

CORPORATE RISK REGISTER

May 2026

Summary Corporate Risk Register May 2026

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	Mar 26	Jun 26		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 26	Oct 26		19-21
CRRO2	Power failure/lack of IPS/UPS resilience due to electrical infrastructure	Aug 15	Director of Estates & Facilities	16	Jan 26	July 26		22-24
CRRO13	Brotherton Wing, Blocks 11, 12 and 32 physical condition	Jan 24	Director of Estates & Facilities	16	Jan 26	July 26		25
Health & Safety Risk <i>Minimal</i>								
CRRO4	Staff absence Health, Safety and Wellbeing	Oct 20	Director of Human Resources	16	Mar 26	Sept 26		26-28
Change Risk <i>Cautious</i>								
CRR09	Risk that LGI site development project fails to deliver objectives	March 26	Director of Finance	16	April 26	Oct 26		29-31
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	Apr 25	Oct 26		32-34
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	Apr 25	Oct 26		35-37
Clinical Risk								
Infection Prevention & Control Risk <i>Minimal</i>								
CRRC1	Healthcare acquired infection	Mar 19	Chief Medical Officer	16	Apr 26	Oct 26		38-49
Patient Safety & Outcomes Risk <i>Minimal</i>								
CRRC4	Emergency Care 95% Constitutional Standard	May 14	Chief Operating Officer	20	Dec 25	Jul 26	ED LGI	50-54
CRRC5	18-week RTT constitutional standard	May 14	Chief Operating Officer	20	Mar 26	Sep 26	Ophthalmology / Cardiac Surgery	55-61

CRRC6	62-day cancer constitutional standard	May 14	Chief Operating Officer	16	Dec 25	Jul 26	MDT & Pancreatic Breast Only	62-66
CRRC7	Failure to achieve 28 day cancelled operations standard	May 14	Chief Operating Officer	16	Mar 26	Sep 26	Cardiac	67-69
CRRC9	Patients waiting longer than 6 weeks following referral for diagnostics tests	May 14	Chief Operating Officer	16	Jan 26	July 26	Breast cancer	70-73
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	Mar 26	Sep 26	MMPS	74-77
CRRC11	Risk that patients presenting with mental health conditions wait for prolonged periods in ED and acute admission pathway due to sustained operational pressures.	April 26	Chief Nurse	16	April 26	Oct 26		78
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	Feb 26	Aug 26		79-82
CRRF2	Insufficient operational capital allocations	May 23	Director of Finance	20	Feb 25	Aug 26		83-85
CRRF3	Risk of supply chain failure	April 26	Director of Finance	16	April 26	Oct 26		86-88
External Risk								
Regulatory Risk								
CRRE1	CQC Registration – breaches of Regulation(s) Maternity and Neonatal Services	Jul 25	Chief Nurse	16	Feb 26	Aug 26		89-94
CRRE2	CQC Registration – breaches of Regulation(s) Well-led	Nov 25	Chief Nurse	16	Feb 26	Aug 26		94-97

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 <ul style="list-style-type: none">Chief NurseChief Medical OfficerDirector of Human Resources and Organisational Development				
													Date Added to CRR: May 2023 Last reviewed: June 2025 (Updated Sept & Dec 2025) Next Review: April 2026				
													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 algin 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	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>Redeployment of non-clinical, specialist and management midwives at times of 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</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>to meet national KPI's of 1:1 care during the intrapartum period and 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>Adult Therapies AHPs Corporate Task and Finish Group established to identify potential impacts. 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>Only applicable at CSU not inclusive of other AHP groups</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.</p> <p>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>

<p>Radiographers (Radiology)</p> <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>Radiographers (Radiology)</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>Band 6 CT radiographer gaps at CDC</p>	<p>Radiographers (Radiology)</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>Limited number of places available due to back-fill requirements.</p>	

20 apprentice ODPs per year by increasing to 10 students per year from Huddersfield University and 10 from Sheffield Hallam University.		
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</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>management, cover and leave to ensure workforce responsive to the service demands.</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.</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>The effect is that for about 2/3s of the year staffing levels are well below the average annual level.</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>	Unknown at present as impact still evolving.
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</p>	

	information has been provided to each CSU.	
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. 	Specific mitigation plans and actions for each of these are detailed in CSU OWAPs

	<ul style="list-style-type: none"> • Gaps in Medical Physics Clinical Scientists • 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.		

<p>Future You programme implemented to create workforce plan, recruitment and retention strategy for the Nursing Associate role. Progress reviewed through NMAWG and RMG</p> <p>Deputy DME overseeing PA undergraduate placement program at LTHT.</p>		
<p>Use of temporary workforce (bank and agency), including specialist agencies to provide observation, supervision and safe care to patients.</p> <p>Monitoring of staffing requirements through daily staffing meeting, weekly variable pay submissions, and weekly reports to Director of Finance.</p>		
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.
<p>Risk of staff absence due to potential Industrial Action</p> <p>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.</p> <p>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:</p>		

CRRO1: Risk of a viral pandemic	C = 5	15	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
	L = 3								Target Score				Current Score		Initial Score	
Risk Description: There is a risk 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: April 2026 Next Review: October 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 planCurrent internal plan requires a full transition from influenza-specific modelling to the 2026 Pathogen-						<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.Plan has been updated internally based on COVID-19 experience and 2023 EPRR core							

	Agnostic National Strategy published 25/03/26.	standards. Full framework update is in progress with a revised completion date of Autumn 2026 due to Resilience Team staffing deficiencies.
Individual clinical and corporate plans are in place, defining the local response to resource loss (Staff, IT, and Utilities).	Lack of evidence that all plans (specifically corporate support) are updated to reflect post-COVID-19 requirements (e.g., mass remote working and PPE logistics).	CSU business continuity plans are performance managed through the Business Continuity Sub-Group to EPCG to ensure standardisation and remove "placeholder" content.
Plans contain specific steps for redeploying staff and maintaining "Life and Limb" services during periods of high absence.	Inconsistency in depth between clinical BCPs (high detail) and corporate BCPs (generic detail), creating "point of failure" risks in essential support functions.	Implementation of a rolling programme of pandemic-specific desktop exercises to validate that plans are "live" and staff are competent in their roles.
Established Operational (Bronze), Tactical (Silver) & Strategic (Gold) structures provide a framework for Trust-wide pandemic escalation and decision-making.	Absence of a formal "stress test" to prove that corporate services (DIT, Estates, Portering) can meet the simultaneous surge demand of all clinical CSUs at once.	Resilience leads provide direct support to CSU Business Continuity Leads to align local action cards with the Trust's central Pandemic Response Strategy.
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. 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)	<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.

