

Winter planning 2026/27

Finance and Performance Committee Wednesday 26th August 2026

Presented for:	Information
Presented by:	Joanne Wood, Director of Operations
Author:	Joanne Wood, Director of Operations
Previous Committees:	None

Freedom of Information Act (FOIA) Exemption	☐ YES (restricted from the FOIA) ☒ NO (available to the public under the FOIA)
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Link to Strategic Objective	Focus on care quality, effectiveness and patient experience
Link to Provider Capability Assessment	Access and delivery of services
Link to CQC Well-led Statement	Shared Direction and Culture
Regulatory Impact	Regulation 17: Good governance

Key points	Purpose
This paper provides the Board with a high-level assessment of LTHT's 2025/26 winter response, identifies the principal lessons learned, and sets out the priorities required to improve resilience ahead of winter 2026/27.	Information
The LTHT winter plan will be reviewed by the Finance and Performance Committee in August 2026 and will return to the Board with an update in September 2026.	Information

Risk Appetite Framework			
Level 1 Risk	Level 2 Risks	(Risk Appetite Scale)	Impact
Workforce Risk	Workforce Supply Risk - We will deliver safe and effective patient care through having adequate systems and processes in place to ensure the Trust has access to appropriate levels of workforce supply.	Cautious	Operating within
Operational Risk	Business Continuity Risk - We will develop and maintain stable and resilient services, operating to consistently high levels of performance.	Cautious	Operating within
Clinical Risk	Capacity Planning Risk - We will ensure that capacity is planned to meet the demand for elective and non-elective	Cautious	Operating within

	(acute) admissions to our hospitals, managing this risk to provide safe treatment and care to our patients.		
External Risk	Partnership Working Risk - We will maintain well-established stakeholder partnerships which will mitigate the threats to the achievement of the organisation's strategic goals.	Cautious	Operating within

1. Purpose, recommendation and key assurance messages

This paper asks the Finance and Performance Committee to confirm whether it is assured that LTHT has a structured and proportionate winter planning approach for 2026/27. It summarises the evidence for expected adult and children's demand, describes the planned operational, workforce, infection prevention and system mitigations, and identifies the residual risks that will require active monitoring and escalation.

Overall, the plan provides assurance that the main winter risks have been identified and that a programme of mitigations, governance and escalation is in place. The principal residual risks relate to peak bed demand, specialty mismatch, infection prevention constraints, workforce availability, timing of system capacity, and the safe use of non-standard escalation spaces or corridor care where required.

Planning has started earlier than last year and has been informed by 2025/26 learning, current NHSE requirements and system partner workshops.

A summary of the relevant resilience documentation, including the Decision Management Tool for adults, children's services and infection prevention and control, is also referenced within this paper.

There is a requirement for a standard Board Assurance Statement (BAS) to be completed and submitted nationally by 30th September 2026. The Board completion of a section A of the BAS describes the Trusts approach to winter based on section B of the BAS which is the winter plan checklist. A support document summarising the BAS checklist accompanies this paper for ease of reference of the committee.

2. Learning from winter 2025/26 and planning approach

Each summer, LTHT plans for increased inpatient and non-elective pressure while maintaining elective and cancer recovery commitments. The programme uses previous winter learning, national and local briefings, demand modelling, mitigating actions and updates to Trust resilience documentation and the Decision Management Tool.

This year's planning has been informed by a review of 21 data sets and constitutional standards, an LTHT multidisciplinary leadership reflection workshop on 18th May 2026, and a city system leader workshop on 6th July 2026. The 2025/26 winter learning was submitted to Public Board on 30th July 2026 and has shaped this year's plan. The data sets reviewed are listed in Appendix 1.

A summer readiness plan is underway, with agreed timescales and named owners.

2.1 High level summary of summer readiness actions

- Preparation and agreements for opening additional inpatient wards during winter, with agreed notice periods and identified leaders, so they can respond safely and quickly if pre-agreed pressure triggers are met.
In progress. Complete by end of August 2026
- Fundamental review of the LTHT Operational Response Guidance, Full Capacity Plan and Decision Management Tool, including established trigger points and corridor care arrangements.

Complete

- Clinical Service Unit tri-team-led summer working group for both LGI and St James's sites, with three key objectives: optimise specialty bed base size, develop an improved patient flow model, and provide assurance on plans to decongest Same Day Emergency Care and assessment units.
In progress. Complete by end of August 2026
- Thirty-day challenge to support the patient flow and care campaign. Our vision is that no bed stays empty for longer than 45 minutes when a patient is waiting for one. This focused on learning and embedding meaningful, lasting improvements to patient flow and care.
In progress.
Complete by end of August 2026
- Self-assessment of the NHSE Model Discharge document published on 7 July 2026.
In progress.
- *Completed*
- Self-assessment against the Get It Right First Time (GIRFT) national Urgent and Emergency Care document, published on 14th July 2026.
Completed
- Self-assessment of the newly published NHSE March 2026 corridor care guidance.
Embedded by August 2026, with monthly review by the Quality, Safety and Assurance Group. Complete

2.2 System agreed actions

- Strengthening escalation and decision-making in system flow, including refining system governance, escalation routes and decision thresholds. This aligns with forthcoming system changes, including the ICB operating model and the developing Leeds Provider Partnership.
In progress. Complete by end of August 2026
- One-hundred-day proactive care test of change, testing and scaling up the multi-neighbourhood proactive care and discharge model that commenced in July 2026.
In progress. Complete by November 2026
- Reduce the number of inpatients with No Criteria to Reside by improving intermediate care.
In progress. 2-year improvement trajectory agreed and being tracked
- Develop a single WYAAT policy for repatriation of patients to embed a consistent approach, timely response, accountability and escalation processes.
In progress. Complete by end of September 2026

Section 3 now follows the structure of Section B of the winter BAS checklist and summarises the evidence, mitigations and remaining risks that support completion of Section A.

3. Board assurance checklist: evidence and mitigations

The following section summarises the Board assurance checklist and the actions in place to mitigate winter risk. The West Yorkshire ICB winter paper is due at Finance and Performance Committee on 1st September 2026; plans will be stress-tested at an NHSE event in the week commencing 14th September; ICB Board sign-off is scheduled for 22nd September; and winter reporting starts in October.

3.1 Prevention

There is a plan in place to deliver frontline healthcare worker flu vaccinations and long-stay inpatient vaccination for patients staying over 21 days, and to record this activity.

Staff

At LTHT, flu vaccine uptake was 53.7% last winter, a 9.7 %-point improvement on the previous year. The latest available national average was 38.7% in 2024/25. For 2026/27, delivery will focus on sustaining this improvement and achieving a minimum further 5 % increase in uptake with an aim for majority completion by 30th November 2026.

A staff communications strategy has been developed to reflect winter pressures across individual CSUs, supported by data from the 2025/26 campaign, which showed a clear correlation between higher flu vaccination rates and lower sickness absence due to respiratory and cold or flu illnesses. This correlation remains central to the 2026/27 campaign messaging to drive uptake.

Both walk-in and bookable appointments will be available throughout the vaccination campaign across all Trust sites, with information provided at CSU level to support delivery of the minimum 5% improvement in vaccination.

All vaccination activity is recorded on ESR, including whether those vaccinated are clinical or non-clinical staff using a flag system, to ensure national reporting accuracy. Uptake of staff vaccination is tracked and shared at Clinical Service Unit, Director and Trust level weekly to understand progress.

Inpatients

The inpatient influenza and COVID-19 vaccination campaign for LTHT is scheduled to commence on Thursday 1st October 2026. Vaccinating eligible hospital inpatients with a length of stay of 21 days or more is a critical opportunity to protect those at greatest risk of severe illness who may have missed vaccination in the community, while also helping to reduce hospital-acquired infections and winter pressures on the NHS.

Eligible inpatients for the influenza vaccine include adults aged 65 years and over, adults aged 18–64 years in clinical risk groups. Eligible inpatients for the COVID-19 vaccine include adults aged 75 years and over and immunosuppressed patients aged 6 months and over.

