feedback of lessons from HCAI incidents to clinicians is variable across LTHT, in some areas learning may not be shared effectively. Not all CSU's have a designated Consultant Microbiologist to support.</p>	<p>HCAI PSIRF process now live across the Trust in bed holding CSU'S.</p> <p>The Post Infection Proforma (PIP) remains as paper, current mitigation to upload paper copy of document onto PPM in place. This is impacting on the ability to rapidly review learning and identify themes. Request for work submitted to digitalise the post infection</p>

<p>Kaizen office supporting implementing PSIRF for HCAI. Rapid process Improvement Workshop 30 day report out March 2024, 60 day report out April, with planned phased roll out in Cardio-respiratory CSU.</p> <p>Trial areas increased to understand impact in other specialties. Oncology CSU and two wards within Adult Critical care participating with Abdominal Medicine and Surgery and Leeds Children's Hospital scheduled to participate mid July 2024. Trust wide participation from January 2025</p> <p>Development of CSU microbiologist role to include reporting of themes and trends from HCAI case reviews to CSU clinicians, reporting to IPCT to allow trust-wide learning-consultation completed implementation as part of annual commitment.</p> <p>Consultation between Medical IPC Lead, Clinical directors and medical directors to identify a process that will facilitate Consultants to participate in HCAI Patient Safety Incident reviews has been completed and process for clinical review agreed. The new process for clinical review included in the HCAI PSIRF CSU consultation October 2023</p> <p>DIPC requested a clinically led thematic review of HCAIs following an increase in cases in August to expedite learning. CSU thematic led review returns September 30, 2023. Review by DDIPC and Medical IPC Lead October-learning incorporated into the HCAI Annual Commitment report outs.</p>		<p>proforma-no progress to date. PPM report of PIP uploads being worked up – will identify CSU Compliance to support rapid review and early identification of themes. HCAI PSIRF Coaching clinics commenced September 2025</p> <p>Trust HCAI MDT review clinics commenced however theses are more established in PSIRF trial areas. Escalation process in place at HCAI group for those CSU's where clinics not yet developed.</p> <p>HCAI deteriorating position 2025/26, position paper presented to executives 28.7.25 and QAC 21.09.25. HCAI risks and meaningful learning to be integrated into the quality framework of the trust. key recommendations supported which include embedding PSIRF within quality structures, Trust wide vascular access device safety group established July 2025 and staphylococcus aureus decolonisation process to be supported by a fresh campaign October 2025.</p>
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<p>Revised and strengthened the IPC governance committee structure to enable the Trust to ensure monitoring and oversight occurs and assurance is reported and recorded through the appropriate IPC structure and integrated within the Trust Quality and Safety governance structure.</p>		
<p>Assurance: HCAI assurance is monitored through the Infection Prevention and Control Governance Structure.</p> <p>Latest BAF and Health and Social Care Act 2008: Code of Practice document for health and adult social care on the prevention and control of infections and related guidance published December 2022, changes incorporated into the IPC AP & BAF.</p> <p>Recruitment for Medical AMS lead role completed.</p> <p>Covid-19 assurance is monitored through the Trust OIPC group and IPC governance structure.</p> <p>Board oversight is provided through the Infection Prevention and Control Annual Programme and combined Board Assurance Framework, published by NHSE in May 2020.</p> <p>Cross-ref: CRR04- Integration of the IPC Annual programme and new Board Assurance Framework within the reset work streams completed, and CSU's are invited to provide an assessment of their position against the programme at the operational infection prevention and Control Group (OIPC) and HCAI group. Control now integrated into CRR01, and workstreams have now moved into transforming services workstream. CSU's presenting assurance to OIPC against the annual programme and BAF.</p>		

<p>Medical Workforce redesign completed. New Medical IPC Lead role appointed 1 September 2022. Review of current medical leadership to support the Medical IPC Lead completed recommendations adopted. Trust wide IPC Medical appointments made to AMS post September 2023 IPC Medical Anaesthetic and Surgical Lead December 2023 IPC Medical High Consequence Infectious Disease post February 2023 supporting wider IPC plan. Successful recruitment to Microbiologist role, December 2024. IPCN development plan in place. New JD to include AHP in approved. IPCT Successfully recruited too. Team now at full establishment</p>	<p>Consultant Virologist capacity limited- not all CSU's have a designated Consultant Microbiologist to support the HCAI reduction strategy</p>	<p>Review of virology IPC provision underway. Review of Microbiologist CSU alignment through workplan process.</p>
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CRR4: Emergency Care 95% Constitutional Standard	C = 4	20	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
	L = 5		1	2	3	4	5	6	8	9	10	12	15	16	20	25
									Target Score						Initial Score	Current Score
Risk Description: Failure to achieve the 95% 4 hour emergency care Constitutional Standard caused by increases in department attendances, insufficient rostered workforce to meet the needs of patients and long delays in patient placement into the hospital bed base. This can lead to a congested department resulting in patient harm, impacting on patient outcomes, patient experience, increased infection risk and staff morale.													Executive Lead: Chief Operating Officer			
													Date Added to CRR May 2014			
													Last Reviewed: August 2025			
													Next Review: December 2025			
													Committee reviewed at: Finance & Performance Committee			
Controls			Gaps in Control						Further Mitigating Actions:							
Daily management established including 8.30 am huddle, CSM status reviews and report and patient flow and discharge huddles, escalation meetings chaired by Director of Operations or Deputy Chief Nurse and silver meeting as required aligned to the operational response guidance in place. -There is a bronze and silver command escalation process both within LTHT and across the city system.			Sustained high numbers of patients within the bed base with no reason to reside impacting on hospital capacity and ability to place new patients who require an acute bed placement. This impacts on ED congestion.						Early identification of patients without a reason to reside in hospital and referral to the Transfer of Care hub for review of the patient’s on-going care needs. Daily report to system partners including pathway specific delays Early identification and escalation of patients awaiting repatriation to other hospitals and any patients awaiting transfer into LTHT. Escalation process ensures director presence at the 8.30 am huddle and escalation of patient delays to bronze and then tri team members as daily management. Summary operation centre email sent to CSU’s for organisational context and specific actions. When demand for inpatient beds outstrips capacity there is a suite of requested actions as per the Operational flow guidance document for standard work and certain pre agreed triggers.							

<p>Daily monitoring and reporting of 4-hour performance Implementation of the National OPEL with data feed to the RAIDR app for local and regional oversight of key ED pressures.</p>	<p>Timeliness of bed allocation by CSUs to ED National best performing quartile of hospitals delivers no more than 5.4% of patient in ED for longer than 12 hours. LTHT currently at 7.1%</p> <p>Absence of real time electronic bed state and real time bed and patient placement overview.</p> <p>Current process is 2 hourly safety rounds commence at 4 hours in department. Gap in control for frailer/ more vulnerable patients that may need safety rounds from arrival.</p> <p>Gap in control is the 2 hourly safety round compliance and 12 hours from decision to admit and 24 hours in department is not currently clinically reviewed outside the CSU.</p>	<p>The daily monitoring and RAIDR real time reporting enables real time responsiveness to developing delays across several urgent and emergency care areas. Weekly director review of ECS with a review of safe ,effective care and understanding enablers to timely care and alternatives to admission where appropriate. Tracking of OPEL and “Front Door” ED and ambulance waits using the RAIDR within the operational centre. Twice daily meetings held by the Urgent Care team to ensure capacity and demand met. Operational planning guidance trajectory to deliver 78% ECS by March 2026 submitted with workstreams and measures to enable delivery developed and is monitored through the CSU service delivery framework. Productivity and efficiency ED metrics being developed for June 2025 and wil be reported through the weekly Director Tri meeting. ED Patient 2 hourly safety rounds completed and recorded with assurance checks completed. Long waiting patients within the ED for more than 12 hours from bed request are escalated as per the patient flow guidance document. Daily, weekly and monthly report and review by Directors at weekly huddle. Patients over 24 hours in ED reported on the weekly Executive score card and through NHSE KLOE daily reports.</p>
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<p>Patients with mental health conditions with long waits for a mental health bed are flagged on the Daily Operation report within LTHT.</p> <p>There is an escalation process to LYPFT (mental health Trust) and ICB.</p>	<p>There is insufficient mental health inpatient bed capacity to meet demand.</p> <p>Limited impact from current escalation process.</p> <p>SOP for care of patients with mental health conditions to be developed which describes necessary clinical monitoring and actions required for maintenance of patient safety including escalation process for patient or staff safety concerns.</p>	<p>All patients awaiting over 24 hours in the ED will be reported on the NHSE KLOE for SCC engagement. Review of data and collective understanding of the patients presenting with MH related conditions in addition to patients requiring very specific mental health care has been reviewed and agreed.</p> <p>Established task and finish group established with LYPFT and CAMH's (Adult and children's mental health services) and police meets fortnightly to agree escalation process, build on collaborative working and expert input at the time of most value to the patient and future scoping collaborative offers to better meet the needs of this complex care group.</p> <p>SOP for care needs of patients with mental health conditions to be developed by July 2025 including escalation processes</p>
<p>Alternatives to ED attendance and patient streaming in place to most appropriate route via the Same Day Response city offer and streaming to GP, Minor injuries, Minor illness service and Same Day Emergency Care Units (SDEC).</p>	<p>Same Day Emergency Care Units at times of inpatient bed availability pressure have patients placed in them overnight which impacts on their ability to function as admission avoidance due to space and staff.</p>	<p>Continued monitoring of ED attendance profile.</p> <p>Launch of front door streaming for all patients who self-present to ED with a GP letter to appropriate SDEC/speciality to reduce non added value time a patient spends in ED</p> <p>Primary Care Access Line continues to work in collaboration with ambulance service to route where clinically appropriate direct to ED and/or to alternatives to ED.</p>