LTHT Incident Response Plan which would be activated in case of a pandemic.		<ul style="list-style-type: none"> Incident Response Plan has been completely re-written and is regularly being tested and exercised.
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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: January 2026 Next Review: July 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.							
Estates Handbook updated for emergency plans with detailed processes and regular review.			This handbook provides the Estates on-call team with information of what can be done when power interruptions occur but does not assist with the shortcomings of the installed systems.						The handbook is reviewed annually.							
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 E&F Bronze Command & available electronically via documents management system but would require in-depth electrical knowledge to fully understand.						Reviewed annually and updated as resilience is improved.							

<p>HTMs are not retrospective, and areas were designed to comply with best guidance at the time of design and construction.</p>	<p>HTMs are not applied retrospectively, HTM 06-01 was introduced in 2007 (current version 2021) so many areas remain non-compliant to current guidance 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>	<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 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>
<p>Awareness of the electrical shortfalls in UPS and IPS provision in clinical category Grade A areas is</p>		

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.	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>Therefore, the draft 5-year capital plan includes £10m for addressing this specific risk across 26/27 & 27/28. Full designs to be completed 25/26.</p>

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: January 2026			
													Next Review: July 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.							
Capital Scheme in progress to remove F Floor extension and install new roof covering, target completion Q2 2026/27.									Controls 1-2 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 underway to repair the roof, this doesn't affect access, or the staff evacuation procedures.						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: April 2026					
												Next Review: August 2027					
												Committee reviewed at: HR SMT					
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 through delegated group of health and wellbeing activity across the Trust.																	
Annual staff survey to measure staff views in relation to the People Promise: We are safe and healthy. The overall 2025 results for the Trust showed that for each of the three sub-themes, including burnout, showed the Trust scored around the average.																	
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. Assurance processes are rolled out to all CSUs and is supported by the Operational HR team.						Policy requires updating						Review of policy underway					

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 Operational HR and 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.	Line manager capability and capacity to apply the Supporting Attendance policy and wellbeing conversations.	Targeted HR support is being provided to assist with management in identified areas.
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.	OH are reviewing activity and where appropriate delivering some activity virtually.

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 achieved the highest flu vaccination rate for a large acute trust.		.
Suicide Prevention strategy has been updated and a post-intervention 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 April 2026.

CRRO9: Risk of failure to deliver the LGI Site Development Project	C = 4	16	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
	L = 4		1	2	3	4	5	6	8	9	10	12	15	16	20	25
												Target Score		Initial score	Current score	
Risk Description: There is a risk that the LGI Development Site Project fails to deliver its objectives as a result of: <ul style="list-style-type: none">NHP’s announcement of delays regarding the construction of the new hospital at the LGI until 2032 which will delay the full delivery of the Innovation Village (however, phased delivery is possible)a failure by the Trust to reach agreement with LCC to address the future of the A58M Inner Ring Road tunnel which will allow Clarendon Wing to be developed as part of Phase 2 of the LGI Development Site project; If the project is not delivered, the Trust will: <ul style="list-style-type: none">not reduce the size of its estate and continue to incur on-going high backlog maintenance costs and operational issues for buildings which are not fit for purpose;be unable to deliver the majority of the city’s economic growth as expected as part of the Leeds Innovation Arc;suffer reputational damage; not realise its aspirations to fully deliver healthcare innovation opportunities and improvements for the West Yorkshire region;be unable to deliver outstanding Learning, Education & Training Facilities for the Trust;fail to increase collaboration between the NHS, academia and the health technology sector;fail to ensure that future uses of the LGI Development Site estate are complementary to the delivery of Hospitals of the Future.													Executive Lead: Director of Finance Date Added to CRR: May 2020 Last reviewed: April 2026 Next Review: October 2026 Committee reviewed at: LDS Project Team meeting			
Controls			Gaps in Control						Further Mitigating Actions							
Assurance A robust set of project delivery governance and controls are in place involving key stakeholders within the Trust and with other partners (LCC, WYCA, SGI). A phase 2 delivery plan for the phased delivery of the Innovation Village) is currently being considered.									Initial discussions with LCC have commenced regarding the-future of the A58M Inner Ring Road tunnel.							

<p>The Project currently reports into the Infrastructure Committee which was set-up in November 2024.</p> <p>The Trust has obtained professional advice on specific issues relating to the Innovation Village.</p> <p>The rigour and monitoring of the project has been enhanced by the appointment of a project manager to assist with successful delivery of the project.</p>		
<p>Guidance and Market Position</p> <p>The Trust complies with the NHS Estates Code and the Trust's Standing Orders, coupled with advice from advisors and position in the market to provide a clear steer on most appropriate disposal route and best value.</p> <p>The LDS Project Team formally review the property market and investor position on a 6 monthly basis and report the findings to RIC.</p>		
<p>Stakeholder Engagement</p> <p>Engagement with Trust staff and external stakeholders is being undertaken to support the Project (on-going).</p> <p>Formal and informal discussion are ongoing with LCC, Leeds University and Leeds Beckett University regarding the Innovation Village.</p>		

<p>Frequent discussions with potential developers to assess continued interest in the Innovation Village.</p> <p>An improved relationship has been achieved with the Little Woodhouse Community Association.</p>		
<p>Mix of uses for the Innovation Village</p> <p>Work is ongoing with Cushman & Wakefield to determine the most viable mix of uses for the Innovation Village and this will be shared at Infrastructure Committee when completed.</p>		<p>The Trust will influence the uses for the remaining LDS to be complementary to the delivery of HofF.</p> <p>A phase 2 delivery plan for the phased delivery of the Innovation Village (disposal of the remainder of the surplus LGI site identified for the Innovation Village) is currently being considered in development.</p>