City population

The 2026/27 vaccination campaign for the city population begins on 1st September 2026, prioritising flu vaccines for pregnant women, children and under-18s in clinical risk groups. The main flu and COVID-19 rollouts begin in October 2026, with the aim of full coverage of eligible groups and improved uptake, especially among vulnerable populations. Efforts include targeted messaging, non-porcine vaccine options, and community engagement through programmes such as Community Champions. A system-wide approach will support

increased vaccination rates, focusing on disadvantaged areas, those with long-term conditions, frailty and pregnant women. A communication plan across the GP confederation has been developed to share progress by practice.

3.2 Occupancy and discharge

There has been a review of the discharges across each pathway required to manage bed demand and occupancy. These pathways have been developed jointly with system partners, with agreed escalation and actions.

Admission and discharge profiles are available in PPM+ at Trust, site, service and ward level. The Operations Centre uses this information to identify pressure points and support early intervention, including mutual aid between specialties where appropriate.

Patients with ongoing care needs who no longer meet the Criteria to Reside are visible through the system dashboard, with daily trend and patient-level data available according to role. Process improvements have commenced for Pathway 1 and Pathway 3 patients to reduce length of inpatient stay on those pathways. These improvements are expected to release approximately 20 occupied beds per day. In addition, the planned community rehabilitation offer is expected to support five additional discharges, releasing a further 10 occupied bed days. From October 2026, active recovery community capacity is expected to support 10 additional discharges per week, releasing a further 20 occupied beds per day. Together, these actions are expected to reduce the daily No Criteria to Reside (NCtR) count by 50 by 1st April 2027. Delivery will be tracked weekly against the improvement trajectory and overseen by LTHT operational and adult social care senior responsible officers. No Criteria to Reside figures are included in Appendix 2.

Referrals for ongoing care needs are mapped daily across the city. LTHT continues to work with the Transfer of Care Hub to increase weekend referrals, particularly for Pathway 1 patients.

Weekly city-wide review of long-stay NCtR patients is established. A new weekly forum for inpatients with a Criteria to Reside and long length of stay is being established, chaired by the LTHT Deputy Chief Operating Officer.

Alternatives to hospital admission include:

- 100-day test of change city proactive care programme, due to complete in November 2026.
- Primary care access line delivered by LTHT for the city, taking 7113 calls per month.
- Home Ward frailty and respiratory virtual wards, which prevent attendance or admission to hospital with a virtual ward capacity of 55 and 12 patients respectively.
- Six Same Day Emergency Care (SDEC) units covering medicine, elderly care, surgery, oncology, gynaecology, children's services and multi-specialty care at the Leeds Infirmary.

NHSE has identified Leeds as an exemplar site and system for admission avoidance for people aged over 65 and has included an extract from Leeds in its learning resources. Further improvement opportunities continue to be reviewed.

3.3 Capacity

There has been a review of operational capacity, including workforce, to support timeliness of care and delivery of cancer and inpatient elective care.

LTHT uses previous bed modelling and the latest NHSE information to assess the additional capacity required each winter.

Table 1 summarises the methodology used for this year's adult bed model.

Any new information from the North East and Yorkshire regional winter plan testing event in September will be incorporated into the model.

Table 1. Summary logic used in the 2026 adult bed modelling for two scenarios.

Modelling Category	Flu Scenario	No criteria to reside Scenario	Elective Scenario	Non-elective Scenario
Scenario 1 Most likely case	The volume and curve of last year flu with the more likely December increase	Average of the last 2 years	Elective inpatients match last year with the peak of January elective inpatients more evenly spread	Match last year's total
Scenario 2	Match last year's total	Last year's run rate	Elective inpatients matched last year	Match last year's total +2%

Using the variables outlined in Table 1, the weekly adult inpatient bed requirements between September 2026 and May 2027 have been modelled using the most likely Scenario 1.

As last year, the model includes patients in Emergency Departments (ED's) awaiting an inpatient bed and patients awaiting step-down from critical care. This gives a fuller view of demand and supports planning to reduce ED congestion and protect critical care capacity.

Table 2 summarises the predicted maximum, minimum and mean bed deficit for scenarios 1 and 2 between 1 September 2026 and 31 March 2027, before mitigation.

Table 2. Summary of adult bed modelling before any mitigation

		Maximum Deficit	Minimum Deficit	Mean Deficit
Scenario 1 – Most likely case	100% Occupancy	-215	+81	-56
	98% Occupancy	-248	+48	-87
	96% Occupancy	-281	+15	-120
Scenario 2 – Flu more impactful, demographic growth not mitigated by improvements	100% Occupancy	-247	+80	-66
	98% Occupancy	-280	+47	-99
	96% Occupancy	-313	-4	-135

For the adult bed model, the peak period of pressure is predicted to occur in January and February 2027 in both scenarios, as shown in Appendix 3. National planning guidance recommends 92% bed occupancy. LTHT is currently tracking at 96% occupancy year to date and has modelled winter on that basis, consistent with previous years and reflecting the balance between demand, available capacity, workforce and financial constraints.

Adult bed mitigations include 30 additional beds on J33 from November 2026, further additional capacity through Beckett Wing from January 2027 for eight weeks, seven-day opening of J24 from November as a recurring winter scheme, and 27 LGI beds from November 2026.

Two further CSU schemes will support admission avoidance or earlier discharge through respiratory nurse specialist and allied health professional input, building on evidenced benefits from last year's winter investment.

Delivery of the additional capacity and CSU schemes will be monitored through corporate operations team, with early escalation of delivery risks. Quality risks will be escalated through the Quality and Safety Assurance Group.

Based on Scenario 1, the impact of additional winter ward capacity and further mitigations is shown in Table 3.

Table 3. LTHT remaining adult bed mean deficit over the winter months, November 2026 to March 2027, at 96% occupancy.

Scheme	Nov	Dec	Jan	Feb	Mar
LTHT Adult total bed deficit before mitigations 96% occupancy	-116	-169	-259	-170	-83
J33 additional beds opened	30	30	30	30	30
J30 additional beds opened	0	0	30	30	30
J24 additional 3 beds opened	3	3	3	3	3
L12 additional beds opened	27	27	27	27	27
Admission avoidance at LGI SDEC - through AHP support and respiratory nurse specialist teams at SJUH	8	8	8	8	8
LTHT Adult total bed benefit of mitigations	68	68	98	98	68
LTHT Adult remaining deficit after LTHT mitigations	-48	-101	-161	-72	-15
Reduction in NCtR patients in LTHT	25	30	40	40	50
Remaining adult bed deficit	-23	-71	-121	-32	35

December and January are expected to be the most pressured months, with the greatest remaining adult bed deficit after Trust mitigations. It is expected the LTHT surge plans and City partners short term assessment capacity will provide partial mitigation of peak demand in December and January. In addition to surge capacity in and out of hospital the ICB is currently in the procurement process for 10 additional permanent residential beds and exploring the cost and availability of spot purchase beds for dementia care. These additional beds are not currently in the winter plan as timeframes are not confirmed.

The winter city capacity will be monitored through the system visibility dashboard and reported to the Active System Leadership Executive Group.

Children's

Children's bed modelling has been completed and includes the number of children in the bed base with COVID-19, flu and RSV infections to predict the increase in demand on the children's bed base over winter. The graphs for the Children's CSU bed modelling are available in Appendix 4. Table 4 and table 5 demonstrate the logic, maximum, minimum and mean bed deficit without mitigations.

Table 4. Summary logic used in the 2026 Children's CSU bed modelling for the two scenarios.

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

Table 5. Summary of children's bed modelling before any mitigations: October 2026 to 31 March 2027.

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

The mitigations below are expected to support the Children's CSU during winter pressure by providing a positive capacity position against mean demand and additional flexibility to respond to demand peaks. The remaining risk is that short periods of flu, RSV or COVID-19 demand may exceed modelled assumptions, requiring close operational monitoring and timely escalation.

Table 6. LTHT remaining children's bed deficit over the winter months, October 2026 to March 2027, at 96% occupancy.

