The Leeds Teaching Hospitals NHS Trust

CORPORATE RISK REGISTER

November 2026

Board summary:

The risk management committee met on 5th November 2026, chaired by the Chief Operating Officer.

The committee reviewed corporate risks relating to Staff absence, Health, Safety and Wellbeing, Risk of viral Pandemic, Healthcare Acquired infection and Supply Chain Failure. A corporate risk related to the LGI site development project failing to deliver objectives was deferred to January 2027 as the risk had been reassigned from Finance to Estates and Facilities.

A new corporate risk related to sepsis was proposed and will be discussed at the December meeting for acceptance to the corporate risk register.

Adult Therapies, Outpatients, Head and Neck and Leeds Dental Institute presented their CSU risk registers. Finance also presented their risk register.

Summary Corporate Risk Register November 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							*Cautious*	
Workforce Deployment Risk							*Cautious*	
-	-	-	-	-	--	-	-	
Operational Risk								
Business Continuity Risk							*Cautious*	
CRRO1	Risk of a viral pandemic	May 18	Chief Operating Officer	15	Nov 26	Apr 27		5-7
CRRO2	Power failure/lack of IPS/UPS resilience due to electrical infrastructure	Aug 15	Director of Estates & Facilities	16	July 26	Jan 27		8-10
CRRO13	Brotherton Wing, Blocks 11, 12 and 32 physical condition	Jan 24	Director of Estates & Facilities	16	July 26	Jan 27		11
Health & Safety Risk							*Minimal*	
CRRO4	Staff absence Health, Safety and Wellbeing	Oct 20	Director of Human Resources	16	Sep 26	Mar 27		12-19
Change Risk							*Cautious*	
CRR09	Risk that LGI site development project fails to deliver objectives	March 26	Director of Estates & Facilities	16	Nov 26	Apr 27		20-22
Information Technology Risk							Cautious	
CRRO10	Cyber-attack leading to potential loss of IT systems and/ or data	May 22	Chief Digital & Information Officer	20	Apr 25	Oct 26		23-25
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		26-28
Clinical Risk								
Infection Prevention & Control Risk							*Minimal*	
CRRC1	Healthcare acquired infection	Mar 19	Chief Medical Officer	16	Nov 26	Apr 27		29-40
Patient Safety & Outcomes Risk							*Minimal*	
CRRC4	Emergency Care 95% Constitutional Standard	May 14	Chief Operating Officer	20	July 26	Jan 27	ED LGI	41-46
CRRC5	18-week RTT constitutional standard	May 14	Chief Operating Officer	20	Sep 26	Mar 27	Ophthalmology / Cardiac Surgery	47-54

CRRC6	62-day cancer constitutional standard	May 14	Chief Operating Officer	16	July 26	Jan 27	MDT & Pancreatic Breast Only	55-66
CRRC7	Failure to achieve 28 day cancelled operations standard	May 14	Chief Operating Officer	16	Sep 26	Mar 27	Cardiac	64-66
CRRC9	Patients waiting longer than 6 weeks following referral for diagnostics tests	May 14	Chief Operating Officer	16	July 26	Jan 27	Breast cancer	67-72
Capacity Planning Risk							*Cautious*	
CRRC10	High occupancy levels and insufficient capacity and flow across the health and Social care system causing impact on patient safety, outcomes and experience.	Sept 15	Chief Operating Officer	16	Sep 26	Mar 27	MMPS	73-76
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		77-78
CRRC12	Corridor care in Emergency departments and in ward areas	July 26	Chief Nurse	20	July 26	Jan 27		79-81
Financial Risk								
Financial Management & Waste Reduction Risk							*Cautious*	
CRRF1	Failure to deliver the financial plan 2025/26	May 14	Director of Finance	20	Aug 26	Feb 27		82-85
CRRF2	Insufficient operational capital allocations	May 23	Director of Finance	20	Aug 26	Feb 27		86-88
CRRF3	Risk of supply chain failure	April 26	Director of Finance	16	Nov 26	Apr 27		89-91
External Risk								
Regulatory Risk								
CRRE1	CQC Registration – breaches of Regulation(s) Maternity and Neonatal Services	Jul 25	Chief Nurse	16	Aug 26	Feb 27		92-97
CRRE2	CQC Registration – breaches of Regulation(s) Well-led	Nov 25	Chief Nurse	16	Sep 26	Feb 27		98-101

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 inherent risk
Cautious - Preference for safe options that have a low degree of residual 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).