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
													Target Score			Initial & Current Score
Risk Description: <ul style="list-style-type: none">There is a risk that the Trust will be unable to recover IT systems or data in the event of a successful cyber-attack, impacting on the treatment and provision of care to patients. This could be caused by.<ul style="list-style-type: none">a National cyber-attack resulting in significant service disruption, harm to patients and financial loss.a cyber-attack that has been introduced into the Trust by a staff member. <p>This could result in service disruption, delay to patient care and potential financial loss.</p> <ul style="list-style-type: none">There is an additional risk that a cyber-event affecting the Trust could spread to other NHS organisations.These risks are enhanced due to the technical debt within the Trust, reliance on legacy infrastructure, complex server environments with multiple versions and operating systems deployed and a very complicated application estate with many unsupported applications.The war in Ukraine and subsequent activity has all UK institutions on higher alert. There has been one successful attack on a UK health IT supplier that has severely impacted on care delivery in primary, out of hours and ambulance services.													Executive Lead: Chief Digital & Information Officer			
													Date added to CRR: May 2022			
													Last Reviewed: April 2026			
													Next Review: Oct 2026			
													Committee reviewed at: DIT Committee			
Controls			Gaps in Control						Further Mitigating Actions							
A supported, modern digital infrastructure.			There are gaps at most levels of the Trust’s digital infrastructure. The current digital five-year capital plan is currently showing a circa £70m deficit.						There are now funded projects and plans across: <ul style="list-style-type: none">EUCNetworkData CentreTelephony The funding of the ongoing five-year plan is essential to the remediation of this risk. The current digital five-year capital plan is currently showing a circa £70m deficit.							

Perimeter security. The network has monitoring, and prevention technologies deployed.	There is a limit to the capabilities of the technologies and a very well-funded cyber actor, e.g., nation state or organised crime, if determined would be able to cause disruption and harm.	The Network renewal project will enhance this control, but there will always be risks with well-funded and committed cyber actors.
End User Device Monitoring. All end user devices have Microsoft technologies deployed to monitor if malicious activity may be happening. This is monitored nationally by NHSD.	Not all devices are covered with the Microsoft technology to monitor for malicious activities.	EUC team regularly review to maximise the cover opportunity from Microsoft monitoring technologies.
Vulnerability management processes supported by the new BMC Discovery CMDB. This includes the management and actioning of CareCert alerts provided to the Trust from NHSE.	There is a focus on the top 12 systems, to understand the totality of the estate that supports them and the services and risks associated. The remaining applications are not as well understood.	There is a plan to prioritise services beyond the top 12 and assess the next tranche over the next year (resources dependent).
Improved user education, including annual mandatory IG training for all staff and internal communications raising awareness of cyber risks.	All staff complete the mandatory IG training, this is a once-a-year activity.	Increased focus and quantity of phishing-based training. Additional internal comms activity during the year, e.g., screen savers
End User Compute Modernisation Programme	There are a diminishing number of Windows7 devices in the Trust, but the risk will remain while the estate is migrated.	Completed this to 99%. Work is ongoing to complete the final 1%.
Business Continuity Plans are in place for use in the event of an IT system failure as a consequence of a cyber-attack or other reason. This mitigation is owned by the Emergency Preparedness Team working in conjunction with CSUs and DIT. Please refer to Emergency Preparedness Business Continuity risk, controls and mitigating actions.	The plans in relation to the main 12 clinical systems are currently under review and do require strengthening especially in relation to unplanned outages. This is a significant task requiring a high degree of input from the EP team and CSU's. Business continuity plans are not able to mitigate prolonged system failures.	Using the outputs provided to the EP Team , the current status of business continuity plans in relation to each of these systems has been reviewed and work prioritisation is ongoing to improve this.

Systems and data are backed up on a regular basis	Under the Cyber Remediation Programme, the top 12 systems have been assessed and amendments made to ensure their backup and recovery is appropriate.	All new systems which the Trust host are placed in ExponentialE with appropriate backup and recovery.
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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
										Target Score				Initial & Current Score		
Risk Description: There is a risk of potential harm to patients due to a lack of funding to bring the Trust’s current IT estate to a minimally supported standard, let alone maintain or refresh it (applications, infrastructure) to ensure it remains fit for purpose, supported and cost effective. <ul style="list-style-type: none">Applications.<ul style="list-style-type: none">The number of aging clinical and non-clinical applications exceeds that which DIT's current resources (both people and budget) are able to maintain and upgrade to a minimum supported standard. This could potentially result in harm to patients due to inability to deliver projects relating to the maintenance/ upgrade of core clinical applications. There is a need to prioritise which projects should proceed (and which will not), recognising that many will not proceed. These services/ systems include PAS, PACs, ED (Symphony), Emeds, Theatres (Galaxy), Critical Care, Maternity and Neonates.Infrastructure.<ul style="list-style-type: none">There is a risk that Trust IT Systems fail due to Trust Servers running on unsupported Operating systems. These systems no longer receive updates or patches to rectify issues identified, some potentially relating to cyber security. In the event of failure, there could be a detrimental impact on clinical and operational service delivery.Project Resources.<ul style="list-style-type: none">There is a risk that Trust demand for DIT led projects cannot be met as the number of requests exceeds what can be delivered with available resources (both people and budget).This could potentially result in harm to patients due to omission of delivery of projects relating to patient care improvements.There is a need to prioritise which projects should proceed (and which will not), recognising that many will not proceed.													Executive Lead: Chief Digital & Information Officer Date added to CRR: January 2023 Last reviewed: April 2026 Next Review: October 2026 Committee reviewed at: DIT Committee			

<ul style="list-style-type: none"> This could lead to clinical teams attempting to deliver digital projects without full and formal engagement with DIT, creating wider risks to the Trust from poor investment decisions, poor resilience or the introduction of potential cyber weaknesses. <p>Related to risk 10353.</p>			
Controls	Gaps in Control	Further Mitigating Actions	
Prioritisation Group meeting fortnightly to review and agree priority of new works.	<p>Potential for Group not to be able to agree a priority, may require an escalation process.</p> <p>Insufficient resource in DIT to commence new projects.</p>	<ul style="list-style-type: none"> - A Project Prioritisation Group has been established within the Project Delivery Life Cycle (PDLC) with Clinical and Operational representation. A Prioritisation Decision Support tool has been developed to assist that group in considering the impact, complexity and resource implications of all project requests. This approach was approved by Corporate Ops in May 2021. - Paper outlining the risks of current DIT revenue funding and DIT capabilities presented and supported at F&P March 2024. - Discussions underway to address DIT 5 year revenue funding approach. - Task and finish group with CCIO and Clinical Directors to consider options to increase digital funding. - CSUs validating the backlog of prioritised digital projects which are unlikely to commence in next 2 years due to lack of DIT resources. 	
DIT 5-year capital plan engagement with roadmap.	Unlikely to receive sufficient funds to meet all project needs.	Deployment teams to work with CSUs to understand their requirements and Digital Roadmaps, to aid planning and alignment with the DIT capital plan	
Workforce strategy focus on improved recruitment & retention.		Vacancy control panel in place.	