Business continuity plans in place for times of high acuity/ attendances to ensure safe patient placement when ED capacity is inadequate for demand.	The estate footprint constraints within EDs specifically lack of surge space at LGI adult and children's ED.	St James's ED has "yellow area" as a surge plan at times of pressure. LGI ED has the surge area for adults out of hours in radiology. Nurse and medical staffing reviewed to ensure patient safety and timeliness of care across a larger footprint. Agreed surge plans for extremis developed as part of a Decision Management Tool to space within or adjacent to the ED's Minor injury straight to test is routine practice to support rapid test and treat/decision
System Gold action plan developed through Active System Leadership Group.	Community capacity to support timely transfer of patients from acute bed base. Complexity of discharge pathways. Baseline of patients in the hospital bedbase that do not need to be in their remains at 12 to 15% of the total inpatient bedbase Measurable impact of system actions.	Implementation and monitoring against the key objectives through Active System Leadership Group and Active System Leadership Executive Group.
Seasonal reflections, learning for 2024/25 and planning with CSU's and system partners for 2025/26.	Unpredictable activity levels and demand.	Annual review of the operational response guidance and impact at CSU level is developed and monitored through daily operational processes. Overall impact is reviewed as part of the winter review process with learning taken forward to inform the next round of seasonal planning. System owned schemes monitored for implementation and impact at Active System leadership meetings. Modelling versus actuals is reviewed to enable responsive configuration of services, state of readiness and discussed pan city.

CRR5: 18-week RTT Constitutional Standard	C = 4	20	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
	L = 5								Target Score					Initial Score	Current Score	
Risk Description: There is a risk that the Trust will not deliver 18-week RTT constitutional standard as a result of waiting list growth and reduced levels of activity combined with referral growth in some areas, and reduced levels of productivity across some specialities in outpatients, diagnostics and theatres. This results in a poor experience for patients. There is a risk that some patients may experience harm, including deteriorating symptoms and condition and impacts on health and wellbeing while waiting for treatment. There is a reputational risk for the organisation and the risk of increased scrutiny and additional capacity being required at increased cost.													Executive Lead: Chief Operating Officer Date Added to CRR: May 2014 Last Reviewed: September 2025 Next Review: March 2026 Committee reviewed at: Finance & Performance Committee			
Controls						Gaps in Control				Further Mitigating Actions:						
The 2025/26 priorities and operational planning guidance requires NHS providers to achieve 5% improvements in RTT performance, 1 st OP waits, and less than 1% of the total waiting list to be over 52 weeks. The expectation is a return to full RTT delivery by the end of the current Parliament in 2029						ERF will be capped in 2025/26 with flat funding allocations for ICS. Some specialities are experiencing higher referral growth and will require significantly increased activity				Theatre, Diagnostic and Outpatient productivity schemes are well established and are increasing levels of productivity across pathways.						
Clinical validation of all follow-up patients waiting beyond anticipated review date requested to determine if patient suitable for discharge, conversion to PIFU, requiring of urgent review or able to wait. Robotic Process Automation (RPA) supports the administrative validation of the entire RTT waiting list and is further supported by targeted clinical validation						Validation does not deliver any additional capacity in areas where backlog continues to grow. Volume of patients means that capacity to undertake reviews is limited and may require cancellation of clinics				CSUs are working through PIFU protocols to support the validation outcomes and embedding wider PIFU options in specialities. This is further supported by. - the roll out of GIRFT: Further Faster handbooks across 15 specialties. - e-Outcomes - Reduction of low clinical outcome activity - Clinic Utilisation						

Implementation of telephone and video conferencing facilities have enabled non-face-to-face appointments to be delivered.	<p>Not suitable for patients where investigation or examination is required.</p> <p>Virtual activity does not clock stop as many patients RTT pathways as face-to-face activity.</p>	<p>Face to face activity is restored where clinically required. Alternatives to follow-up (PIFU) and remote monitoring of patients continue to be developed, but uptake is not as rapid as hoped.</p> <p>GIRFT Further Faster best practice shared with CSUs to maximise non face to face activity. Delivery to be reviewed through service delivery accountability meetings with Directors of Operations</p>
Triage of referrals enables identification of some patients at risk of harm if appointments are delayed.	<p>Quality of referrals from GPs can vary.</p> <p>Primary Care collective action may reduce uptake of Advice and Guidance</p>	<p>Delivering easier access to consultant opinion for GPs ahead of referral through enhanced advice and guidance systems</p> <p>Focus on improving Advice and Guidance. This is also included as part of our activity planning submission and the outpatient's productivity and efficiency PID for 2025/26.</p>
Delivery contracts have been revised to link to 2025/26 planning guidance to focus on key outcomes. 65-week & 52-week delivery trajectories agreed with each CSU-	<p>Demand variation from winter modelling / Covid modelling will impact elective delivery.</p> <p>Some specialties have larger waiting lists and / or more constrained capacity to deliver planning guidance requirements.</p>	<p>LTHT Winter Plan approved to manage capacity through anticipated spikes in non-elective demand and to protect elective capacity.</p> <p>Chief Operating Officer / Deputy Chief Operating Officer and Director of Operations meet with CSUs that are unable to meet agreed trajectory. Additional support identified and recovery actions agreed. In response to Elective Tier 1 scrutiny from NHSE additional recovery plans have been submitted by specialties with 52 week breach</p>

		risks and their actions are being through fortnightly review meetings held by the COO/DCOO and progress is reported to the Executive on a weekly basis.
Single points of access in some specialties will allow onward referral of routine activity to AQP's spreading burden across providers	AQPs will be subject to same restrictions on activity as LTHT.	Go live of CDCs (Community Diagnostic Centres) will increase funded capacity for some specialties particularly in imaging and physiological assessments/tests. Planned expansion of CDC capacity across 7 days
Effective advice and guidance can support primary care decision making and reduce unnecessary referrals	Absence of standardised system/approach to support the capture, recording and reporting of advice and guidance into EPR prevents roll-out to all specialties. Primary Care collective action may reduce uptake of Advice and Guidance	Standardised approach to receiving, recording and reporting advice and guidance in development.
Development of guidance and offer of support in development of patient initiated follow up (PIFU) pathways helps reduce unnecessary appointments in outpatients releasing capacity for other patients.	Some pathways require remote monitoring or use of apps - no current portal link to EPR.	GIRFT Further Faster best practice includes guidance on the use of PIFU which will support ongoing efforts to develop PIFU pathways.
Recovery plans allocate available theatre, critical care, ward and staff capacity to areas of greatest clinical risk.	Prioritises clinically more urgent patients and so does not improve RTT position. There is insufficient capacity in specialties that are prioritised to reduce risks: <ul style="list-style-type: none"> • Cardiac surgery 	Additional Business cases being developed to expand theatre capacity at the LGI within existing estate and into weekend working.

	<ul style="list-style-type: none"> • Max Facs surgery • Endocrine surgery • Neuro surgery • Plastic surgery • ENT surgery • Paediatric surgery <p>Delay of the BTLW programme reduces planned expansion of theatre capacity at the LGI</p>	
Use of Royal College guidance to prioritise elective activity to improve planning for capacity allocation to patients with greatest clinical need.	Prioritises clinically more urgent patients and so does not improve RTT position or reduction of longest waiting patients.	Patient safety, quality or governance risks are escalated through CSU Governance Meetings in line with Quality Governance Framework.
A process for undertaking harm reviews for any patient listed for treatment has been approved by QSAG. These reviews assess the likelihood of a patient suffering harm as a result of extended waits and prioritising treatment for any at increased risk. Reviews are to be repeated every 3 months for patients who have waited over 52 weeks.	The process approved is time consuming and requires forms to be completed manually and uploaded to PPM+.	
A process for the clinical and administrative review of P2 patients was approved by QAC in October 2023, as well as the process for monitoring compliance and risks via the creation of standard agenda item of P2s at Clinical governance meetings and speciality access meetings.	CSUs may not have the capacity to deliver the frequency of clinical validation required for P2 patients.	CSUs to create risk register entry for any specialty where they are unable to treat P2 patients within 28 days and their mitigations to patient harm. Now a standard item on CSU access meetings and clinical governance meetings
Established arrangements are in place to allow additional outpatient and inpatient activity to be scheduled outside normal working hours.	<p>Pension taxes had reduced number of additional sessions provided by consultant staff.</p> <p>BMA rate card has reduced the number of sessions provided by consultant staff</p>	Additional medical payments agreed to support additional activity specifically for treatment of long waiting patients