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

Workforce capacity

The winter surge areas will be supported by increased Registered Nurse (RN) staffing levels. Registered Nurse vacancies continue to improve, with the vacancy rate reducing to 6.9%, compared with 8.2% in 2025/26 and 13.2% in 2024/25. The Trust has a strong pipeline of newly qualified nurses who will have completed their supernumerary period and joined the substantive workforce by December 2026. In some specialist areas, supernumerary periods will be longer to support competency development and safe transition into practice.

Clinical Support Worker (CSW) vacancy levels have remained relatively stable at approximately 200 Whole Time Equivalents (WTE) in July 2026, significantly reduced from almost 800 WTE in December 2022. This position is anticipated to improve through the continuation of the Trust's rolling New to Care recruitment programme, which welcomes approximately 30 new Band 2 Clinical Support Workers each month, supporting both workforce supply and widening participation objectives.

Workforce safety will be monitored against pre-determined agreed safe staffing levels across the 92 LTHT inpatient wards. The process for this is through the daily staffing safety review, including twice-daily review of the safety wheel by designated Heads of Nursing. This will support early identification of staffing pressure, escalation of areas of concern and deployment of available staff to priority areas during periods of winter pressure. This process is completed through the working week, on weekend and bank holidays and helps us mitigate risks if bank staff availability is constrained.

An ED workforce winter uplift to support increased acuity and admission avoidance will be supported through winter funds. ED 24-hour medical rota reviews have taken place supported by human resource colleagues to offer more resilience and continuity, reducing short notice changes of shifts and to maximise workforce availability at key points. Medical and elderly care medical cover has also received a workforce uplift to support winter activity both in and out of hours.

Wellbeing for our workforce during pressured times is a combination of CSU local events and messaging underpinned with signposting Trust wide information on how to access support of their health, wellbeing and potential financial worries.

3.4 Flow, corridor care and escalation

Corridor care and Emergency Department crowding are being mitigated, including through GIRFT recommendations and defined safety measures. Ambulance handover performance will be maintained, clear system escalation routes are in place, and rotas have been reviewed to maximise decision-making capacity at times of peak pressure, including weekends.

Corridor care is monitored daily through five corporate reports that describe the current operational position and is reported nationally each day. Compliance with GIRFT corridor care safety measures is reviewed monthly at the Quality, Safety and Assurance Group. The surge and escalation documents include defined triggers to minimise corridor care.

Appendix 7 maps the potential escalation spaces available across the estate. Many of these spaces rely on non-standard areas, temporary reconfiguration or corridor care, so their use will require clear escalation triggers, clinical risk assessment, staffing checks and recovery plans to return areas to normal function as soon as possible.

Leeds ambulance handover performance is among the strongest in the country. Proactive collaborations to avoid unnecessary ambulance conveyance include:

- Direct access to the Primary Care Access Line.
- Call before conveying of any care home patient by phoning an elderly care physician.
- Direct conveyance to Same Day Emergency Care units for medical and elderly patients.
- Escalation to system partners

Weekend resilience across all staff groups, including senior decision makers, will be reviewed through rota management. Key pressure areas will attend the Friday weekend briefing to confirm their weekend cover plans and identify any escalation requirements.

3.5 Infection prevention and control

Plans, infrastructure and IPC governance are in place, including patient cohorting. LTHT is rapidly working up the new NHSE mandate that fit testing is recorded on ESR for all staff groups from October 2026, ESR will be complimented by METRA at LTHT to record type of mask to support with supply and demand and all relevant PPE stock and flows are in place for periods of high demand. There is both a nurse and medical roster with a High Consequence Infectious Disease (HCID) trained/fit tested staff member on duty and flagged for each ED by site and shift. This is the same for the infectious disease unit that is based at SJUH.

LTHT have an environmental assessment of all wards by air exchange rates. For infection cohorting wards there is an agreed increased cleaning regime and monitoring of this. Decisions are made about areas to cohort with Microbiology clinicians, IPC team and clinical CSU senior team this includes bay or full ward cohort decisions dependant on virus and patient group. Cohorting decisions are logged on the site reports and weekend briefing. Plans to cohort a ward for flu patients will need to remain flexible and adaptable, depending on where pressures are greatest in the hospital at the time. For this reason, cohorting will continue to be a multidisciplinary team decision.

The LTHT Operational IPC Group, chaired by the Medical Director for Operations, meets fortnightly. A September 2026 meeting will focus on the winter plan. The group supports

development of the adult, children's and IPC decision management tools, including arrangements for periods of extreme pressure.

During winter, ward teams and the IPC team work together in real time, seven days a week, to respond to demand and cohorting requirements. Decisions are guided by acuity, specialty, virus type and strain, and expected duration of capacity impact. Daily flu and COVID-19 inpatient reports and twice-daily IPC reports on ward restrictions support monitoring and placement decisions.

Improved IPC measures have reduced bed closures compared with the previous year. A PPM+ side-room utilisation form supports flexible patient placement, and compliance is monitored weekly by the Operations Centre and shared with CSU Heads of Nursing.

The Operations Centre hosts a Friday afternoon weekend briefing for on-call teams. A member of the IPC team describes anticipated cohorting plans, allowing questions to be raised and addressed before the out-of-hours and weekend period.

Fit testing

Weekly fit testing sessions are in place in the Emergency Departments. The nursing staff in our paediatrics, LGI adult and SJUH Emergency Departments are priority areas and are achieving the target of staff tested. Fit testing is included as part of new starter weeks which supports compliance.

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

PPE stock

Clinical areas maintain agreed PPE stock levels. Additional stock can be requested through Materials Management or ordered directly from NHS Supply Chain, with urgent delivery available within 24 hours where required.

NHSSC has a Resilience Team and is currently planning its winter response and increasing stock levels accordingly. To support accurate forecasting and stock availability, LTHT IPC and procurement teams will liaise when any changes to policy or procedure may affect PPE use.

Infection Prevention Control senior nurse weekend cover will commence in November 2026 to support expected winter peak pressures.

3.6 Leadership and operational grip

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

Seven-day out-of-hours cover includes Head of Nursing, General Manager and Director on-call arrangements. Senior Clinical Site Managers are based at SJUH and LGI, with additional maternity support planned to release CSM capacity for timely patient placement. Consultant-level medical leadership sits within specialty services.

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

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

Severe weather and infrastructure contingency plans are reviewed and tested via the Emergency Preparedness team.

OPEL Framework

The national OPEL Framework applies to acute, community and mental health providers. It includes revised definitions, scoring criteria, metric weightings and actions for providers and NHS England regional teams.

LTHT OPEL Metrics

LTHT uses nine standard acute metrics to assess pressure and calculate OPEL scores at site and Trust level:

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

LTHT OPEL data is sent automatically every two hours through RAIDR, which also provides visibility of other acute trusts, ambulance handover position and the ICB position.

A twice-daily Key Line of Enquiry report is sent to the System Co-ordination Centre to provide operational context and confirm that required OPEL actions have been enacted. The SCC supports intervention on key flow issues, including escalation for out-of-area repatriations and mental health patients in Emergency Departments or the bed base.

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

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

The Trust Operational Response Guidance has been reviewed to align with OPEL actions. It includes surge plans for extreme pressure and a planned approach to balancing risk across sites if Emergency Department overcrowding creates patient safety concerns. Surge areas and temporary escalation spaces are described in Appendix 7.

4. Quality and performance implications

It is recognised that the Emergency Departments were crowded during the winter months last year. The new corridor care definition and nationally mandated daily reporting provide a further marker of patient experience and quality of care for winter 2026/27. The summer work plan is focused on reducing delays and improving timeliness of care for patients. A paper will be presented to the Quality Assurance Committee on 20 August 2026 describing the plans to maintain quality of care during winter 2026/27.

5. Financial implications

In 2026/27, an LTHT winter fund of £4.4 million was approved at executive level. This has been aligned to Clinical Service Units to support increased staffing in the Emergency Departments, increased capacity across adult and children's services, and additional winter pathways and resources across the organisation. A new governance process was established last year, with fortnightly tracking of spend against each approved winter scheme and funds released when it was evident that the actions and associated costs were being incurred. The £4.4 million allocated for winter 2026/27 will follow the same governance process.