	Currently there is insufficient revenue resource to replace all vacant posts.	
Upgrade of existing Server Operating systems where possible	Whilst work is underway to upgrade Server Operating Systems within the resource capacity of the team, there are c150 systems 'not in progress' due to lack of resources. It costs approx. £30k per system upgrade, would require an increase of estimate 13 Project Managers to address the backlog in one year. Total cost estimate £8m including hardware.	Formal Project started. So far 87 servers decommissioned 60 upgrades in progress.
Investigation & analysis of type of data growth and what is in use. Consider deleting data	Potential requirement for retention of data as per policy Unable to delete some Data due legal requirement to retain.	Able to delete some data (Genomics NPIC) where appropriate to do so. This is underway
Ensure Business continuity plans in place in the event IT systems are unavailable.	Not as effective as normally operating system	

CRRC1: Risk of exposure to HCAI	C = 4	16	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
	L = 4								Target Score					Current Score	Initial Score	
Risk Description: 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: April 2026 Next Review: Oct 2026 Committee reviewed at: IPCSC 20.8.25 QAC 21.8.25 Risk Committee 25.09.26 HCAI Group 5.11.25 IPCSC 28.01.2026			
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,			Documentation of staff immunisation assessment for childhood infectious diseases, such as measles and pertussis, is						Occupational health is working to close the gap in information about immunisations for the							

<p>such as measles and pertussis commenced in November 2024 for all new starters. 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>not comprehensively recorded for all existing staff. This means if there is an outbreak we do not have the information available to identify unvaccinated staff who may be at risk. When validation of the data from ED was reviewed a 15% gap in information about immunisation status was identified.</p>	<p>highest risk areas i.e. ED and PED. To be completed by March 2026.</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>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>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>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 DIPIC, 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>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>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>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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External audit of the HCAI performance data processes completed all recommendations adopted quarterly audit data compliant.		
<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>
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>NNU Major Outbreak Control closed. Oversight and scrutiny of interventions required to sustain control provided by CSU. Robust action plan implemented including programme of education completed, and routine monitoring of compliance is providing assurance.</p> <p>Refurbishment of NNU ahead of the planned BTLW agreed. 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>LGI NNU has experienced new outbreaks of infection related to practice and environment.</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>Water safe workstreams led by CSU in progress. Executive meeting on water safety held to agree immediate recommendations 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>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>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.</p> <p>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</p> <p>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</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>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>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>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>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 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>Feedback of lessons from HCAI incidents to clinicians is variable across LTHT, in some areas learning may not be shared</p>	<p>HCAI PSIRF process now live across the Trust in bed holding CSU'S.</p>

<p>CSUs manage individual HCAI case reviews, incidents, and Outbreak Meetings with support from Consultant Microbiologists, IPCT, Antimicrobial Pharmacists and DIPIC/DDIPC.</p> <p>Successful recruitment to Microbiologist role. post holder commenced January 24</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>effectively. Not all CSU's have a designated Consultant Microbiologist to support.</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 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>DIPC requested a clinically led thematic review of HCAs 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>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</p>		

<p>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.</p> <p>IPCN development plan in place.</p> <p>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 Emergency Department (ED) 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: January 2026			
													Next Review: July 2026			
													Committee reviewed at: Finance & Performance Committee			
Controls			Gaps in Control						Further Mitigating Actions:							
<p>Daily management and oversight established including:</p> <ul style="list-style-type: none">➤ 8.30 am huddle➤ CSM status reviews and report➤ patient flow and discharge huddles➤ escalation meetings chaired by Director of Operations, Medical Director or Director of Nursing➤ early identification and escalation of patients awaiting repatriation to other hospitals and any patients awaiting transfer into LTHT➤ summary operation centre email sent to CSUs for organisational context and specific actions required <p>When demand for inpatient beds outstrips capacity there is a suite of requested actions as per the LTHT Operational flow guidance document for standard work against certain pre agreed triggers.</p>			<p>Sustained high numbers of patients within the bed base with no criteria to reside impacting on hospital capacity and ability to place new patients who require an acute bed placement. This impacts on ED congestion.</p>						<p>Review of operational response guidance, use of surge and corridor care is being undertaken in January 2026 aligned to new national guidance and LTHT learning to date.</p> <p>City home First programme focus over the next 3 months is converting pathway 1 to pathway 0 and pathway 3 length of stay.</p>							

<p>-There is a leader on point and silver command escalation process both within LTHT and across the city system.</p>		
<p>Daily monitoring and reporting of 4-hour performance.</p> <p>Use of the National OPEL system with data feed to the RAIDR app for local and regional oversight of key ED pressures.</p> <p>Twice daily meetings held by the Urgent Care team to ensure capacity and demand met.</p> <p>Weekly meeting chaired by Director to update on ECS performance with a review of safe, effective care and understanding enablers to improving timely care. This included ECS against the nationally submitted trajectories for annual improvements and the delivery of the actions the CSU described for this.</p> <p>Operational planning guidance trajectory to deliver 78% ECS by March 2026 continues to be monitored submitted with workstreams and measures to enable delivery developed and is monitored through the CSU service delivery framework.</p> <p>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.</p> <p>Daily, weekly and monthly reports are shared with tri team and director teams.</p>	<p>National best performing quartile of hospitals delivers no more than 5.4% of patients in ED for longer than 12 hours. LTHT currently at 7.6%.</p> <p>Absence of real time electronic bed state and real time bed and patient placement overview.</p> <p>Timeliness of bed allocation by CSUs to ED.</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</p>	<p>ED team currently developing an improvement plan to ensure there are no gaps in control for the 2 hourly safety rounds.</p> <p>Director of Nursing reviewing the weekly quality report to include ED occupancy (crowding), the number of patients admitted from ED who have been in the ED from arrival for longer than 12 hours and use of corridor care. To be completed by end of February 2026.</p> <p>Making Every Day Count Event across the Trust in February 2026 to embed daily rhythm and timeliness of discharge and reallocation of the hospital beds.</p>