Use of Independent sector capacity.	<p>Independent Sector capacity has returned to business as usual with priority given to low complexity high tariff activity that doesn't necessarily support RTT performance in at risk specialities.</p> <p>There is currently minimal capacity for paediatric elective activity at tariff in the Independent Sector</p>	CSUs prioritising access to the Independent Sector to support most at risk specialities. The ICB has supported limited volumes of patients to IPT to the Independent Sector for non-admitted and admitted activity in Orthopaedics, General Surgery, , Plastics, , and ENT.
ICS Elective coordination group established to support regional recovery of admitted waiting list through a collaborative approach to increase elective capacity in low complexity / high volume specialties	Available WYAAT capacity is often at additional cost due to local provider payment mechanisms	Agreement that additional activity will be delivered and only material costs recovered.
Develop Elective hub at WDH to increase elective activity that can be delivered.	Re-allocation reduces capacity for other specialties.	Allocations linked to WL position as well as ability to treat P2 patients, and ability to utilise overnight stays so reducing demand on inpatient capacity at SJUH and LGI
Reallocation of elective theatre allocations to support specialties with capacity and demand mismatch		
Weekly collaborative critical care clinical prioritisation review by LGI and SJUH CSUs to support listing of clinically urgent patients and to match listed activity to anticipated capacity.	Critical Care capacity can change overnight due to staffing absence or high numbers of unplanned admissions and result in on day cancellations.	
The Planned Care Programme, and Outpatient P & T Programme within the Transforming Services Programme is focussed on workstreams that enable best use of resources, productivity, efficiency, and the optimisation of elective patients for surgery through a number of workstreams to keep increasing performance	<p>Impact of unplanned pressures on elective bed base</p> <p>Willingness of clinicians to do extra work due to pension / tax issues.</p>	Recognising the pressures on teams, and the pressures on the organisation, the improvement work through theatres has focussed on those areas less impacted by loss of elective beds.

against key KPIs such as utilisation / Day case rate / Elective LoS / Average Case per session / DNA/WNB rate / cancellation (patient and hospital) rates / first to follow up rate / advice and guidance provision	Capacity to focus on improvement work alongside operational pressures.	<p>A specific Theatre productivity and efficiency PID for 2025/26 developed to deliver an increase in list utilisation and cases per session by individual specialities and theatre suite.</p> <p>A specific Outpatients productivity and Transformation PID for 2025/26 developed to deliver increases in advice and guidance, clinic utilisation and activity (focusing on clearing the backlog and repurposing capacity to deliver more new outpatient appointments).</p> <p>These projects will report through the Waste Reduction Board chaired by the CEO and will increase the elective activity delivered by the Trust.</p> <p>Each project will reassess productivity expectations in line with required activity targets for delivery of RTT improvement requirements in 2025/26</p>
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CRR6: 2WW, 31 Day and 62-Day Cancer Constitutional Standard	C = 4	16	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
	L = 4		1	2	3	4	5	6	8	9	10	12	15	16	20	25
										Target Score					Current Score	Initial Score
Risk Description: There is a risk that the Trust will not meet the 28 day, 31 day and 62 day constitutional standards related to cancer diagnosis and treatment due to increasing referral rates from primary care, insufficient capacity that is not flexible to respond to peaks in demand, diagnostic pathways. This results in a poor patient experience. Some patients may experience harm, including deteriorating symptoms and condition and impacts on health and wellbeing while waiting for treatment. There is a reputational risk for the organisation and the risk of increased scrutiny and additional capacity being required at increased cost.													Executive Lead: Chief Operating Officer Date added to CRR: May 2014 Last Reviewed: July 2025 Next Review: December 2025 Committee reviewed at: Finance and Performance Committee			
Controls			Gaps in Control						Further Actions Planned:							
Operational plans to meet the waiting time standards set out in the NHS Constitution (2012), monitoring against the following standards: <ul style="list-style-type: none">28 day Faster Diagnosis Standard measures wait from receipt of an urgent referral for suspected cancer, receipt of urgent referral from a cancer screening programme, or receipt of urgent referral of any patient with breast symptoms (where cancer not suspected) to the date the patient is informed of a diagnosis or that cancer is ruled outA maximum 2-month (62-day) wait from receipt of an urgent GP (or other referrer) referral for urgent suspected cancer or breast symptomatic referral, or urgent screening referral, or consultant upgrade, to first definitive treatment of cancer			Variation in capacity requirement Demand control						Monthly accountability meetings with the COO and Deputy COO by Cancer Pathway. Task and finish groups looking at LIM work to streamline pathways. Reviewed PTL process implemented Pathology PTL in place, Radiology PTL to be introduced in June 2025							

The 2025/26 Cancer National Priorities and operational planning guidance to improve the 62 day position sets out a recovery of 75% by March '26 recognises that the delivery of 85% will not be achieved nationally.	85% of patients should receive their cancer treatment within 62 days.	Full organisational pathway management of cancer pathways with support from LIM Monthly accountability meetings with the COO and Deputy CoO to review all cancer pathways. Appointment of a MDOP for Cancer
The Trust has a Cancer operational policy in place which has been approved by the Trust Board.	None	Annual review in line with required updates
Cancer Strategy was launched in February 2024 which sets out ambitions for improvement of cancer services over the next 3 to 5 years.		Transformation of Cancer service for ongoing LIM and support work. CSU ownership through the 7 commitments and Gap analysis completed for Years 1 and 2 of the strategy – actions for gaps to be agreed at the Cancer Transformation Group
<p>Radiotherapy Task and Finish group established to review Capacity and Demand.</p> <p>Radiotherapy are now delivering within standard waiting times.</p> <p>Cat A referrals are currently being booked to start around 22-24 days from referral.</p> <p>Cat B referrals are being booked to start around 23-25 days from referral</p> <p>Cat C patients are currently starting 25-28 days from referral</p> <p>Cat D patients are currently being booked to start at day 26-29</p>	<p>-</p> <p>Business Case on Staffing review for phase of growth in service to maintain service delivery within turnaround times.</p>	<p>Radiotherapy continue to review their workforce and on going recruitment need for growth in service. Ensuring that there is a clear strategy.</p> <p>However, through on going review of pathways and recruitment success into the team the Linac utilisation is on average over 100% with additional sessions being delivered across weekends and is now within target.</p>

Pathology turn around times across cancer pathways	Turn around of samples within 7 days (Trust standard) is currently not achieving	<p>A Task and Finish Group has been established with a full review of workforce within the Lab. A LIMS review has been completed looking at the perfect week.</p> <p>A Business case for staffing has been approved and recruitment has started attracting 40 applicants for 4 posts.</p> <p>Benchmarking is being completed and the team have made contact with a number of pathology labs including Nottingham.</p> <p>The Alliance and Trust has supported funding for home stations to enable Pathologist to report from home, these are currently on order. Any new job adverts will include the provision of Home stations.</p> <p>Production board introduced into the Lab and weekly trajectory monitoring produced.</p> <p>Trajectories based on impact of appointment of new starters is being completed.</p> <p>Meetings with Clinical leads to review capacity and demand and develop ongoing solutions, alongside reviewing need to outsource.</p> <p>Visit to Cambridge is planned in June/July</p>
Recovery plan in place for the skin backlog position		<p>Skin backlog maintained at acceptable level currently although oversight maintained weekly at the PTL meeting</p>

MDT Review	Capacity within MDT due to volume of patients for review.	Review of all MDTs to ensure that they are in line with recommended standards, where a patient does not need to go through MDT this is clearly recorded and patient proceeds to treatment following a standard of care. This will ensure capacity is released for patient review offering more timely care
Breach review to be undertaken for all patients that breach 62 days Harm reviews undertaken for patients waiting longer than 104 days	Delays in treatment for patients waiting longer than national standard	Breach review learning completed, action plans in place for all pathways The RCAs are completed by the Corporate Cancer team but where there is suspicion of harm this is devolved to CSUs for review/assessment for greater learning and implementation of change. Process for harm assessment below 104 days to be agreed and implemented in the CSU's (led by Kelly Cohen)
The Trust maintains and publishes timed pathways, agreed with the local commissioners and any other Providers involved in the pathway, taking support from the WY&H Cancer Alliance for key areas	Referrals from other providers do not always occur in a timely manner to support delivery of 62 performance. LTHT capacity does not match the demand to deliver treatment within 62 days.	Maintain oversight at Cancer Centre Trust Board and report through IQPR. Weekly PTL meetings reviewing long waiting patients clear documented actions. Overview of tracking by CSU and cancer site of the total number of patients waiting throughout their pathway to ensure clear weekly understanding of the position and actions are being taken.
Delivery Contracts with CSUs have been updated in line with the 25/26 agreement and are reflected within the Service Delivery Meetings and Integrated Accountability Meetings		Recovery plans and trajectories are in place with joint accountability meetings across CSUs to reflect management of the full patient pathway
Appropriate management of cancer referrals	2ww referrals have continued to increase to higher levels than previously seen,	Cancer Escalation and Service delivery oversee the delivery of cancer waiting times, with

	causing increased activity and delivery challenges particularly in Breast (2 spikes), Skin, Colorectal and Head and Neck Late referrals from other organisations.	escalation as required to DOP's and GM's via email and Cancer Board
Weekly surgical/ HDU prioritisation processes continue to be in place, with additional operating accessed in the Independent sector where possible/ appropriate. Clinical triage process established and continues weekly for HDU/HOBS cases should any further surges result in the requirement to reduce/ suspend cancer surgical activity	Bed, theatre, HDU staffing and patient priorities not optimally aligned due to continuing acute bed pressures.	Teams to continue to access Independent Sector capacity and to use surgical prioritisation to support allocation of theatre capacity. Cancer surgical recovery requirement re backlog and routine run rate being refreshed and fed through Reviewed through the CSUs 6-4-2 process for booking of elective procedures Linking of Optimal Pathways transformational work with referring trusts work programmes to improve timely transfers.
Down time of Chemocare system presents risks to timely delivery of Chemotherapy services. A business continuity plan is in place and a recovery plan has been created to allow the service to return to normal delivery as soon as possible. No episodes of downtime exceeding 24 hours have occurred	Unplanned downtime of the Chemocare system presents a significant risk to both adult and paediatric chemotherapy services. This could result in disruption and the cancellation of patient treatments, less favourable patient outcomes and an adverse impact on cancer survivorship as well as reputational damage to the organisation.	A solution is in testing stage to reduce this risk further, awaiting final result.