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: November 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.	• There has been no update to either the national pandemic plan nor the Leeds outbreak plan post covid-19 • Some specific recommendations from the 2023 EPRR core standards review in relation to PPE training and resources have not been implemented • Exercise to validate plan needed • Current workload in relation to HCID (mpox in particular) impacting on updating of pandemic plan • Current internal plan requires a full transition from influenza-specific modelling to the 2026 Pathogen-Agnostic National Strategy published 25/03/26.	• Plan has been updated internally based on covid-19 experience and other relevant guidance • New framework for response being developed; due for completion November 2025 • Oversight of plan and preparedness at High Consequent Infectious Diseases group • Discussion 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 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	• Assurance that up to date business continuity plans are in place for all services within the trust.	• 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'	• Mask fit testing training levels • PPE training levels	• Challenges in relation to training have been escalated through Operational IPC and more is being made available through a train the trainer programme targeted specifically on those areas most likely to be impacted(ED, J20, SIM, children's, critical care (adults and paediatrics) and women's).
Surge and Escalation Arrangements (OPEL) LTHT Incident Response Plan which would be activated in case of a pandemic.	• Assurance that all CSU surge and escalation plans are up to date	• Surge and escalation plans form part of winter planning and preparedness.

		• Incident Response Plan has been completely re-written and is regularly being tested and exercised.

CRRO2: Power Failure due to Electrical Infrastructure/lack of IPS/UPS resilience	C = 4 L = 4	16	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
						Target Score								Current Score	Initial Score	

Risk Description: There is a risk of power failure at a Trust site (ward or clinical area)

Due to failure to comply with HTM 06 01 caused by outdated electrical infrastructure and the absence of complete IPS/UPS resilience in Clinical Category Grade A: Life support/complex surgery (Risk to patient due to loss of supply) or Grade 1: Medical support services (Risk to business continuity due to loss of supply) locations.

May result in a poor patient experience; a failure to protect patients or staff from serious harm or fatality; loss of stakeholder confidence; and/or a material breach of CQC conditions of registration or HSE prosecution

Executive Lead: Director of Estates & Facilities

Date added to CRR: August 2015
Last Reviewed: July 2026
Next Review: January 2027

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.

HTMs are not retrospective, and areas were designed to comply with best guidance at the time of design and construction.	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.	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 business case(s), to secure the required investment. 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. 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.
Awareness of the electrical shortfalls in UPS and IPS provision in clinical category Grade A areas is		

required. Electrical action cards have been provided by Estates to Clinical, this will be reviewed 6-monthly.		
UPS/IPS systems have been installed in a number of clinical category A locations.	There are still a number of Clinical category A areas without UPS/IPS systems.	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). Therefore, the draft 5-year capital plan includes £10m for addressing this specific risk across 26/27 & 27/28. Full designs to be completed 26/27. The required compliance works for CAH has been tendered, works are due to commence July 2027.

CRRO13: Brotherton Wing, Blocks 11, 12 and 32 physical condition	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 Brotherton Wing becoming unsafe for occupying patients, staff and visitors.
- Due to a failed roof covering, deteriorating building fabric and aged engineering services (impacting statutory compliance requirements).
- Resulting in a risk to patient safety and quality of care, poor working environment for LTHT staff and a negative impact on LTHT reputation from patients, staff and visitors.

Executive Lead: Director of Estates & Facilities

Date added to CRR: Jan 2024
Last reviewed: July 2026
Next Review: January 2027

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, 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

CRR04: Colleague health, safety and wellbeing	C = 4 L = 4	16	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
									Target score					Current score	Initial Score	

Risk Description:	
There is a risk that colleagues experience physical or psychological harm, reduced effectiveness at work, or absence from work due to ill health, work-related stress, burnout, violence and aggression, sexual harassment or sexual misconduct involving colleagues or third parties. This may adversely affect colleague safety and wellbeing, patient care and experience, operational delivery, financial sustainability, the Trust's ability to attract, recruit, engage and retain colleagues, and compliance with legal and regulatory duties.	Executive Lead: Chief People Officer **Date added to CRR:** June 2020 Last reviewed: September 2026 **Next Review:** November 2026 **Committee reviewed at:** People Function Senior Leadership Team