Patients over 24 hours in ED reported on the weekly executive score card and through NHSE KLOE daily reports.	department is not currently clinically reviewed outside the CSU.	
<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>All patients awaiting over 24 hours in the ED will be reported on the WTER document for SCC and NECS.</p> <p>Fortnightly group with LTHT urgent care team and LYPFT colleagues developed a dashboard with referral data that is reviewed together monthly.</p>	<p>There is insufficient mental health inpatient bed capacity and services to meet demand in Leeds with multiple LYPFT patients needing to be placed out of area. This results in mental health ED patients waiting a disproportionate amount of time in ED.</p> <p>Limited impact from current escalation process.</p>	<p>A national bid for increased mental health services has been co-produced and submitted by Leeds for NHSE central funding. This includes a 2-year plan to develop a mental health Same Day Emergency Care (SDEC) adult unit at SJUH site to support care, admission avoidance and a mental health appropriate environment. Awaiting confirmation of success of bid in January 2026.</p> <p>New SOP for care of patients with mental health conditions in ED to be developed, aligned to NHSE recommendations, which describes necessary clinical monitoring and actions required for maintenance of patient safety including escalation process for patient or staff safety concerns.</p>
<p>Alternatives to ED attendance and patient streaming in place to the 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) with a weekly review of delivery and performance of this via the weekly Director meeting with Urgent Care team.</p> <p>Primary Care Access Line in place to prevent unnecessary ED attendances where clinically appropriate and route to alternatives to ED.</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>Ambulance winter HALO scheme not being provided this winter 2025/26 .</p> <p>Role of HALO is to support and educate on the job alternatives to ED , use of PCAL and ambulatory areas, virtual wards.</p>	

<p>Business continuity plans in place for times of high acuity/ attendances to ensure safe patient placement when ED capacity is inadequate for demand.</p> <p>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.</p>	<p>The estate footprint constraints within EDs specifically lack of surge space at LGI adult and children's ED and SJUH ED adults.</p> <p>ED occupancy is now reported through RAIDR and shows both sites at over 100% routinely and SJUH ED running at 140% plus.</p>	<p>Currently developing capital plans and bids by February 2026 to increase footprint and refurbishment aligned to NHSE model ED requirements.</p>
<p>Seasonal reflections, learning for 2024/25 and planning with CSU's and system partners for 2025/26 occurs annually and is logged and shared across the system.</p>	<p>Unpredictable activity levels and demand.</p>	<p>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.</p> <p>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.</p>
<p>Daily management and oversight established including:</p> <ul style="list-style-type: none"> ➤ 8.30 am huddle ➤ CSM status reviews and report ➤ patient flow and discharge huddles ➤ escalation meetings chaired by Director of Operations, Medical Director or Director of Nursing ➤ early identification and escalation of patients awaiting repatriation to other hospitals and any patients awaiting transfer into LTHT 	<p>Sustained high numbers of patients within the bed base with no criteria to reside impacting on hospital capacity and ability to place new patients who require an acute bed placement. This impacts on ED congestion.</p>	<p>Review of operational response guidance, use of surge and corridor care is being undertaken in January 2026 aligned to new national guidance and LTHT learning to date.</p> <p>City home First programme focus over the next 3 months is converting pathway 1 to pathway 0 and pathway 3 length of stay.</p>

<p>➤ summary operation centre email sent to CSUs for organisational context and specific actions required</p> <p>When demand for inpatient beds outstrips capacity there is a suite of requested actions as per the LTHT Operational flow guidance document for standard work against certain pre agreed triggers.</p> <p>-There is a leader on point and silver command escalation process both within LTHT and across the city system.</p>		
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CRR5: 18-week RTT 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: 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: March 2026 Next Review: September 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 (LTHT up by 4.6% overall) and will require significantly increased activity..				Theatre, Diagnostic and Outpatient productivity schemes are well established and are increasing levels of productivity across pathways. ICB/NHSE have made some ‘sprint’ payments available for additional activity in Q4.						
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						

		<ul style="list-style-type: none"> - Reduction of low clinical outcome activity - Clinic Utilisation
Administrative validation of the total waiting list as a housekeeping exercise running from Q1 – Q4. Q4 includes the use of an external company to deliver rapid review and validation of targeted areas of the waiting list where patients have been discharged and clocks continue to run.	Validation work may not deliver the improvement to RTT as the volume of validation is across the total waiting list and not just 0 – 18 weeks. It is also aimed at removing patients who have already been treated and discharged, but with no clock stop or removing duplicate entries.	Use of digital innovation
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 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>

<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>	<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>Director of Operations, Finance, HR Business Partners and Heads of Nursing meet with CSUs via monthly IAMs (Integrated Accountability Meetings) to review delivery against all 4 pillars and agree actions and further escalation to executives if required.</p> <p>Service Delivery Accountability Meetings held monthly between DOP and CSU team to provide traction on service delivery and actions to deliver or bring back to trajectory.</p> <p>Additional support identified and recovery actions agreed.</p>
<p>Single points of access in some specialties will allow onward referral of routine activity to AQP's spreading burden across providers</p>	<p>AQPs will be subject to same restrictions on activity as LTHT.</p>	<p>Go live of CDCs (Community Diagnostic Centres) will increase funded capacity for some specialties particularly in imaging and physiological assessments/tests.</p> <p>Planned expansion of CDC capacity across 7 days continues to be developed.</p> <p>Business case for development of Seacroft site approved by NHSE for delivery in 2027. Development of pathways across CDCs identified for 26/27 and associated bids submitted to fund these.</p>

		Transition of CDCs into the Radiology CSU to provide operational, clinical and governance oversight and ensure delivery of future activity through partnership working.
Effective advice and guidance can support primary care decision making and reduce unnecessary referrals	<p>Absence of standardised system/approach to support the capture, recording and reporting of advice and guidance into EPR prevents roll-out to all specialties.</p> <p>Primary Care collective action may reduce uptake of Advice and Guidance</p>	National program for a standardised approach to receiving, recording and reporting advice and guidance via ERS in development to start roll out in April 26.
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.	<p>Prioritises clinically more urgent patients and so does not improve RTT position.</p> <p>There is insufficient capacity in specialties that are prioritised to reduce risks:</p> <ul style="list-style-type: none"> • Cardiac surgery • Max Facs surgery • Endocrine surgery • Neuro surgery • Plastic surgery • ENT surgery • Paediatric surgery 	<p>Additional Business cases being developed to expand theatre capacity at the LGI within existing estate which includes:</p> <ul style="list-style-type: none"> - Use of GSOT 5 days per week for ENT - Additional lists allocated to TRS at Wharfedale - Additional weekend lists for hand surgery and neurosurgery on an ad hoc basis. <p>The approval of the CAH theatre expansion business case will provide additional Orthopaedic and Neurosurgical capacity from late-2028 onwards.</p>