CRR7: Failure to achieve 28 days cancelled operations Constitutional Standard	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: There is a risk that the Trust does not achieve the 28 day cancelled operations constitutional standard due to Industrial Action, 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. This may also lead to reputational consequences, increased scrutiny and increased costs to treat patients.													Executive Lead: Chief Operating Officer			
													Date added to CRR: May 2014			
													Last Reviewed: Sept 2025			
													Next Review: March 2026			
													Committee reviewed at: Finance and Performance Committee			
Controls			Gaps in Control						Further Mitigating Actions:							
To support elective recovery a programme of work led by the Medical Director of Operations and supported by the ADOPs for Planned and Cancer care was established in October 2020 to focus on increasing Critical Care, inpatient and day case capacity, and improving efficiency and patient experience within the elective pathway (Pre-op, Peri-op, and Post op), which will develop and strengthen the controls for CRRP 4. The projects include. British Association of Day case Project Enhanced Care Areas Theatre Productivity & Efficiency Pre-optimisation Development of elective hubs The programme reports monthly through the Theatre Productivity Board.			Focussed on transformation programmes and long-term developments. Impact of unplanned pressures on elective bed base. Frequency of cancelled operations on the day for avoidable reasons and minimising the rate of on day cancellation as much as possible.						Service Delivery Framework and Integrated Accountability Meetings used to support the daily management of CSU KPIs and delivery of the 28-day constitutional target for CSUs.							

<p>Addressing the avoidable reasons for cancelled operations to reduce the number of last minute cancelled operations which are then subject to the 28 day constitutional standard which are, in order or volume:</p> <ul style="list-style-type: none"> - Patient unfit for surgery - Did not attend/was not brought - Cancelled by patient - Operator led change in management plan - Procedure not required - Patient requires further investigations 	<p>Gaps in scheduling, planning and communication processes all contribute to the volume of operations cancelled on the day including:</p> <ul style="list-style-type: none"> - Pre-assessment processes - Providing patients reasonable notice - Reminder/confirmation processes - Adherence to 6-4-2 - Surgical and anaesthetic review of operating lists 	<p>Regular audit and review of cancelled operations. Reset of pre-assessment services to ensure patients are comprehensively reviewed and confirmed fit for surgery. Standardised procedure for the confirmation and reminder services provided to patients about their surgery and surgical dates. Process of surgical and anaesthetic lockdown, in line with 6-4-2, of agreed operating lists prior to day of surgery. Implementation of GIRFT standards and best practice guidance in relation to the above.</p>
<p>Prompt starts for all elective theatre lists to automatically send for patients requiring inpatient or day case capacity. All ACC SJUH patients are automatically sent to theatre and Priority 1-4 patients at LGI are automatically sent to theatre</p>	<p>Co-ordination of theatre/ ward and critical care capacity does not always align leading to greater risk of cancellations.</p> <p>Not all Critical Care patients can be automatically sent for</p>	<p>Daily circulation of planned TCIs and previous cancellation status the day prior to surgery</p>
<p>All CSUs have weekly access meetings to identify available theatre capacity for additional sessions, manage risks and review cancellations and discharge and theatres KPI's using the LTHT scheduling tool.</p> <p>Collaborative CSU process to 'book' patients into an admission area by appointment and lock down of list order to improve patient flow and reduce risk of late starts and subsequent on day patient cancellations.</p> <p>Daily email prompt to CSUs highlighting their 28-day breach risks.</p> <p>G Drive report available to CSUs detailing all LMCO and patients who are booked with 28 days, patients who are</p>	<p>Critical Care capacity can change overnight due to staffing absence or high numbers of unplanned admissions and result in on day cancellations</p>	

<p>undated and at risk of breaching 28 days and those who have been dated outside of 28 days.</p> <p>Weekly collaborative critical care clinical prioritisation review by LGI and SJUH CSUs to support listing of clinically urgent patients and to match listed activity to anticipated capacity.</p> <p>LTHT scheduling tool has been updated with the 'Monte Carlo' simulation to improve scheduling accuracy and theatre efficiency.</p>		
<p>Multidisciplinary BADs Day case project identifying CSUs and individual procedures through PLICS and Model Hospital that could be treated as day case to reduce need for IP beds and risk of cancellation.</p> <p>Use of Independent sector to increase available capacity and treatment options for patients.</p> <p>Monthly focus on 6-4-2 process and Specialty level performance within Theatre Board.</p>	<p>Theatre staff and surgeons are not always available to undertake additional activity in response to peaks in demand.</p> <p>Independent sector contract restricts type of patient able to be transferred for treatment.</p>	<p>Planned Care Dashboard developed to highlight BADs / Day case opportunity by procedure.</p> <p>WDH theatre expansion completed and now operational.</p> <p>GIRFT project embedded in Theatre efficiency project to ensure appropriate patient pathway is followed.</p>

CRRC9: Failure to achieve 6 weeks diagnostics test Constitutional Standard	C = 4	16	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
	L = 4		1	2	3	4	5	6	8	9	10	12	15	16	20	25
										Target Score					Initial Score & Current Score	
Risk Description: There is a risk that the Trust does not achieve the 6 weeks diagnostics test constitutional standard for the defined basket of 15 tests due to capacity constraints from increasing demand and workforce challenges plus the need to recover a backlog generated during the covid-19 pandemic and several periods of industrial action. Delays in achieving the diagnostics tests waiting times may have an impact on patient safety, experience and outcomes, resulting in harm.													Executive Lead: Chief Operating Officer Date Added to CRR: May 2014 Last Reviewed: August 2025 Next Review: January 2026 Committee reviewed at: Finance & Performance Committee			
Controls			Gaps in Control						Further Actions Planned:							
Weekly review of current diagnostic operational pressures at service delivery meeting chaired by Corporate Directors of Operations and Deputy COO. The purpose of this meeting is to identify current delivery of standard, identify key actions to recover deteriorating positions. Actions are monitored by an action tracker. Attendance at weekly Access meetings by Performance team and daily checks on patient bookings and risks to performance			Paediatric Anaesthetic capacity remains challenging impacting on the availability to deliver paediatric diagnostics through theatres. Ultrasound recruitment and additional payment are in place, lack of applicants to new roles. Limitations in skill sets of independent sector and insourced Sonographers.						Continuation of weekly review of operational status - shortfalls to be flagged as soon as possible to facilitate additional capacity/actions to mitigate. Targeted work required between CSUs to manage competing demands for paediatrics to reduce long waiters (i.e. patients waiting >13 weeks) and sustain delivery. Paediatric Endoscopy proposals to improve productivity through sessions have been developed and implemented. Paediatric Endoscopy proposals to use mutual aid theatre capacity provided by Hull. To start in September (LTHT clinicians).							

		<p>Development of a demand modelling tool, understand future clinic templates, estimated conversion from clinic to diagnostic test enabling diagnostic services to respond effectively in advance.</p> <p>Ultrasound are inducting staff from Insourcing company over the next few months with a view creating additional Sonographer capacity at the weekend to support reducing the backlog of waits</p>
To support operational pressures across the organisation, diagnostic inpatient activity will continue to be prioritised. This is managed through daily operational responses facilitated by LHTTs Operations Centre with escalation processes in place for inpatient diagnostics.	Lack of visibility of status of Inpatient requests and investigations due to patients level information being held and booked on several different systems (ICE, PPM, CRIS, TMS)	<p>Request for work submitted to PPM Prioritisation group (DiT) to create a diagnostics visibility column on PPM.</p> <p>Implementation of production boards across diagnostic services with weekly standups to be maintained</p> <p>Review of Radiology consultant workforce on going to ensure resilience to manage fluctuations in demand.</p>
Clinical escalation pathways are in place for urgent diagnostic requests where clinical need requires prioritisation. Within Radiology the on-call clinical teams receive escalations from in- and out-patient settings, and these diagnostics are prioritised according to clinical need. For routine requests, the Radiology CSU has implemented a # alert system for	There is a lack of visibility of the status of routine diagnostic requests for outpatients, which limits the ability to identify harm until a patient review has occurred or a result has become available.	Develop process for clinical validation of non-admitted diagnostic breaches to identify patients at risk of harm from a delay

urgent or actionable results, which ensures that a clinical review is prioritised once the result is available. Where delays to diagnostics have resulted in an adverse outcome, this is recorded via DATIX and managed via CSU and Trust governance structures.		
<p>Monthly Diagnostic recovery escalation meeting has been established in December 2024 for CSUs to discuss their recovery plans and trajectories.</p> <p>Template packs have been provided to CSUs for completion of actions to recovery their diagnostic position.</p> <p>CSUs to be asked to attend by exception</p>	<p>In month increases in demand or acute staffing problems are unpredictable and may cause deterioration in position.</p> <p>Risk of lost capacity due to industrial action.</p>	<p>Recovery trajectories with clear action plans for delivery of the national standards are being developed or are in place. Options being explored to mitigate shortfalls in capacity. CDC activity included in SDAM packs for each CSU providing diagnostics activity for each CDC site to ensure maximising capacity.</p>
To Ensure we have a sufficiently trained workforce available to meet the demands of our patients	<p>A number of diagnostic services report workforce challenges. Including loss of specialist staff to the private sector, and increase non availability due to long term and short term sickness and Maternity leave.</p> <p>Not all CSUs have completed workforce plans for growth in service demand.</p> <p>Modelling out of workforce plans for diagnostic services in line with 25/26 activity growth from CSU requiring use of diagnostics.</p>	<p>Trajectories developed detailing mitigating actions and additional workforce need to mitigate gaps in establishments. Monitoring through SDAMs and Monthly escalation meetings.</p> <p>Continued review of further Insourcing and outsourcing opportunities across Radiology.</p>
Equipment replacement programmes and maintenance.	<p>Funding availability to replace equipment or gain additional equipment for continuation of provision of service.</p> <p>Breakdown of equipment requiring the cancellation of patients.</p>	<p>MRI capacity and demand reviews underway to mitigate the loss of the mobile scanner.</p> <p>MRI relocatable modular unit approval to accommodate demand for current year</p>