6. Risk

The winter plan does not change the Trust's agreed risk appetite, but it does require active management of existing risks relating to occupancy, capacity, system flow and corridor care. Seasonal demand and capacity are reflected in the following corporate risks:

- CRRC10: high levels of occupancy, insufficient capacity and system flow, reviewed by Risk Committee in March 2026 and due to be reviewed again in September 2026.
- CRRC4: failure to achieve the ECS constitutional standard of 95%, reviewed by Risk Committee on 2nd July 2026.
- A newly described corporate risk relating to corridor care, approved through Risk Committee on 2nd July 2026.

7. Communication and involvement

Learning has been informed by a multidisciplinary reflection session in May 2026 involving CSU teams and support services, followed by a Leeds city event in July 2026 with more than 50 colleagues from Leeds organisations, including third-sector representation. This work informed shared planning priorities for winter 2026/27. Two further North East and Yorkshire NHSE events are planned: one on 28th July 2026 and a second in-person event in September 2026, with details to be confirmed. The winter plan will be communicated to tri-teams and service leads at a September winter event and has been co-produced with system colleagues at Leeds place, West Yorkshire and regional level through ICB-hosted winter workshops. Updated internal resilience documentation will be shared with colleagues involved in the daily flow of the hospitals and will be available in the on-call folders.

8. Impact on equality and health inequalities

An EHIA was completed as part of the NHSE winter planning requirement in September 2025. This has been reviewed post-winter.

Key areas of note are:

The proportion of patients attending an Emergency Department who live in areas recorded as being in the most deprived IMD profile was approximately 38% for SJUH, a 2% reduction on the previous winter, and 33% for LGI. This is similar to the previous winter period. Increasing attendance rates in this group are attributed to chronic health conditions that

worsen over the winter months and require more intensive management, compounded by damp housing and lack of heating.

While LTHT has a higher-than-average proportion of patients from more deprived groups attending the Emergency Departments, equity at the point of attendance is maintained by prioritising patients based on clinical urgency, while continuing to work across system boundaries to reduce health inequalities through system programmes of work.

The city influenza vaccination programme was aimed at those with higher chronic disease risk and deprivation. The inpatient influenza vaccination rate increased by 80.3% through implementation of a new process led by medicines management colleagues. The city vaccination rate for influenza improved compared with the previous year, with notable improvement in high clinical risk groups, people with identified learning disabilities, 2- to 3-year-olds and pregnant women.

9. Publication under Freedom of Information Act

This paper has been made available under the Freedom of Information Act 2000.

10. Recommendation

Residual risk and assurance position: The plan provides assurance that LTHT has a structured winter planning approach, informed by prior learning and supported by operational, workforce, IPC and system mitigations. Residual risk remains around peak bed demand, specialty mismatch, infection prevention constraints, workforce availability, timing of system capacity, and the safe use of non-standard escalation spaces or corridor care where required. These risks will be monitored through the Trust operational centre, corporate operations meeting, quality and safety assurance routes, system dashboards and agreed escalation processes, with Appendix 7 reinforcing the need for clear triggers, clinical risk assessment, staffing checks and rapid recovery plans.

The Finance and Performance Committee is asked to note the winter plan, support the earlier planning approach, and confirm whether it is assured that LTHT has a structured and proportionate response to the predicted winter demand and pressures.

The Committee is asked to note that periods of pressure will require use of the Operational Response Guidance and Decision Management Tool to support timeliness, safety and quality.

The Committee is also asked to note that winter predictions will remain under review and schemes may be adjusted if respiratory virus pressures peak earlier or later than expected.

The Committee is asked to consider the Section B Board assurance questions and confirm assurance.

11. Supporting information

Supporting information is included in the appendices, including the data sets reviewed, No Criteria to Reside figures, adult and children's bed modelling, escalation tools, surge and corridor care provision, and the equality and quality impact assessment summary.

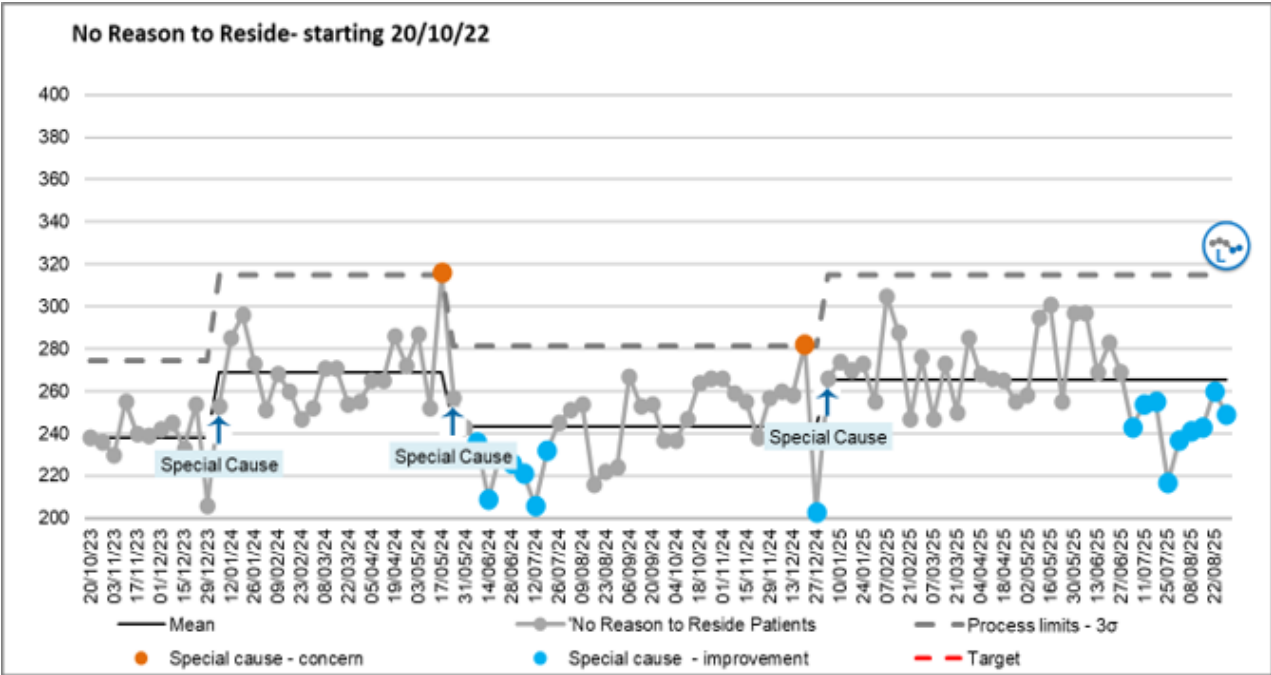
In addition to this a supplementary document labelled Easy read winter planning checklist copied from the BAS section B.