	Delay of the BTLW programme reduces planned expansion of theatre capacity at the LGI	The Paediatric operating capacity remains constrained by workforce (anaesthetics) predominantly but secondarily by estate.
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.	Pension taxes had reduced number of additional sessions provided by consultant staff. BMA rate card has reduced the number of sessions provided by consultant staff	Additional medical payments agreed to support additional activity specifically for treatment of long waiting patients
Use of Independent sector capacity.	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.	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

	There is currently minimal capacity for paediatric elective activity at tariff in the Independent Sector	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. Some offers of mutual aid have been received in 26/27 though these are small in quantity.
Develop Elective hub at WDH to increase elective activity that can be delivered. Reallocation of elective theatre allocations to support specialties with capacity and demand mismatch	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 These have been reviewed in Q3/4 26/27 resulting in additional GA capacity for Plastics and additional ENT capacity. Urology and MaxFac have released under-utilised lists to enable this.
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.	Site wide groups established at LGI first and then SJUH to explore the impact of delayed step downs on critical care and elective capacity which results in on day cancellations.
The Speciality Theatre Utilisation Group, 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 against key KPIs such as utilisation / Day case rate / Elective LoS /	Impact of unplanned pressures on elective bed base Willingness of clinicians to do extra work due to pension / tax issues.	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.

<p>Average Case per session / DNA/WNB rate / cancellation (patient and hospital) rates / first to follow up rate / advice and guidance provision</p>	<p>Capacity to focus on improvement work alongside operational pressures.</p>	<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 WRP (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: December 2025 Next Review: July 2026 Committee reviewed at: Finance and Performance Committee			
Controls			Gaps in Control						Further Actions Planned:							
<p>Operational plans to meet the waiting time standards set out in the NHS Constitution (2012), monitoring against the following standards:</p> <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			<p>Variation in capacity requirement Demand control</p>						<p>Cancer Operational Delivery group established to support collaboration, shared ownership and drive improvements in the challenges that impact all pathways eg pathology, radiology, data.</p> <p>CSUs are working collaboratively at pathway level to build trajectories to deliver each of the component generic milestones per pathway (based on NHSE best practice). These trajectories and enabling action plans will be signed off on 4th December 2025.</p> <p>Services will be held to account at pathway level for delivery against trajectory. Deviation will trigger an escalation to DOP.</p> <p>Reviewed PTL process implemented Pathology PTL in place</p>							

		Radiology PTL in place
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.	Revised trajectory to deliver 67% by the end of March 26 has been supported via Tier 1 process. Appointment of a MDOP for Cancer, a revised cancer board and pathway level deep dives led by the clinical teams to strengthen clinical leadership.
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
<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	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>A Business case for staffing has been approved and recruitment has been completed for Y1. This delivering a continued reduction of TAT in the lab</p> <p>The Alliance and Trust has supported funding for home stations to enable Pathologist to report from home.. Any new job adverts will include the provision of Home stations.</p> <p>Production board introduced into the Lab and weekly trajectory monitoring produced. 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>A pathway navigator post has been implemented to expedite reporting where possible.</p> <p>Pathology CSU focus on plans at specialty level to improve the time to reporting of samples which have been signed out of the lab.</p>
Recovery plan in place for the skin backlog position		Continued reduction in lab TAT for skin pathology. Outsourcing capacity in place to respond to demand growth over forecast level.
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

		<p>treatment following a standard of care. This will ensure capacity is released for patient review offering more timely care.</p> <p>Medical leadership to drive this work is place - a systematic review is being led by the MDOPs</p>
<p>Breach review to be undertaken for all patients that breach 62 days</p> <p>Harm reviews undertaken for patients waiting longer than 104 days</p>	<p>Delays in treatment for patients waiting longer than national standard</p>	<p>Breach review learning completed, action plans in place for all pathways – I don't think this is the case. Review of the RCA process at pathway level to be undertaken to ensure learning is completed and action plans are developed where appropriate.</p> <p>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.</p> <p>A pre-emptive approach to preventing harm caused by delays to timely care is in development. This is being led by the MD Ops. Pathway specific risk triggers will be identified per pathway and prompt an escalated action to expedite that pathway with the aim of preventing avoidable harm.</p>
<p>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</p>	<p>Referrals from other providers do not always occur in a timely manner to support delivery of 62 performance.</p> <p>LTHT capacity does not match the demand to deliver treatment within 62 days.</p>	<p>Maintain oversight at Cancer Board and report through IQPR.</p> <p>Weekly PTL meetings reviewing long waiting patients clear documented actions.</p> <p>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.</p>

Delivery against generic pathway milestones (NHSE guidance)		CSUs are working collaboratively at pathway level to build trajectories to deliver each of the component milestones per pathway. These trajectories and enabling action plans will be signed off on 4th December 2025.
Appropriate management of cancer referrals	2ww referrals have continued to increase to higher levels than previously seen, causing increased activity and delivery challenges particularly in Breast (2 spikes), Skin, Colorectal and Head and Neck Late referrals from other organisations.	Weekly oversight of cancer waiting times via Service Delivery chaired by COO.
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.	Chemocare BCP solution is formally live and this risk can be closed. It is no longer on the oncology or MMPS RR.

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: March 2026			
													Next Review: September 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. <u>including recent review via Specialty Theatre Improvement Groups in Q3 25/26.</u></p> <p>Reset of pre-assessment services to ensure patients are comprehensively reviewed and confirmed fit for surgery.</p> <p>Standardised procedure for the confirmation and reminder services provided to patients about their surgery and surgical dates.</p> <p>Process of surgical and anaesthetic lockdown, in line with 6-4-2, of agreed operating lists prior to day of surgery.</p> <p>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.</p> <p>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>Critical Care capacity can change overnight due to staffing absence or high numbers of unplanned</p>	<p><u>Further work on the collaborative scheduling of patients requiring High Observations Beds to replicate the processes in Adult Critical Care.</u></p> <p><u>Improvements to the LMCO report to show the decreasing time remaining for patients who have not been rebooked for surgery over the 28-day period to improve visibility.</u></p>