		<p>Capital bid developed for potential funding available for CDC MRI scanner.</p> <p>Continued review of Insourcing and outsourcing opportunities across Radiology.</p> <p>Managing conversations with contract providers of equipment to ensure responsive turnaround time for repairs.</p>
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CRRC10: High occupancy levels and insufficient capacity and flow across the health and Social care system causing impact on patient safety, outcomes and experience	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	
Risk Description: There is a risk to maintaining sufficient capacity to meet the needs of patients attending and being admitted for planned/elective care and unplanned (acute) care caused by demand being greater than the available hospital capacity. Current planning guidance describes occupancy should be at 92% or below (85% is generally accepted as being required for efficient flow). Efficiency of patient flow and placement, due to periods of high occupancy, impact on patient safety, outcomes and experience. Patient harms in A&E for patients waiting for long periods for inpatient placement is specifically referenced in risk CRRC4. There is also a risk to the delivery of constitutional standards, impacting on the Trust’s delivery and efficiency ratings and reputation. Cross-referenced to Corporate risks CRRC4, CRRC5, CRRC6, CRRC7, CRRC8, CRRC9, CRRC11 .												Executive Lead: Chief Operating Officer Date Added to CRR: September 2015 Last Reviewed: September 2025 Next Review: March 2026 Committee reviewed at: Finance & Performance Committee				
Controls			Gaps in Control						Further Mitigating Actions:							
Operational: Established Operations Centre with 24/7 clinical site manager’s oversight to maximise capacity use and support patient flow and best patient placement. Weekend on-call team are briefed every Friday with the plan to meet expected demand. Daily operational huddles at 08:30 to assess site-specific pressures and mitigate any safety concerns, led by Directors of Operations and Deputy Chief Nurses with clinical support from site managers.			Fully operationally implemented Live bed state not in place – limited real time admission and discharge data to support understanding of all available capacity. Patient flow and discharge co-ordinators hosted by CSU’s. Devolved model does not enable standard work and maximum efficiency not currently met- plan for a central model in progress						Review of Live bed state development in progress. Team of Patient flow co-ordinators and discharge co-ordinators across the organisation with three daily capacity huddles established to monitor admission and discharges throughout the 24- hour period. Roles and responsibilities outlined to improve consistency in working practice. Discharge lead nurse appointed to work with and provide support to discharge coordinators. Tracking of DMT actions taken at times of pressure and recorded for theming.							

<p>Operational Response guidance and process with identified escalation levels including daily battle rhythm, standard work for silver status and a separate Decision Management Tool for adults, children's services and infection prevention and control.</p> <p>Agreed Full Capacity Protocols (FPC) for surge and Temporary Escalation Spaces (TES)-implementation capture and assurance process measures. <u>This includes utilisation of the Temporary Escalation Spaces (TES) plan.</u></p> <p>Bed modelling analysis to identify expected activity surges based on public health intelligence for COVID, Flu, RSV and Norovirus with a planned local and system response</p> <p>Management of long length of stay patients</p>	<p>Insufficient space and staff to meet expected surges if inpatient numbers increase above expected population growth.</p> <p>There is a city trajectory to reduce the number of inpatients with No Criteria to reside in hospital to less than 160 in July- trajectory not met.</p> <p>Some areas identified for FCP include day rooms on our no criteria to reside wards which will not allow for use of day rooms by other patients. This may increase risk of deconditioning and have an impact on the patient experience on those ward areas at times of pressure.</p>	<p>Weekly report to Trust Quality meeting to understand the frequency of use of TES and safety checks. Monthly report provided to the Quality & Safety Assurance Group (QSAG). Review of TES areas undertaken by Chief nurse in Spring 2025 and minor amendments to spaces allocated made. TES spaces in ED identified and occupancy of these reported daily. SOP for the management of patients in TES in place. Incident reports via Datix reviewed weekly to monitor harms and reported through weekly quality meeting. Full Capacity Plan and exclusion criteria updated to mitigate the risk of harm to patients placed in TES.</p> <p>Additional 3 wards currently open in LTHT to meet the need of patients no longer requiring hospital in patient care. With seasonal plans to meet additional demand.</p> <p>Structure established to ensure a weekly review of the longest waiting patients with no criteria to reside to ensure timely escalation of patients and to identify suitable alternative pathways that will result in earlier discharge.</p>
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<p>Protected elective capacity at SJUH, CAH and Wharfedale Hospitals to support elective (planned patient) capacity</p> <p>All patients on an active elective waiting list receive regular correspondence from the Trust advising them that they are still on a waiting list, and what to do / who to contact if their condition has changed etc</p>	<p>Overall patient experience and potential for patient harm impacted by use of TES beds</p> <p>Continue with high numbers of inpatients with over 21 days length of inpatient stay for both reason and no Reason to Reside patients within hospital bed base.</p> <p>Dr Foster data set identifies further opportunity for length of stay reduction</p>	<p>All patients on an admitted pathway are given a clinical prioritisation status at the point of decision to admit reflecting the expected treatment timeframe and to balance the TCI of patients by clinical priority alongside longer waiting patients. Where those patients are waiting longer than the expected treatment, these patients are reviewed by the clinical and administrative teams to ensure the clinical prioritisation status is accurate, and to escalate patients to be seen more urgently if required.</p>
<p>Tactical:</p> <p>Alternatives to admission-</p> <p>Established Same Day Emergency Care unit 7 days per week</p>	<p>SDEC's across the organisation will host overnight inpatients when the organisation is under significant pressure and demand outstrips capacity.</p>	<p>Medical and elderly SDEC established alongside the SJUH Emergency Department with a focus on increasing admission avoidance and early senior decision making for patients is established This SDEC includes overnight stay for patients who do not need to be admitted but need a short period of observation or treatment through the night. LGI multi- speciality SDEC and enhancement of MSSA unity change from September 2024 continues to be embedded.</p>

<p>Primary Care Access Line receives calls for primary care colleagues, GPs and ambulance services to navigate as clinically appropriate away from ED and admissions to a series of rapid access clinics, specialist advice of a consultant, SDEC or assessment area - Nationally recognised for its success</p> <p>Developed Virtual Ward for respiratory and frailer adults to support early discharge and alternative care for lower acuity admissions</p>	<p>City funding to be established to continue this service.</p>	<p>Review of a Single Point of Access across the city continues to explore a consistent approach for YAS to route to alternatives to admission and patient in right place, right speciality first time.</p> <p>Home telemetry ward developed and delivered by LTHT is evidencing reducing number of bed days for patients on pre agreed pathways</p>
<p>Strategic:</p> <p>Established Leeds urgent community response group with delivery of 2-hour community response 8am till 8pm to avoid ED and admission conveyance.</p> <p>Intermediate Care redesign (called Home First 2 programme) collectively understood with a programme Board and reporting structure. The success of this will reduce length of inpatient stay and number of patients with no criteria to reside in the hospital setting.</p>	<p>National requirement for 24/7 offer not currently delivered.</p> <p>HomeFirst1 programme did not deliver to agreed trajectory of no more than 160 no reason to reside inpatients by July 2025. New trajectory was set but currently over this amended trajectory.</p>	<p>HomeFirst had resulted in a reduction in the number of inpatients without a criteria to reside compared with the previous financial year.</p> <p>Across the city system a reduction in length of hospital inpatient stay has been evidenced through use of a city discharge case manager role. System visibility data set achieved-shared understanding of capacity and impact of changes.</p>