Appendices

Appendix 1: Data sets reviewed

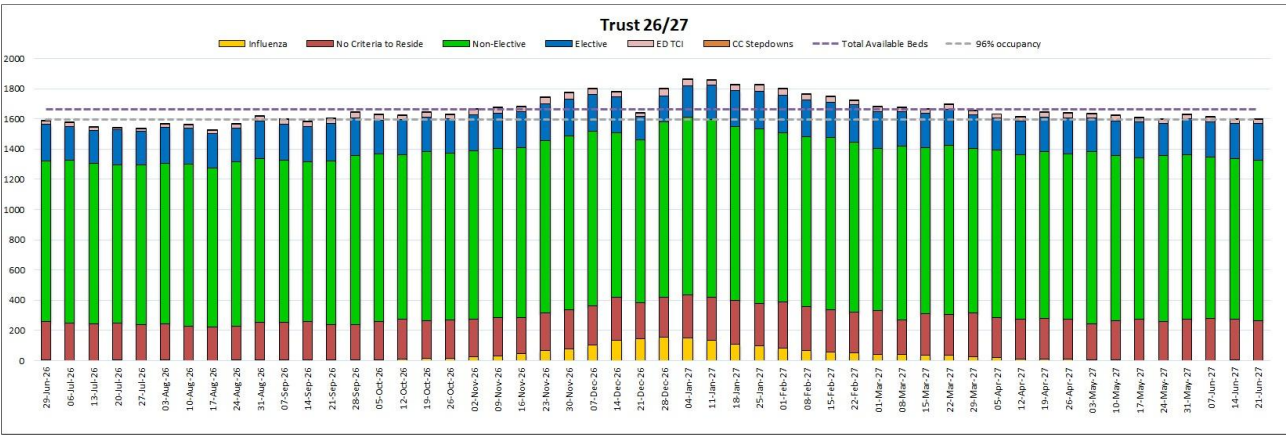
Data Sets Reviewed 2025/2026 Winter Reflection	
Data Title	Data Source
LTHT Inpatient Beds volume and use	PPM+
LTHT Bed Occupancy by day, site adults and children	PPM+
Bed Occupancy by Elective and Non-Elective by Site	PPM+
Flu inpatient beds occupied at midnight	PPM+
Inpatient beds occupied by COVID positive patients	PPM+
Critical Care Delayed Step downs in Bed Base	LTHT PLICS Data
No of patients TCID at midnight in ED	Symphony
LoS data by elective and non-elective and site	LTHT Internal Data G Drive
No Criteria to Reside numbers at midnight	PPM+
ED attendances	Symphony
Ambulance Handovers	YAS BI Dashboard
No Criteria to Reside P1 LoS on pathway	System Visibility Dashboard
No Criteria to Reside P1 number of patients in LTHT bedbase	System Visibility Dashboard
No Criteria to Reside P2 LoS	System Visibility Dashboard
No Criteria to Reside P3 LoS and numbers awaiting care	System Visibility Dashboard
Access to services domain	NHS Oversight Framework Access to Services Domain
Reviewed % of patients with No Criteria to Reside	NEY Analytics Discharge Report
Discharges before 5pm	NEY Analytics Discharge Report
Numbers of patients in the bed base over 21 days with No Criteria to Reside	NEY Analytics Discharge Report
A&E Performance	LTHT Internal Data G Drive
Number of patients waiting for an inpatient bed over 12 hours per day	Symphony

Appendix 2: No Criteria to Reside figures

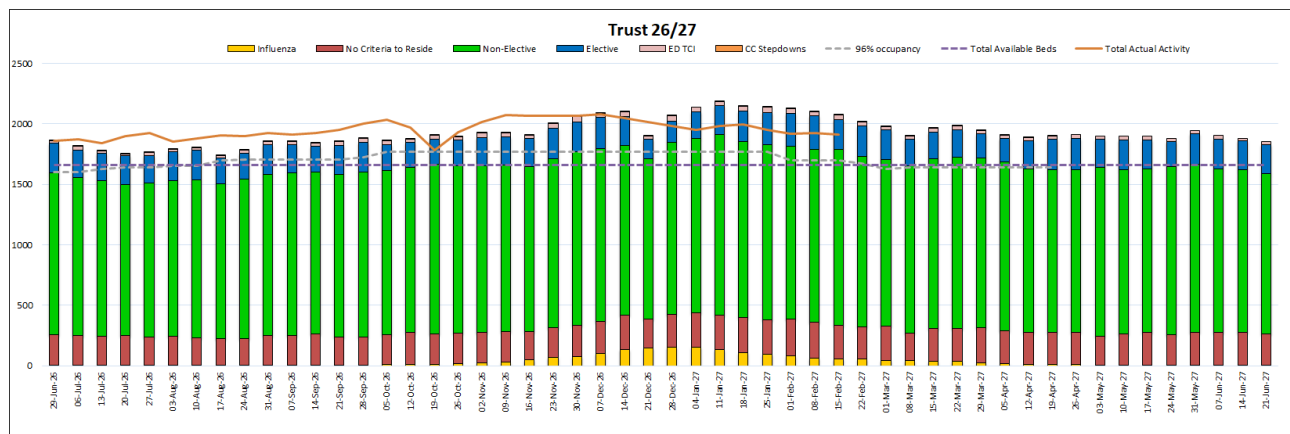


Appendix 3: Adult bed modelling

Scenario 1: most likely adult winter demand scenario, using the assumptions described in Table 1.

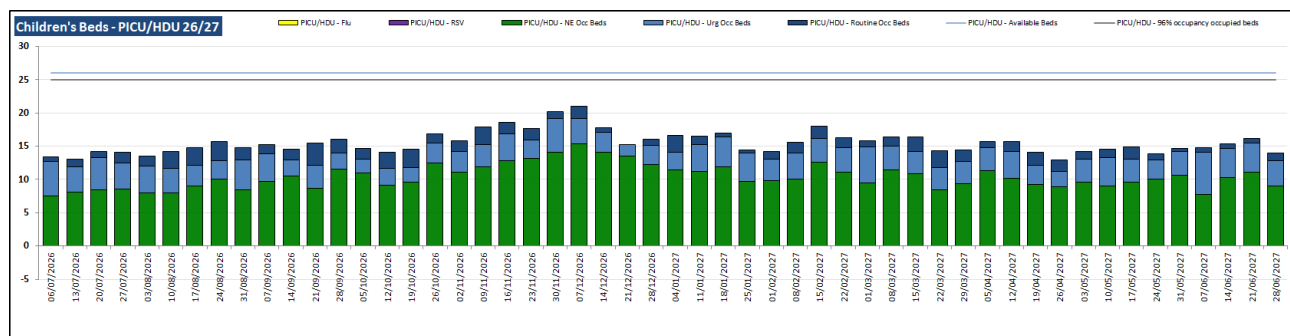
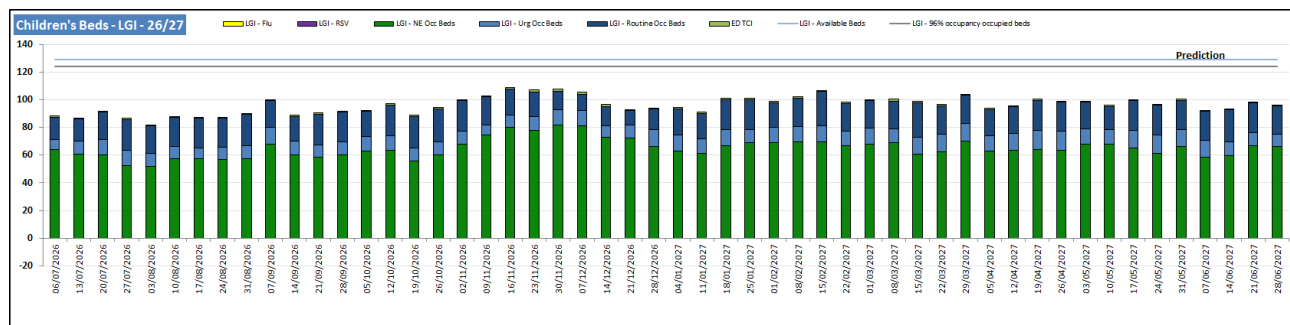


Scenario 2: higher-pressure adult winter demand scenario, used to test the impact of greater respiratory virus activity and non-elective demand.