<p>G Drive report available to CSUs detailing all LMCO and patients who are booked with 28 days, patients who are 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>admissions and result in on day cancellations</p>	
<p>Promotion of day case surgery as standard where clinically appropriate through the use of GIRFT standards 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 Speciality Theatre Utilisation Group.</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	= 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 reportable 15 tests due to capacity constraints from increasing demand and workforce challenges. 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: January 2026 Next Review: July 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 the COO or their deputy. The purpose of this meeting is to identify current delivery of standard against agreed key trajectories, identify actions to recover deteriorating positions or to deliver better than planned. 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.						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 proposal to improve productivity through sessions have been developed and implemented and are now planned and monitored during the embedding phase. Paediatric Endoscopy proposals to use mutual aid theatre capacity provided by Hull where they have spare capacity continues but weekend use of the adult endoscopy suite at the LGI on a							

		<p>weekend is being explored as an LTHT more sustainable option.</p> <p>Ultrasound have inducted staff from Insourcing company over the last few months and have created additional Sonographer capacity at the weekend to support reducing the backlog of waits. Recovery is currently under way and ahead of trajectory. A sustainable approach is being explored to resolve the gap in control of LTHT skilled staff for this.</p>
<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 LTHTs Operations Centre with escalation processes in place for inpatient diagnostics.</p> <p>Implementation of production boards across diagnostic services with weekly standups to be maintained.</p>	<p>Lack of visibility of status of Inpatient requests and investigations due to patient's level information being held and booked on several different systems (ICE, PPM, CRIS, TMS)</p>	<p>Review of Radiology consultant workforce on going to ensure resilience to manage fluctuations in demand.</p> <p>The development of a power BI dashboard to provide oversight and support operational management of diagnostic waiting times.</p>
<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 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</p>	<p>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.</p>	<p>Developing a process for clinical validation of non-admitted diagnostic breaches to identify patients at risk of harm from a delay</p>

and managed via CSU and Trust governance structures.		
<p>Trust level recovery trajectory in place with weekly oversight by Director of Operations and COO.</p> <p>Template packs have been provided to CSUs for completion of actions to recovery their diagnostic position.</p> <p>Recovery trajectories with clear action plans for delivery of the national standards are being developed or are in place.</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>Options being explored to mitigate shortfalls in capacity.</p> <p>CDC deep dive into the activity included in SDAM packs for each CSU providing diagnostics activity for each CDC site to ensure maximising capacity.</p> <p>Review of GP referrals into the CDC versus the LTHT driven activity to understand demand and capacity alongside opportunities and practice variations.</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 2026/2027 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> <p>Recruitment strategy in place within radiology.</p> <p>Development of workforce plans as per the 2026/2027 activity planning and trajectories.</p>
Equipment replacement programmes and maintenance.	Funding availability to replace equipment or gain additional equipment for continuation of provision of service.	<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>Breakdown of equipment requiring the cancellation of patients.</p>	<p>Capital bid developed for potential funding available for CDC MRI scanner.</p> <p>Continued review of Insourcing and outsourcing opportunities across Radiology with quality and cost efficiencies considerations.</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		Initial 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 Emergency Department 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: March 2026 Next Review: September 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 including surge plans. Daily operational huddles at 08:30 to assess site-specific pressures and mitigate any safety concerns, led by			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						Review of digital enablers for patient placement and flow including Live bed state. Review of additional Corridor Care areas to be completed by Chief nurse team in March 2026 spaces in ED identified and occupancy of these reported daily.							

<p>Directors on point with clinical support from site managers.</p> <p>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.</p> <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 refreshed in February 2026. Tracking of DMT actions taken at times of pressure and recorded for theming.</p> <p>Agreed Full Capacity Protocols (FPC) for surge and Corridor care-implementation capture and assurance process measures. <u>This includes utilisation of the plan.</u></p> <p>Weekly report to Trust Quality meeting to understand the frequency of use of Corridor Care and safety checks. Monthly report provided to the Quality & Safety Assurance Group (QSAG).</p> <p>Structure established to ensure a weekly review of the longest waiting patients with No Criteria to Reside to</p>	<p>efficiency not currently met- plan for a central model in progress</p> <p>Insufficient space and staff to meet expected surges if inpatient numbers increase above expected population growth.</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>Currently developing a live occupancy of corridor care use within our Emergency Departments to support insights and patient tracking.</p>
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<p>ensure timely escalation of patients and to identify suitable alternative pathways that will result in earlier discharge.</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>Protected elective capacity at SJUH, CAH and Wharfedale Hospitals to support elective (planned patient) capacity</p>	<p>Overall patient experience and potential for patient harm impacted by use of Corridor care.</p> <p>There is a city trajectory to reduce the number of inpatients with No Criteria to reside in hospital to no more than 160 - trajectory not met.</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>Tactical:</p> <p>Alternatives to admission-</p> <p>Established Same Day Emergency Care unit 7 days per week</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</p>	<p>SDEC's across the organisation will host overnight inpatients when the organisation is under significant pressure and demand outstrips capacity.</p>	<p>Review of the SDEC's and assessment areas and their business continuity plans with learning from winter pressures to ensure resilience and continuity of provision.</p> <p>Call before you convey test of change for ambulance conveyances from care homes in Leeds with a category 3 or 4 (lower acuity).</p>

<p>consultant, SDEC or assessment area - Nationally recognised for its success</p> <p>Developed Virtual Ward for respiratory and frailer adults to support admission avoidance and early discharge and alternative care for lower acuity admissions</p> <p>Developed Home Telemetry ward to support early discharge and monitoring from a patients own home/bed rather than a hospital bed where clinically appropriate.</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>HomeFirst2 programme review has established a new agreed trajectory to reduce by a further 100 No Criteria to Reside patients over the next 2 years however currently running at 330 patients which is 50 more than last year's run rate. City silver has been escalated to gold for Chief Executive actions.</p>