CRRF1: Failure to deliver the financial plan for 2025/26	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
Risk Description: There is a risk that the Trust does not achieve its planned control total in 2025/26. This would have the following impacts: <ul style="list-style-type: none">Reducing the internal funding for the Trust’s ambitious Five-Year Capital programme, leading to:<ul style="list-style-type: none">Limiting the capital programme/not replacing equipmentRelying on external sources of fundingCash shortfall and risk to supplier payment.Potential non-compliance with new medical devices regulation (Regulation EU 2017/45)Reputational damage, as the Trust fails to deliver on a key statutory duty.Potential to cause the Integrated Care System to miss its overall control total													Executive Lead: Director of Finance			
													Date added to CRR: November 2020			
													Last reviewed: November 2025			
													Next Review: February 2026			
													Committee reviewed at: Finance and Performance Committee			
Controls			Gaps in Control						Further Mitigating Actions							
Yearly Board approved five-year plan. The Board agree the Five-Year plan, including Income and Expenditure position and Five-Year Capital Plan. The Board are sighted on risks to delivery of the plan through a risk range and executive agreed mitigation plans			<ul style="list-style-type: none">National Variable Payment System (Payment by Results).No reason to reside issue is not resolved.Restrictions on capital allocation due to funding formula.						<ul style="list-style-type: none">Capital Planning Group puts increasing focus through the year on strength of programme managers forecasts and ability to complete. Confidence levels and risks are specifically addressed.Executive review of Backlog work. Development of an in-house mitigation plan.Detailed review of underlying cost base and associated savings plans.Regular updates to the Executive Team and Finance and Performance Committee including Exec lead on financial risk and associated mitigations.Regular communication with ICS to assess and mitigate risks							

Annual Financial Plan covering Income and Expenditure, Capital and Cash implications is signed off by the Board. In addition to this the Finance and Performance Committee are sighted on the progress of the overall financial plan and detailed delivery of the Waste Reduction plan.	None	<ul style="list-style-type: none"> Regular updates to the Executive Team and Finance and Performance Committee including Exec lead financial mitigations. Regular communication with NHSE to identify and adapt to changes.
Quarterly Fundamental Review of the Trusts Financial Position to Finance and Performance Committee setting out the risk range of the in-year financial position and executive owned mitigations		<ul style="list-style-type: none"> Development of in-house mitigation plan Detailed review of underlying cost base and associated savings plans. Regular updates to the Executive Team and Finance and Performance Committee including Exec lead financial mitigations
Weekly reporting of the Waste Reduction position CSU to the Director and Deputy Director of Finance which in turn feed into Finance Performance Framework CSU meetings, and Financial Improvement Board, chaired by the Trust CEO	Waste reduction is not delivered in full	<ul style="list-style-type: none"> Development of in-house mitigation plan Executive leadership of all programmes Regular meetings with the PMO to assess risks to the programme
CSU ownership of realistic control targets and run rate-based forecasts linked to the Integrated Accountability Framework.	Unplanned essential expenditure pressures arising in-year	<ul style="list-style-type: none"> Development of in-house mitigation plan Regular updates to the Finance Improvement Board, Executive Team and Finance and Performance Committee including Exec led financial mitigations Support to be sought from external parties where appropriate (eg funding for mutual aid)
Operation of the financial performance framework with: <ul style="list-style-type: none"> Monthly Clinical Director signed off forecasts and a RAG rating against CSU agreed Control Totals Escalation meetings with Director of Finance and Deputy Director of Finance for RED rated CSUs Finance Improvement Board, including the Chief Executive and other Executive Directors, for 	None	<ul style="list-style-type: none"> Regular updates to the Executive Team and Finance and Performance Committee including Exec led financial mitigations. Further escalation of underperforming CSUs to Exec-led intervention

oversight of the delivery of the financial plan including waste reduction		
Contracts for income agreed in line with current NHS payment mechanism.	<p>National Variable Payment System (Payment by Results).</p> <p>The cultural shift required moving from the Aligned Incentive Payment system to Variable Payment System (PbR).</p> <p>Insufficient capacity in the coding team impacting on the implementation of PbR.</p> <p>Impact of organisational change at NHS E and ICB.</p> <p>Awareness and understanding of the financial impact of changes in funding and delivering required operational performance in a fixed ERF envelope.</p>	<ul style="list-style-type: none"> • Regular meetings with commissioners and attendance at all ICS finance forums • Regular communication with NHSE to identify and adapt to changes. • Senior team seeking to influence payment mechanism changes • Significant improvement in counting & coding delivered in 24/25. Strategic group has been established in the Trust to support the move to PbR. • Application of Leeds Improvement Methodology to enhance processes and capacity. • CSUs activity and performance is reported to and monitored by the Finance & Performance Committee and the Board.
Implementation of Finance the Leeds Way Improvement Plan	None	<ul style="list-style-type: none"> • Working with other Trusts to identify, share and implement good practice. • Use of the NHSE Improvement and Intervention checklist to ensure good quality controls are in place across the Trust.
Emergency cash funding available to meet payment obligations or unforeseen capital emergencies through NHSE bidding process	This is a bidding process and not all requests will be supported	Discussion with and support from other Trusts who have already had to access emergency cash.
Progress against the five-year capital plan is overseen by the Capital Planning Group including specific prioritisation for the MSE, BME and DIT programmes.	None	CPG puts increasing focus through the year on strength of programme managers forecasts and ability to complete. Confidence levels and risks are specifically addressed

Capital programme - priority bidding process for clinical services/specialty teams overseen by Head of Medical Physics & Engineering and Deputy Chief Medical Officer/Medical Director (Operations).	None.	Any unforeseen equipment failure would lead to immediate re-assessment of current year spending priorities with a view to substitution
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CRRF2: Insufficient operational capital allocations	C = 4	20	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
	L = 5		1	2	3	4	5	6	8	9	10	12	15	16	20	25
						Target score									Initial & current score	
Risk Description: Operational capital allocations to address the Trust's capital risks are insufficient to meet expected programme plans for the current and future years. This will have the following impacts: <ul style="list-style-type: none"> Reducing the internal funding for the Trust's ambitious Five-Year Capital programme, leading to: <ul style="list-style-type: none"> Limiting the capital programme / not replacing equipment / not replacing Estates assets / not replacing Digital assets Greater reliance on external sources of funding Potential non-compliance with regulatory requirements Increased clinical risk due to inability to replace capital assets within agreed replacement schedules, address critical maintenance backlogs, and invest in infrastructure across the capital programmes. Inability to invest in required strategic developments to support clinical services either in development or in improving productivity. Reputational damage, as the Trust fails to invest in equipment, estate and digital infrastructure to support service development. 												Executive Lead: Director of Finance Date added to CRR: May 2023 Last reviewed: August 2025 Next Review: February 2026 Committee reviewed at: Finance and Performance Committee				
Controls						Gaps in Control						Further Mitigating Actions				
Monthly ICB Capital Working Group and ICB Director of Finance meetings to review risks and opportunities at an ICB level as well as discussing priorities and impact on individual Trusts of decision making.						<ul style="list-style-type: none"> Other ICB Trusts show a preference towards top slicing the ICB allocation for specific pressures reducing operational capital budgets for all Trusts Reduction in CDEL allocation to ICB – 2025/26 allocation has reduced by c8%. 						<ul style="list-style-type: none"> Regular updates provided to Director of Finance immediately following the meeting Regular updates provided to Capital Planning Group and any necessary escalations to Finance and Performance Committee. 				
The Trust is developing a risk-based approach to the prioritisation of internal capital funding via the annual refresh of the five-year capital plan. Progress against the five-year plan is overseen by the Capital Planning Group						<ul style="list-style-type: none"> Capital need is not highlighted by CSUs or services and not reported on via the Trust risk framework. 						<ul style="list-style-type: none"> CPG puts increasing focus through the year on strength of programme managers forecasts and ability to complete. 				

including specific prioritisation for the MSE, BME and DIT programmes.	<ul style="list-style-type: none"> • Service risk associated with capital asks is not shared sufficiently with capital programme leads • Risk appetite framework is not fully embedded for the capital programme. 	<ul style="list-style-type: none"> • Confidence levels and risks are specifically addressed. • Capital programme leads are supported by a nominated executive director to ensure that capital programmes are aligned to organisational priorities. • Training on application of the risk appetite framework for capital schemes is in progress. • CSUs encouraged to report risks relating to capital programmes. • Capital programme reported to and discussed with General Managers' meeting every six months • Capital risks discussed at Risk Management Committee, Financial & Performance Committee and Capital Planning Group.
Development of in-house mitigation plan allows for the Trust to respond to changes in funding allocations or utilise slippage in other Trusts.	<ul style="list-style-type: none"> • Restrictions on capital allocation due to funding formula – 25/26 CDEL limit for ICB has reduced by c8% • Restrictions on capital allocation due to decision on New Hospitals Programme funding with delay till 2031. • Capital funding availability may not match the Trust's capital priorities. 	<ul style="list-style-type: none"> • Capital Planning Group puts increasing focus through the year on strength of programme managers forecasts and ability to complete and flex programmes where necessary. Confidence levels and risks are specifically addressed. • Regular updates to Finance and Performance Committee including Exec lead on financial risk and associated mitigations • Regular communication with ICB to assess and mitigate risks • Regular communications with New Hospitals Programme to assess and mitigate risks • Programme leads have developed contingency schemes to utilise any

		additional capital availability on a risk-based approach.
External funding opportunities monitored closely with bid and applications submitted wherever possible	<ul style="list-style-type: none"> • Constrained by available opportunities and timing of funding availability • Bids and applications not always successful • Capital funding availability may not match the Trust's priorities 	<ul style="list-style-type: none"> • Capital Planning Group regularly discuss opportunities to maximise external funding opportunities. • Programme leads have developed contingency schemes to utilise any additional capital availability on a risk-based approach.
The in-year and 5-year Capital programmes are developed based on funding availability, including external, operational capital allocation and internal funding.	<ul style="list-style-type: none"> • Revenue pressures can affect the availability of cash to support the internal financing of capital schemes. • Uncertainty of future capital funding to support multi-year schemes. • Application of funding has been impacted with accounting standard changes – leases now included in CDEL. 	<ul style="list-style-type: none"> • Cash management is in place with the cashflow forecast reported to the Finance & Performance Committee. • The cash risk is reported and monitored at Risk Management Committee and Finance & Performance Committee. • Capital allocations are raised with the ICB Capital Working Group and NHS England. • Work ongoing to understand the requirement and timing of leases, with working groups established to look at alternative models for investment. • Awareness raised in CSUs of the funding availability
Careful consideration of the application of accounting rules to the definition of capital spend vs revenue spend	<ul style="list-style-type: none"> • Availability of capital and revenue allocations impacts on the affordability of operational capital investment. 	<ul style="list-style-type: none"> • Quarterly reviews of historic and future revenue and capital allocation, to assess compliance with appropriate accounting policies.