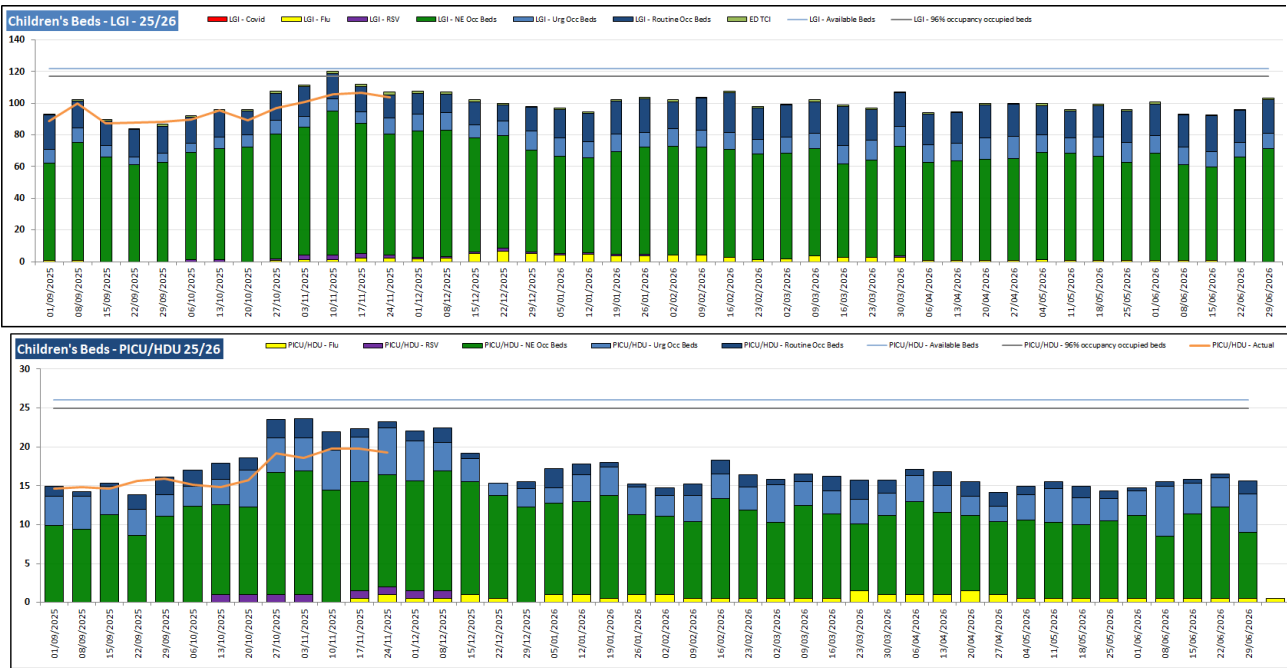


Appendix 4: Children's Hospital modelling

Scenario 1: most likely children's winter demand scenario, including expected flu, RSV and COVID-19 pressures.



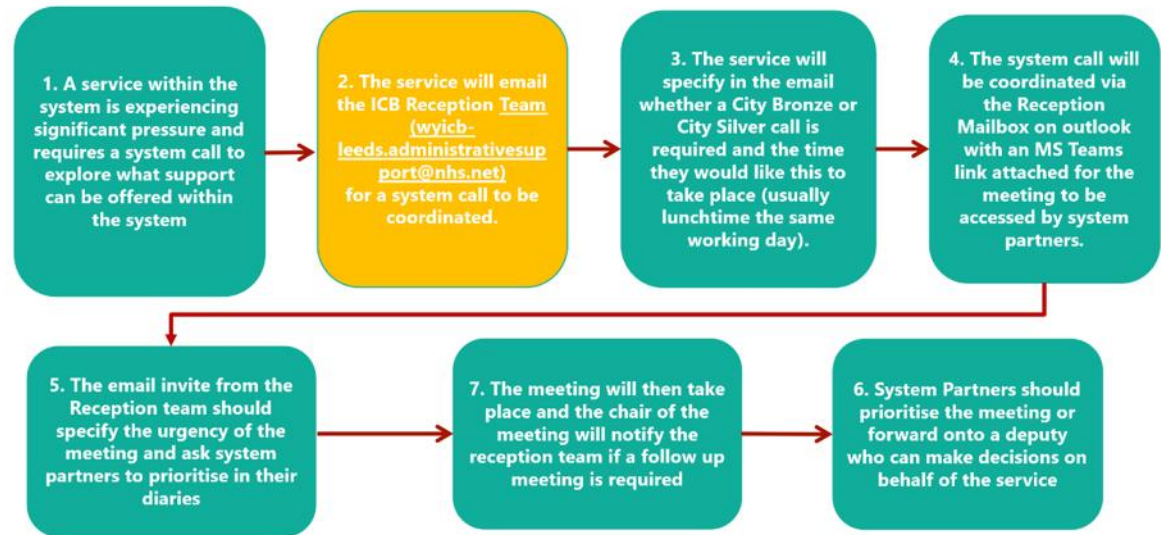
Scenario 2: higher-pressure children’s winter demand scenario, reflecting increased flu and RSV activity.



Appendix 5: Flow chart for the request of a system call

Requests for City call (Bronze, Silver, Gold)

Flowchart of process



Appendix 6: Decision management tool

Decision Management Tool: Children's services**DMT**

Option	A
Action	All District General Hospital / Repatriation patients returned to base hospitals
Benefits	Maintain tertiary and specialist regional service capability Creates acute bed capacity
Risks	No suitable patients/pressure on receiving hospitals

Option	B
Action	Discharges - Escalate delayed discharges - Patients with EDD tomorrow - why not today?
Benefits	Additional Bed capacity Supports patient flow
Risks	Increased clinical risk/clinical reluctance

Option	C
Action	PCAL Divert North Leeds Patients to Harrogate General
Benefits	Admission avoidance
Risks	Small impact/pressure on other units

Option	D
Action	Consider use of specialty paediatricians to review medical patients by reducing / stopping clinics
Benefits	Supports timely discharge
Risks	Impact on OPD waiting times

Option	E
Action	Increased deployment of AHPs on wards
Benefits	Releases AHP workforce to help facilitate discharges from wards
Risks	Will only help 9-5pm

Option	F
Action	Increased deployment of non ward based nurses on wards (Educators and CNS)/cancel all study leave and ask nurses to work clinically. Include Nurse in charge into the numbers
Benefits	Releases CNS, education and research workforce to increase nursing workforce on wards Enables opening of surge beds Is the nurse in charge included in numbers?
Risks	Helps with day time staffing only

Option	G
Action	Utilise surge beds: L40 Panda - 5 Beds L40 - 3 Beds (Bays from 4 to 5) L51 - 3 Beds L52 - 2 Beds L38 - 2 Beds L31 - 2 Beds L50 - 2 Beds Total increase of 19 beds - to red staffing levels in first instance
Benefits	Maximise elective productivity whilst releasing acute beds Potential to protect cancer & urgent capacity Improved flow due to additional medical beds
Risks	Ward on red staffing ratios

Option	H
Action	Cancel routine elective in-patient operating requiring overnight stay (excluding over 65 weeks, P2 and cancer surgery)

Benefits	Protect P2 surgical capacity Release theatre staff for acute list / theatre demand
Risks	Poor patient experience/impact on inpatient waiting lists

Option	I
Action	Staff all beds, including surge to amber and then red staffing levels in first instance
Benefits	Maximise elective productivity whilst releasing acute beds Potential to protect cancer & urgent capacity Improved flow due to additional medical beds
Risks	Risk to patient care - requires Director Approval

Option	J
Action	Consider converting L41 to medical beds (no increase in overall bed capacity however provides a further medical ward)
Benefits	Supports patient flow
Risks	Will reduce elective operating

Option	K
Action	EXTREMIS - Cancel all elective in-patient operating requiring overnight stay including P2 and oncology patients
Benefits	Releases acute bed capacity Reduce number of patients in non-designated areas Release of theatre staff to support ward areas
Risks	Risk to patient safety

Option	L
Action	EXTREMIS - Temporary diversion of activity including YAS from LGI paediatric ED

Benefits	Provides temporary relief of acute pressure
Risks	Reputational harm/requires Director sign off

Option	M
Action	EXTREMIS - Convert as many day-case beds on L49 to inpatient as staffing allows
Benefits	Additional Bed capacity Supports patient flow
Risks	Inadequate staffing