CRR11: Patients presenting with mental health conditions waiting for long periods in the emergency department and acute admission pathway	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 patients presenting with mental health conditions will wait for prolonged periods in the emergency department and acute admission pathway due to sustained operational pressures impacting on patient flow across the health and care system, resulting in patient harm, adverse outcomes, patient experience and failure to deliver constitutional standards (performance).													Executive Lead: Chief Nurse			
													Date added to CRR: April 2026			
													Last reviewed: March 2026			
													Next Review: July 2026			
													Committee reviewed at: Quality Assurance Committee			
Controls			Gaps in Control						Further Mitigating Actions							
Joint ALPS triage at front door. A program of joint triage incorporating a member of the ALPS team is being introduced W/C 30/03/26			Staffing limits within the ALPS team my limit ability to meet 24/7 full cover. Capacity concerns. Improved assessment does not address capacity issues and						Escalation through CSM where patients are experiencing prolonged waits. Monthly operations meeting held with LYPFT to identify concerns and collaboratively address issues.							
Escalation through CSM team reports of patients experiencing prolonged delays waiting for assessment of specialist admissions to MH providers.			Hospital capacity limits opportunity for CSM team to resolve long waits. Other higher priority/ urgency admissions. Patients requiring MH assessment may also have medical needs that complicate care journey and require other specialist input.													
Monthly operations meeting with LYPFT to identify trends and themes around incidents and patient journey.			Capacity and operations issues within LYPFT are outside the control of LHTT team. Recognising the large region LYPFT covers, they are likely to have similar issues in ED’s across the region and may not be able to meet LHTT needs over those of other providers.						GIRFT project has been carried out to understand LYPFT delays and make recommendations to resolve this. Where operations issues cannot be resolved, escalation to COO for senior level discussion.							

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: February 2026				
												Next Review: August 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							

		<p>including Exec lead on financial risk and associated mitigations.</p> <ul style="list-style-type: none"> • 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)
<p>Operation of the financial performance framework with:</p> <ul style="list-style-type: none"> • Monthly Clinical Director signed off forecasts and a RAG rating against CSU agreed Control Totals 	None	<ul style="list-style-type: none"> • Regular updates to the Executive Team and Finance and Performance Committee including Exec led financial mitigations.

<ul style="list-style-type: none"> 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 oversight of the delivery of the financial plan including waste reduction 		<ul style="list-style-type: none"> Further escalation of underperforming CSUs to Exec-led intervention
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

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 assetsGreater reliance on external sources of fundingPotential non-compliance with regulatory requirementsIncreased 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: February 2026			
													Next Review: August 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 TrustsReduction 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 meetingRegular updates provided to Capital Planning Group and any necessary escalations to Finance and Performance Committee.							

<p>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 including specific prioritisation for the MSE, BME and DIT programmes.</p>	<ul style="list-style-type: none"> • Capital need is not highlighted by CSUs or services and not reported on via the Trust risk framework. • 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"> • 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 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.
<p>Development of in-house mitigation plan allows for the Trust to respond to changes in funding allocations or utilise slippage in other Trusts.</p>	<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

		<ul style="list-style-type: none"> • 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.

CRRF3: Risk of supply chain resilience failure	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	
														Current Score			
Risk Description: There is a risk of supply chain resilience failure, resulting in products and materials not being available due to ongoing global disruption, leading to rising energy, transport and shipping costs, and risk of cyber-attacks, which impact on the supply chain. This may lead to patient harm, adverse outcomes, patient experience and failure to deliver constitutional standards (performance), as a consequence of delays in receiving supplies.													Executive Lead: Director of Finance				
													Date added to CRR: April 2026				
													Last reviewed: April 2026				
													Next Review: May 2026				
													Committee reviewed at: Finance and Performance Committee				
Controls						Gaps in Control						Further Mitigating Actions					
LTHT Commercial Procurement and Supplies Controls and Actions:																	
Procurement procedures, contract management																	
National Resilience Group – engage with national team to anticipate supply shortages and agree actions to mitigate risks																	
Skills training programme for procurement team						Not all procurement staff have the required training and skills to engage with suppliers.											
National alerts re global supplies shortages, procedure for responding to alerts																	
Increased stock holding capacity – Dolly Lane																	
Network with suppliers to negotiate costs and supply availability																	
List of alternative suppliers to mitigate risk of product supply disruption						Nationally sourced products – not always advance warning of supply shortage. Some products are supplied by a single source.											

LTHT Medicines Procurement and Supply Controls and Actions:		
Engagement with national and regional medicines contracts where possible; noting Suppliers will have undergone due diligence, and purchase volumes are (broadly) planned for.	Suppliers more frequently withdrawing from contracts where a shortage is known or predicted, to protect themselves from off-contract claims	
Skills training (CIPS) for medicines purchasing team	Prohibitive cost per person and has to be found from within existing budget, plus 12-18 month training time. High turnover exacerbates this, compounded by VISA rule changes	Move to more innovative recruitment strategies e.g. apprenticeships to improve retention
Engagement with wider networks and organisations e.g. regional and national Specialist Pharmacy Service procurement teams, NHSE and DHSC medicines shortages teams and their supporting guidance and processes. For example a regional or national allocations system for a particular shortage, or peer support/mutual aid across the region.	The number of niche specialties at LTHT can sometimes mean peer support and national guidance is of limited value	
Maintain appropriate stocks of medicines, including a critical list of 'must-keep' medicines	Shortages almost impossible to predict, therefore critical list challenging to maintain. LTHT stockpiling would adversely impact other organisations therefore need to maintain appropriate procurement behaviours.	
Maintain effective clinical communication networks within the Trust to allow rapid, effective information sharing and support rapid decision-making. Includes dedicated MMPS Shortages Group.		
Effective Supplier relationships; ensuring due diligence is conducted when engaging with new Suppliers, risk is spread where possible, and early-warning signs are recognised	Supplier performance is variable and deterioration can be sudden e.g. driver availability, broader commercial decisions to move medicines to a more profitable market	
Appropriate risk assessments and due diligence is conducted for alternative medicines purchased in a shortage scenario	Trust sometimes has to commit to buying an alternative imported medicine prior to being able to undertake QA/QC assessments. Lead times for imports can vary due to regulator import-approval timelines and delays in ports/borders.	Often product information e.g. labels, Patient Information Leaflets and suchlike can be emailed by the Supplier to enable assessment prior to purchase

Daily upload of medicine stock holding to NHS England, facilitating organising stock management and mutual aid across organisational boundaries		
Systems in place across West Yorkshire facilitating the instigation of silver command meetings to manage shortages at a West Yorkshire or place level as needed		

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: February 2026 Next Review: June 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. External independent review of perinatal deaths (MBBRACE-UK 2023), commenced January 2026.	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.	Oversight of different workstreams and improvement plans (MSSP, CQC).	

<p>Regulation 12 Safe Care and Treatment Regulation 17 Good Governance 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 Joint action plan with Medicines Management focusing on medication storage review. 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. 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 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 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 Perinatal Improvement 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: February 2026			
													Next Review: June 2026			
													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.

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).