CRRE1: CQC Registration – breaches of Regulation(s) Maternity and Neonatal Services	C = 4	16	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
	L = 4		1	2	3	4	5	6	8	9	10	12	15	16	20	25
									Target Score				Initial Score		Current Score	
Risk Description: There is a risk to the Trust’s conditions of registration with the Care Quality Commission (CQC) due to Warning Notice under Section 29A of the Health and Social Care Act 2008 (maternity staffing), breaches of Regulations and failure to meet the fundamental standards under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) (as amended): Regulation 12 Safe care and Treatment Regulation 15 Premises and Equipment Regulation 17 Good Governance Regulation 18 Staffing This may impact on the provision of safe care to patients in maternity and neonatal SERVICES, confidence and experience of people who use these services, reputation, and capacity to respond to the regulatory requirements and scrutiny.													Executive Lead: Chief Nurse			
													Date added to CRR: July 2025 Last reviewed: November 2025 Next Review: December 2025 Next Full Review: January 2026			
													Committee reviewed at: Quality Assurance Committee			
Controls			Gaps in Control						Further Mitigating Actions							
Regulation 12 Safe Care and Treatment Programme of engagement with people and families who use maternity and neonatal services. Engagement event 1 September 2025. Trauma informed workshop provided in June 25 for 40 clinical staff (maternity services). Being a Trauma Informed Organisation session provided at Trust Board time-out on 26 June 2025.			Staff not experienced in managing trauma informed conversations with people and families who use maternity and neonatal services.						Further support and training plan to be provided by MSSP.							
Regulation 12 Safe Care and Treatment Programme of listening events with staff. Staff surveys. Civility culture workshops for staff.			Capacity of maternity and neonatal senior leadership team to host listening events with staff.						Bi-weekly virtual briefing events established and to be led by the CSU Quad team, supported by DOP and Execs. Additional senior leadership support provided to CSU, including Director of Operations (Corporate Operations) and Lead Nurse (Corporate Nursing).							
Regulation 12 Safe Care and Treatment Standard Operating Procedure – neonatal designation and escalation. Monthly report to Chief Medical Officer and Chief Nurse, submitted to CQC.									Maternity Escalation Policy developed Maternity Escalation Policy and Operational Pressures Escalation Levels Framework							

Monthly HRG report reviewed at NHSE Quality Improvement Group (QIG).		
Regulation 12 Safe Care and Treatment Trust participation in national rapid maternity investigation, announced by Health Secretary in June 2025, to examine 14 NHS Trusts to identify key priorities and recommend one set of national actions to improve safety and quality across all maternity and neonatal services in England. Report to be published December 2025.	Capacity of maternity and neonatal senior leadership team to participate in national review.	Capacity and support to be reviewed when Terms of Reference for national review published.
Regulation 12 Safe Care and Treatment Trust participation in independent maternity investigation, announced by Health Secretary in October 2025.	Capacity of maternity and neonatal senior leadership team to participate in independent review (whilst taking part in national review) whilst delivering services and improvements. Terms of Reference and scope of review not yet known.	Leadership capacity and support to be reviewed.
Regulation 12 Safe Care and Treatment Neonatal Peer Review by NHSE 16-17 July 2025. Final report received October 2025. Action plan in response to 5 concerns raised	1.Closure of cots at SJUH compromised overall capacity impacting across the network. 2.Clarity regarding number of cots commissioned by ICB/NHSE, how this relates to operational cots and underpinning nursing establishments. This impacts on required workforce and skill mix. 3.Gaps in AHP provision, current staffing falls below required standards due to underfunding. 4.Absence of accessible psychological support for all disciplines 5.Neonatal team providing mutual aid to paediatric services reducing neonatal staffing and increased workload.	Action plan reviewed at QSAG 14 August 2025. Response provided by Trust with action plan 20 August 2025. Final report received October 2025.
Regulation 12 Safe Care and Treatment Regulation 17 Good Governance Maternity and neonatal services improvement plan. Independent chair appointed to lead Maternity and Neonatal Programme Transformation Board to strengthen oversight and governance.	Oversight of different workstreams and improvement plans (MSSP, CQC).	Integrated improvement plan now incorporated into single action plan, for oversight and assurance. Working groups established by designated leads.

<p>Regulation 12 Safe Care and Treatment Regulation 17 Good Governance</p> <p>Maternity Safety Support Programme (MSSP) – monthly MSSP Quality Improvement Group (QIG), to provide oversight of improvement plan and assurance.</p> <p>Support from Maternity Improvement Adviser(s) (MIA). Actions developed in response to review of MIS year 5 and 6.</p> <p>MIA review of MIS year 5 and 6 to inform improvement plan.</p> <p>Equality Diversity and Inclusion (EDI) diagnostic undertaken 1-2 July 2025; awaiting findings from review.</p>	<p>Capacity to deliver improvements.</p> <p>Maternity Incentive Scheme (MIS) year 5 and 6 reviewed by MIA and not achieved.</p>	<p>Support provided by MSSP – 2 members (MIA) of MSSP commissioned to provide direct support to improvement programme.</p> <p>Discretionary funding application approved by NHSR for funding to support improvements and compliance with MIS safety standards (September 2025).</p> <p>Improvement Director appointed for 12 weeks to support review of ward to board governance and maternal and neonatal improvements.</p> <p>NHS Resolution engagement lead to provide support/training re year 7 submission.</p>
<p>Regulation 15 Premises and Equipment</p> <p>Joint action plan with Medicines Management focusing on medication storage review.</p> <p>Daily compliance checklists signed off by nurse-in-charge and subject to weekly spot audits by pharmacy staff. Findings from assurance visits shared with ward managers at the time of visit, actions logged and tracked centrally by Medicines Management.</p> <p>Monthly compliance reports reviewed by the Medicines Management Governance Group, and concerns escalated through clinical governance structures.</p>	<p>Variable compliance re management and storage of medicines.</p>	<p>Daily compliance checklists.</p>
<p>Regulation 15 Premises and Equipment</p> <p>Revised process for the monitoring, procurement and maintenance of equipment required to provide safe care, including CTG machines.</p> <p>Process for the oversight of estate jobs that require completion, including escalation.</p>	<p>Availability of equipment</p>	<p>A review of the total number of CTG machines available and required for the service undertaken.</p>
<p>Regulation 15 Premises and Equipment</p> <p>Infection Prevention and Control (IPC) guidelines and audit programme.</p>	<p>Variable compliance re infection prevention and control.</p>	<p>IPC review of infection prevention and control practices, overseen by IPC Sub-Committee.</p>

Environmental cleaning and audit programme. HCAI report to Quality Assurance Committee.		
Regulation 15 Premises and Equipment Quarterly audit of neonatal cot-side resuscitation equipment against Resuscitation Council UK standards.	Assurance that Resuscitation Council UK standards are being met.	Audit undertaken of all cot-side resuscitation equipment to ensure 100% compliance with Resuscitation Council UK standards.
Regulation 17 Good Governance Resources to support CSUs and corporate teams in preparation for CQC inspection, including quality statements, key questions and self-assessment: CQC – Quality Statement and Preparing for Inspection – Leeds Teaching Hospitals NHS Trust	Capacity of maternity and neonatal senior leadership team to engage in CQC preparations.	Support in preparation provided by quality team/PSQM – peer support provided through Quality Governance Forum.
Regulation 17 Good Governance Inspection report from CQC (maternity and neonatal services) published 20 June 2025. Letter setting out breaches of Regulation and how the Regulations were not being met. Trust response setting out improvement actions and how these will be measured and monitored, for assurance.	Capacity to manage regulatory requests alongside improvement work. Gaps in senior leadership provision due to absence.	Additional leadership capacity and support provided to the maternity and neonatal teams, including Medical Director Operations, Director of Operations, Improvement Lead, Corporate Nursing, focusing on oversight of improvement plan. Further Exec review of capacity and wrap-around support to be completed in November.
Regulation 17 Good Governance Perinatal assurance report to Quality Assurance Committee, report to Trust Board.	Flow of assurance to Board (perinatal risks).	Review of assurance flow to Board, including KPIs to be undertaken and completed by end of November 2025. Weekly exception report developed for Executive Directors weekly meeting.
Regulation 17 Good Governance MIS year 7 submission - support from Maternity Improvement Adviser(s) (MIA). Quarterly review meetings led by Chief Nurse. Independent assurance provided by Trust auditors (PwC).	Capacity of maternity and neonatal senior leadership team to review all evidence requirements and deliver MIS year 7 submission.	Additional resource (MIS lead) included in discretionary funding approved by NHS Resolution.
Regulation 17 Good Governance Complaints and PALS process with oversight provided by Director of Midwifery, Head of Midwifery, Clinical Director, General Manager.	Capacity to manage all enquiries following publication of CQC inspection reports (maternity and neonatal services) On 20 June 2025.	PALS helpline established to support CSU in the handling of enquiring for people who use maternity and neonatal services. Process for monitoring the number of enquiries and escalation to clinical team where this is requested.
Regulation 17 Good Governance	Full MDT attendance to represent all areas to review patient safety incidents/PMRT.	Monthly Governance pack shared across CSU (email and hard copies).