Decision Management Tool: Adult services

Adult Beds Decision Management Tool: Approved June 2025

A	B	C	D	E	F	G	H
Reverse board inpatients for a maximum of 4 hours as per surge plan to decongest ED / Assessment Areas	Reduce non-clinical Consultant, AHP and Senior Decision Manager sessions and revert to clinical sessions in day as per CSU agreements	Bed into med/federally SDEC Has 24 cubicle spaces 3 stage plan beds up to 18 patients overnight	Utilise beds closed due to IPC reasons using the IPC DMT (Utilising 7 day IPC cover)	Bed into MSAA up to 9 patients, with a return to assessment function possible with 8 bedded patients	Request on-call Consultant team to attend site as per specialty pressures medical escalation plan	Enact the Full Capacity Plan and use of Temporary Escalation Spaces (TES) This will be completed in order: Surge spaces, TES	Open additional unstaffed inpatient capacity: 2 beds on J23 (current office) Up to 14 beds on L14 Up to 18 beds on X37 Ensure 4 bed spaces on J82 Discharge lounge late/overnight
Release bed capacity earlier to decongest the ED Assessment areas	Additional SDM support to provide review of patients and support decision making	Additional Bed capacity Supports patient flow Release ward staff to cover other areas	Additional Bed capacity Supports patient flow Maintain Cancer / Tertiary activity Release ward staff to cover other areas	Additional bed capacity to reduce congestion within the EDs	Additional SDM support to provide review of patients and support decision making	Additional bed capacity to reduce congestion within the EDs	Acute Bed capacity Supports patient flow Maintain cancer / tertiary activity
Potential for patients to be boarded over the 4 hour maximum if issues arise.	Impact on non-clinical activity which may have longer term impacts, e.g. teaching, development etc.	Existing training rooms deteriorate further Increase in sickness levels Inability to deliver safe patient care Increased patient and staff complaints Increased turnover of staff Inability to staff all wards safely	Risk associated with actions are outlined within the IPC DMT	Risk of reduced capacity available for the assessment function of MSAA the following day, which could result in patients remaining in the ED to await assessment and treatment.	Impact on other planned activity for the following day which could impact on Outpatient / elective delivery.	Please see the ESA SOP for further details	Existing staffing levels deteriorate further Increase in sickness levels Inability to deliver safe patient care Increased patient and staff complaints Increased turnover of staff Inability to staff all wards safely
I	J	K	L	M	N	O	P
David Beevers 24/7. Extension of 6 day facility Bed surgical planned or acutes up to 9	Open additional ward capacity to support site pressures: J39 (29 beds) J31 (28 beds) J32 (38 beds) L12 (27 beds)	Reconfigure JAL for surgical step & 23 hour day case patients (7 beds) (Consider in conjunction with CC expansion plan) Please note: 6 staff members are required in the unit to support the fire evacuation due to the stairs at the fire exit.	Open J25 as a 12 bedded short stay area	Use all bed capacity even if it results in mixed sex breaches	Surge into an additional 3 spaces within Green area within the SJUH ED	Double up in SJUH ED cubicles	Cancel elective inpatients in clinical priority order: 1. Routine Electives - P5/P4/P3 2. Urgent Electives - P2
Increased bed capacity Supports patient flow Maintain cancer / tertiary activity	Acute Bed capacity Supports patient flow Maintain cancer / tertiary activity	Maximise elective productivity whilst releasing acute beds Potential to protect some cancer / urgent capacity Improved flow due to earlier cancer election as on main	Additional bed capacity to reduce congestion within the EDs	Supports patient flow from A&E Potential to prevent temporary YAS diversion	Acute Bed capacity Supports release of ED assessment capacity and supports ambulance handover cubicles	Acute Bed capacity Supports release of ED assessment capacity and supports ambulance handover cubicles	Preserve as much elective cancer work as possible but considers urgent cases of equal priority
Not live with CQC recommendations Privacy and dignity issues Poor patient experience Increase in patient complaints Damage to Trust reputation	Existing staffing levels deteriorate further Increase in sickness levels Inability to deliver safe patient care Increase patient and staff complaints Increased turnover of staff Inability to staff all wards safely	Increased patient harm & clinical risk Patient status changes from curative to palliative Deterioration in RTT & impact on recovery plan & cancer performance Increased waiting time Risk of routine electives becoming urgent / acute Increase in patient complaints Damage to Trust reputation Professionally unacceptable	Risk to existing activity through J25 which will include a large number of patients who would need to be cancelled at short notice and rearranged.	Poor patient experience Privacy and dignity issues Damage to Trust reputation Professionally unacceptable	Existing staffing levels deteriorate further Increase in sickness levels Inability to deliver safe patient care Increase patient and staff complaints Increased turnover of staff Inability to staff all wards safely	Existing staffing levels deteriorate further Increase in sickness levels Inability to deliver safe patient care Increase patient and staff complaints Increased turnover of staff Inability to staff all wards safely	Deterioration in RTT & impact on recovery plan Increased waiting times for patients Increase in patient complaints Increased risk of 52 week breaches Primary care referral impact Risk of routine elective patients becoming urgent/acute Deterioration in patient condition

Decision Management Tool: extremis actions

	Option	BC Level	Decision level	Comments
1	Open additional unfunded bed capacity if available 1a. In hours 1b. Out of hours	1	LTHT Exec	Risk-assess staffing across all clinical areas and deploy available staff to priority areas where safe to do so. Standard operating procedures should confirm out-of-hours staffing, equipment, medicines and supply requirements.
2	Medical staffing. Cancel all SPA and then non-urgent/ <48w outpatient clinics and redirect all medical staff to ward work or ED 2a. On day activity cancelled 2b. Cancel next 48 hours (recovery plan) 2c. Request on-call consultants to remain on site or to reattend for critical or major incident declaration	1	LTHT Director	Apply the Medical Escalation Policy and confirm the specific medical actions required, including consultant ward rounds, afternoon discharge huddles, senior review of Pathway 0 patients and review of pending diagnostics.
3	Cancel non-urgent planned therapies activity to deploy additional therapists to ED and wards	1	LTHT Director	Therapy escalation actions should be confirmed through the relevant CSU escalation plan.
4	Bed >18 patients into medical SDEC – ensure rapid recovery plan is in place for 5 patients to be warded at 8am	1	LTHT Director	Requires confirmed nursing and medical staffing plans and a rapid recovery process to return the area to its assessment function as soon as safe to do so.
5	Request a consultant enriched 48 - hour front-door rota (similar to industrial action periods).	1	LTHT Exec	Requires Executive approval and should be targeted to the areas of greatest front-door pressure, including Emergency Medicine, acute medicine, orthogeriatrics and emergency general surgery. Targeted to ED/SIM and orthogeriatrics/Acute Medicine/ EGS
6	6a. Stand down CHOC theatres and transfer orthogeriatric/ trauma patients from LGI to CAH 6b. Stand down WGH theatres and transfer pre-agreed patient groups from main sites	1	LTHT Director	Consider use of CHOC workforce/ theatres for acute TRS trauma if inpatient trauma cases > threshold. Need to identify patients suitable for emergency transfer to WGH in event of critical incident. Would need specific medical and nursing models – identify a named consultant for daily ward round if outlier LOS anticipated to be >24 hours.

7	Transfer LGI patients to SJUH or CAH to utilise all available beds (or vice versa) 7a. No criteria to reside patients to Beckett Wing/ SIM/CAH 7b. LGI frailty patients with ongoing medical needs and no surgical care required 7c. GIM or elderly patients to L12/ LGI capacity 7d. Convert J24 to medical beds 7e. Convert J11 to acute medical beds	1	LTHT Director	Would need specific medical and nursing models – identify a named consultant for daily ward round if outlier LOS anticipated to be >24 hours.
8	Admit medical patients onto SAU/ GATU	1	LTHT Director	SAU DMT is being described by AMS including actions to create continuous capacity (one assessment room always available). Needs joint CSU recovery plan to expedite rapid return of assessment function and elective cancellations
9	Bed > 16 patients into MSAA – need recovery plan to maintain assessment unit function	1	LTHT Director	Needs nurse and medical staffing plan. Rapid recovery flow chart to be described – upper limit is use of all beds
10	“Down tools” evoked. All CSU and senior leaders are asked to be on site for a ‘down tools’ - immediate walk-rounds of all clinical areas, medical reviews, risk assessments and to ensure balanced safety across all areas	1	LTHT Director	Initiate immediate senior clinical and operational walk-rounds of priority areas, with actions focused on balancing safety, accelerating reviews and supporting discharge or transfer decisions. City Gold – what would be the equivalent actions for ASC/LYPFT/LCH and VSCE
11	Convert L26 to inpatient ward beds by cancelling planned DC activity	1	LTHT Director	Needs nurse and medical staffing plan. Rapid recovery flow chart to be described – needs red line
12	Transfer younger adults (16 – 18 yr) to Paediatric bed-base	1	LTHT Director	Feasible only if pre-existing transition patients. Would need consultant paediatric review and a way to identify from PPM – need handover or risk loss of medical oversight – for review by Children’s Director tri