Patient safety incident reporting process, weekly review of incidents by CSU (WIIRM). Process for reviewing all patient safety incidents that are categorised as moderate harm, or above by Risk Management leads, including PMRT reviews graded C or D, and MNSI referrals for investigation.		MIA Lead and Governance Team to undertake in depth review of Governance systems & processes (October 2025).
Regulation 17 Good Governance Communications plan, including the management of media enquiries and Freedom of Information (FOI) requests.	High volumes of FOIs received into the CSU. Capacity to manage these requests within the designated FOI response timeframe.	Working group 4 – Engagement & Communication established led by Director of Operations and Communications Manager.
Regulation 17 Good Governance Monthly reports (by exception) to Risk Management Committee, focusing on key risks, controls and mitigating actions, reporting to Board.		
Regulation 18 Staffing Response to letters under Section 29A and Section 31 of the Health and Social Care Act 2008. Weekly assurance reports on maternity staffing and neonatal designation at the St James's location, including breaches of the 24-hour standard. Revised daily staffing review and escalation process. Birthrate+ review. Neonatal staffing assurance report against BAPM guidance. Staffing report to Perinatal Assurance Group and QAC.	Vacancy gaps remain until posts appointed to. Inability of non-clinical, specialist and management midwives to complete their work due to redeployment to support the clinical service. Decrease in the specialist workforce to support timely governance processes and shared learning in a nationally high-profile/risk service. Inability at times of high acuity where all mitigating actions have been exhausted to meet national KPI's of 1:1 care during the intrapartum period and supernumerary status of the labour ward co-ordinator. This directly impacts on safety and achievement of the evidential requirements of the Maternity Incentive Scheme.	Recruiting up to the Birthrate+ Funded establishment of 367.5 WTE. Approved by the Executive Management Team in November 2024. 40 WTE midwives have since been appointed, with the majority due to start between September 25 and November 2025. Immediate assessment of critical workforce gaps completed to identify areas requiring urgent action and short-term support to maintain safe and effective care.
Regulation 18 Staffing Standard Operating Procedure (SOP) – escalation and management of gaps in medical rotas.	Gaps in consultant and resident doctor rotas.	Long-term consultant locum posts (2) appointed, to start in November/December. Resident doctor recruitment in progress, to be completed November 2025.

British Association of Perinatal Medicine (BAPM) medical staffing standards compliant from 28 September 2025, with 18 WTE Neonatologists in post ensuring separate 7-day consultant cover at LGI and SJUH.		
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CRRE2: CQC Registration – breaches of Regulation(s) Well-led	C = 4	16	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
	L = 4		1	2	3	4	5	6	8	9	10	12	15	16	20	25
									Target Score			Initial Score		Current Score		
Risk Description: There is a risk to the Trust’s conditions of registration with the Care Quality Commission (CQC) related to well-led due to breaches of Regulations and failure to meet the fundamental standards under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) (as amended): Regulation 16 Receiving and Acting on Complaints Regulation 17 Good Governance Regulation 18 Staffing This may impact on the provision of safe care to patients, confidence and experience of people who use our services, reputation, and capacity to respond to the regulatory requirements and scrutiny.													Executive Lead: Chief Nurse			
													Date added to CRR: Nov 2025			
													Last reviewed: November 2025			
													Next Review: December 2025			
													Committee reviewed at: Quality Assurance Committee			
Controls			Gaps in Control						Further Mitigating Actions							
Regulation 16 Receiving and Acting on Complaints Complaints Improvement Plan. Weekly complaints and PALS response times report to CSUs and corporate leads. Oversight and monitoring by Head of Nursing and Deputy Chief Nurse. 6 monthly Quality Framework Review Meeting with CSUs. Report to Quality Assurance Committee.			Trust meeting national standards for acknowledging complaints (48 hours) and responding in writing (6 months) – not all CSUs meeting local 20, 40, 60-day standards. Capacity in Patient Experience team to support CSUs. CSU resources to manage complaints variable. Rise in the total number of complaints following media coverage.						Root and branch review of Patient Experience service and complaints/PALS to be undertaken, including resources and capacity, in November 2025. PHSO and NHS Complaints Standards organisational assessment tool to be implemented and reviewed at PEEG, November 2025.							
Regulation 17 Good Governance Resources to support CSUs and corporate teams in preparation for CQC inspection, including quality statements, key questions and self-assessment: CQC – Quality Statement and Preparing for Inspection – Leeds Teaching Hospitals NHS Trust																
Regulation 17 Good Governance Inspection report from CQC (well-led) published 20 June 2025. Letter setting out breaches of Regulation and how the Regulations were not being met. Trust response setting out improvement actions and how these will be measured and monitored, for assurance.			Capacity to manage regulatory requests alongside improvement work.						Resources to manage regulatory response and compliance to be reviewed at Improvement Steering Group in November 2025.							

Letter from NHS England (7 October 2025) setting out Enforcement Undertakings under section 106 of the Health and Social Care Act 2012. Leeds Teaching Hospitals NHS Trust Improvement Plan. Weekly Improvement Steering Group chaired by Chief Executive.		
Regulation 17 Good Governance Provider Capability Assessment – completed and submitted to NHS England October 2025.	Gaps identified in Provider Capability Assessment.	Review of submission at Board time-out 24 October 2025. Mid-year review to be undertaken with NHSE and Board to monitor progress. Self-assessment to be undertaken ahead of well-led external review in Q1 2026/27.
Regulation 17 Good Governance CSU management and governance structure in place. CSU Quality Assurance Group framework. Risk Management Committee – oversight of significant risks.	Clarity re escalation process required. CSU Quality Assurance Groups variable – changes to CSU leadership.	Workshop to be delivered on the management and review of risks and risk registers, with refreshed resources provided (to be completed March 2026). CSU Quality Assurance Group framework to be reviewed in December 2025, focusing on reporting and routes of escalation.
Regulation 17 Good Governance Trust Board and Committee structure.	Changes at Board and Exec Director level impacting on stability, response and decision-making.	Review of Exec Director portfolios and lines of accountability to be undertaken in January 2026. Mid-year reviews to be undertaken with NEDs. Board development programme to be reviewed, focusing on listening, learning, curiosity, just culture and psychological safety – to be completed April 2026.
Regulation 17 Good Governance Patient safety incident reporting process, weekly review of incidents by CSU. Process for reviewing all patient safety incidents that are categorised as moderate harm, or above by Risk Management leads. Patient Safety Incident Response Plan (PSIRP). WYAAT shared learning group. Trust learning hub. Support provided by designated Patient Safety Specialists who have completed NHSE Patient Safety Training Level 3 & 4.	CSU understanding of the principles of the Patient Safety Incident Response Framework (PSIRF) variable, including application of methods and tools to undertake patient safety incident investigations.	PSIRF maturity self-assessment to be undertaken in December 2025 and shared with WYAAT for benchmarking purposes. RPIW to be undertaken in November and December 2025, facilitated by KPO, focusing on sharing learning from Never Events.

Regulation 17 Good Governance Monthly reports (by exception) to Risk Management Committee, focusing on key risks, controls and mitigating actions, reporting to Board.	CSU management of risk registers variable – changes to CSU leadership.	Workshop to be delivered on the management and review of risks and risk registers, with refreshed resources provided (to be completed March 2026).
Regulation 17 Good Governance Freedom to Speak Up (FTSU) framework – supported by FTSU Guardian and Champions. Annual FTSU Guardians Office Self-Assessment. FTSU report to Workforce Committee.	Capacity and resources required to support CSUs and other teams is limited.	Review of resources required to deliver FTSU Guardian role and associated work to be undertaken in December 2025, including communication plan to promote FTSU.
Regulation 17 Good Governance Board leadership visit programme.	Programme does not cover all areas or focus on 24/7 care provision.	Review of Board leadership visit programme to be undertaken for 2026/27, focusing on responsiveness and including out of hours visits to wards and departments.
Regulation 17 Good Governance Equality, Diversity and Inclusion (EDI) framework MSSP diagnostic report - EDI.	Approach to EDI variable across the Trust.	Comprehensive review to be undertaken of the Trust approach to EDI, based on 15 key areas agreed with NHS England.
Regulation 18 Staffing Mandatory training framework. Report on mandatory training to Workforce Committee. Individual staff records recorded on ESR. Mandatory Training Steering Group.	Compliance with mandatory training variable across CSUs and staff groups, notably doctors in training.	Review of mandatory training compliance by subject and staff group to be completed to identify priority areas for improvement and report findings to Workforce Committee (to be completed March 2026).