13	Enact a version of continuous flow - 2 patients are moved from ED to each agreed ward in the next hour to balance clinical safety until OPEL de-escalation is secured 13a. Reverse boarding against expected discharges is standard DMT action (level 1) 13b. Corridor care is enacted at risk – no expected ward discharges (level 2+)	2+	COO CNO	Assumes all reverse boarding and corridor spaces plus discharge lounge capacity are already in use.
14	Cancel all surgery for next 24 hours – including cancer and P1 patients who are not currently in bed base	2+	COO	Enact theatre prioritisation meeting to be chaired by MD ops or dCMO. Request CSU recovery plan for cancer, P2 and >48ww patients. Request for mutual aid to transfer P1 patients would likely meet criteria to trigger a Major Incident notification
15	Request immediate repatriation of all patients awaiting onward care at another trust 15a. Waiting more than 48 hours 15b. Waiting less than 48 hours 15c. Transfer patients to EDs in receiving trusts	2+	COO	Exec escalation to ICB for mutual aid would be a Level 2 incident. Needs patient safety checklist for CSUs to ensure safe handover. Option of repatriation to trust EDs if no inpatient beds available (to discuss with WYAAT – Critical or Major Incident action and needs to include YAS SOP)
16	Establish a short-stay critical care/HDU/Level 1 facility in PACU to facilitate continuation of P1 surgery	2+	COO	Pre-agree prioritisation of PACU areas to be stepped down first and proposed medical/ nursing staffing model
17	Executive action to request City Gold response	2+	COO/ deputy	Follow agreed protocol for in- and OOH
18	SYSTEM - request immediate discharge of patients with no criteria to reside on Pathway 1-3 18a. Same-day	2+	LTHT Exec	Assumes City Gold has been stood up. Need a system DMT with agreed immediate actions in event of critical incident (7- day service) including urgent options for bridging or temporary arrangements/ family interim plans

	18b. Next day 18c. 48 hours (recovery plan)			LTHT co-ordination plan - Ops Centre to describe
19	SYSTEM - request immediate repatriation of patients with no medical CtR who are awaiting LYPFT bed 19a. Same day 19b. Next day 19c. 48 hours (recovery plan)	2+	LTHT Exec	Needs LYPFT to describe immediate actions. Ops centre to outline LTHT co-ordination plan.
20	SYSTEM – ICB escalation to request ambulance divert or tertiary referral stand-down	3	LTHT Exec	There are some specialties/ services which could be diverted with minimal risk, and some which can never be diverted without significant patient or system risk. This needs to be documented and held by EPPR (KC) Requesting ambulance diverts or standing down tertiary referrals should be classified as a Level 3 Major Incident response. This action moves beyond local capacity management and directly impacts the regional West Yorkshire network. As this necessitates multi-agency formal coordination with NHS England (Region) and YAS , it may need to be declared as a Major Incident to ensure the wider clinical risks across the regional footprint are managed.

The following appendix summarises potential surge, corridor care and fit-to-sit capacity by site. These areas should be used only through agreed operational escalation processes and with appropriate clinical risk assessment.

Appendix 7: Current surge and corridor care provision

Key message: LTHT has mapped potential escalation spaces across the estate and has a clearer view of where additional patients could be placed during extreme pressure. However, much of this capacity relies on non-standard spaces, corridor care, or temporary reconfiguration. The key assurance message is therefore not simply that extra spaces exist, but that they must be governed tightly through escalation triggers, clinical risk assessment, staffing checks and rapid recovery plans to return areas to normal function as soon as possible.

Leeds General Infirmary ward areas

CSU	Surge Location	Surge Number	CORRIDOR CARE	CORRIDOR CARE total	Additional CC	Total Additional CC	Fit To Sit
Cardiology	L14 x 6 beds (up to 12 + 2 beds)	6	L16 x 1 (day room) – Low L19 x 1 bed (day room) – Low	2	L18 – (LT1) 2 L18 – (LT1)		L18 x 1 bed (Nurses Station)
Head & Neck	Nil	0	L23 x 1 bed (consultation room) Low	1	SR 8 – (LT1) +cc L23 – (MT2)	2	
Neurosciences		0	L24 x 2 beds Low L25 x 2 bed Low	4	L24 – (LT1) 2 L25 – (LT1)		L17 x 1 Chair
TRS	L34 x 1 bed L10 x 2 beds -surge L35 x 2 bed (day room) MSAA 6 beds (MSAA + 3 beds – only used when CC is instigated due to impact on flow)	11 (14)	L10 x 1 bed (day room) Low	1 CC	L10 – (LT1) 6 L09 (Bay 15-18) (MT2) L09 (Bay 9-24) (MT2) Full Enaction use of MSSA X 12 beds = HT3		
Children's	L40 x 6 beds (to be used first) L52 x 4 beds L49 x 6 beds L49 x 13 beds	29	Nil	0		0	

CAH	3 beds C2 bay	3				0	
Winter Capacity	L12 x 1 bed treatment room L12 1 bed therapy room	2	Nil	0			1 bed in bay
Total Adults		19 (22)-		8	12		3
Total Children's		29		0			
Total		48 (51)		8			3

St James's University Hospital ward areas

CSU	Surge location	Surge total	CORRIDOR CARE	CORRIDOR CARE total	Additional Proposed CC	Fit To Sit
SIM	J20 x 2 closed ID rooms J32 x 3 beds J30 x 1 bed J31 x 1 bed J26 x1 bed J29 x1 bed (when no MH pt)	9	1 x bed J07 (additional bed in a bay) (Low)	1	0	1 x bed J08 (corridor)/only used in as very last resort – high score for all the below. 1 x bed J15 (corridor) 1 x bed J16 (corridor) 1 x bed J17 (corridor) 1 x bed J19 (corridor) 1 x bed J21 (corridor) Beckett Wing ward (1 bed in each day room on which ever ward is open, contingent on a definite discharge that same day)

Respiratory	Nil	0	J11 day room x 1 (Low)	1	0	1 x bed J12 1 x bed J09
AMS	J91 x 1 (treatment rm) J92 x 1 (treatment rm)	2	1 x J91 (middle of a bay) 1 x J92 (middle of a bay) Each of above can be raised x2 on J91/J92 but score High on risk assess 1 x J49	3	J49 (MT2) J50 (HT3)	
Oncology	JONA side rooms (2) J93 x 1 bed J98 x 1 bed J94 x 1 day case rm J97 x 1 sensory rm	6	1 x bed J93 (middle of a bay) HT3 1 x bed J98 (middle of a bay) HT3 Additional patients may be placed on wards J93 & J98 in bays a HT3 maximum of 2 on each ward, but wards would need additional RN	2 (4)	J93 (LT1) dayroom J93 (LT1)/Window J98 (LT1) - Room	
Urgent Care			1 x bed J28 (Meeting/relatives room behind Nurses station)	1	0	1 x bed J27 (Nurses Station)
Total		17		8 (10)	5	9 (not including Beckett wing day rooms)

Emergency Department Full Capacity Plan

St James's University Hospital (SJUH) Emergency Department (ED) Full Capacity Plan							
Trolleys / Beds / Chairs	FCP1 (Surge)	FCP2 *(OOH)	T1-8 (CC)	CC Trolleys 1-10 & CC Chairs 11 – 20	Doubling in A, B, C, 16, 21, 23	Total Surge & CC	Total OOH
	9	6	8	20	6	43	49

Leeds General Infirmary (LGI) Emergency Department (ED) Full Capacity Plan					
Trolleys / Beds / Chairs	FCP1	FCP2 (OOH)	CC	Total	Total (OOH)
	4	7	14	18	25