Controls	Gaps in control	Further mitigating actions
Violence and aggression prevention and response arrangements include incident reporting and escalation, local risk assessment, security and operational responses, support for affected colleagues and governance reporting.	Current evidence does not yet demonstrate that controls are consistently implemented or effective across all services. Baseline measures, control owners, compliance expectations, incident frequency and severity trends, post-incident support, learning and links between local and corporate risks require confirmation.	Deliver the Violence and Aggression approved, prioritised action plan with named owners, due dates, intended impact and evidence measure for every action. Confirm the governance route, review frequency and escalation thresholds. Report progress and impact to the Risk Management Committee (RMC), then reassess the risk score using verified incident, compliance and colleague-experience evidence. Owner: Craige Richardson, Deputy Chief Executive/Director of Estates and Facilities. Violence and Aggression priority actions due: 20 December 2026

		First RMC progress report due: 7 January 2027.
Sexual Safety arrangements include the developing Trust Sexual Misconduct Policy, Sexual Safety guidance and communications, reporting and support routes, Human Resources (HR) and safeguarding processes, regional reporting arrangements, nominated leadership and the developing Sexual Safety Charter assurance approach. These arrangements address sexual misconduct involving colleagues, patients, service users, visitors and other third parties.	The Sexual Safety control environment is not yet fully embedded. Further assurance is required that governance, policy, preventative risk assessment, accessible reporting routes, timely and trauma-informed response, case oversight, specialist capability, support, organisational learning and Board assurance operate consistently. Intelligence is held across different routes and requires triangulation to identify patterns, areas of concern and emerging risk.	Complete and implement the Sexual Misconduct Policy and supporting operating arrangements. Confirm and communicate the interim reporting, support, safeguarding, case-management and escalation arrangements that apply pending implementation of the final policy. Confirm programme ownership and governance; complete the Sexual Safety Charter assurance assessment; define reporting, escalation and case-oversight routes; strengthen manager and investigator capability; maintain regional reporting; and establish an integrated evidence set covering prevention, reporting, response timeliness, support, learning, outcomes and equality impacts. Owner: Anna Edgren-Davies. Policy and operating model due: 31 March 2027. Charter assurance assessment due: 31 March 2027. First integrated assurance report: June 2027.
The Health and Wellbeing Strategy, People Improvement Framework and core people metrics provide governance and escalation routes for colleague health, safety and wellbeing risks. Violence and aggression is reported through established governance arrangements, including twice-yearly reporting to People Committee and Board. An integrated CRR04 assurance	Available colleague-survey, sickness-absence, incident and programme evidence demonstrates continuing exposure across several elements of the risk. The integrated assurance framework requires further development to include burnout, violence	Enhance the integrated CRR04 assurance framework to include burnout, violence and aggression, sexual safety, post-event support and moving and handling. Define the baseline, trajectory, reporting frequency,

framework currently brings together outcome, control-compliance and colleague-experience measures across sickness absence and work-related stress.	and aggression, sexual safety, post-event support and moving and handling. Further work is also required to define the baseline, trajectory, reporting frequency, tolerances and escalation thresholds for each measure. The current score remains 16 because significant exposure continues across several risk areas and there is not yet sufficient integrated evidence to demonstrate that key controls are consistently implemented and effective across all services. A reduction in likelihood will require sustained evidence of improved outcomes, control compliance and organisational learning.	tolerances and escalation thresholds for each measure. Owner: Anna Edgren-Davies, supported by relevant control leads. Initial framework for People Function Senior Leadership Team review due: 30 November 2026. First integrated assurance report to People Committee due: 9 April 2027.
The annual NHS Staff Survey provides an important measure of colleague wellbeing and experience in relation to the People Promise theme, *We are safe and healthy*. The 2025 survey results were around the national average across the three associated sub-themes, including burnout. Despite ongoing improvement activity, the rolling sickness absence rate was 5.32% in August 2026 compared with the Trust target of 4.9%. Continued focus is required to reduce variation, improve colleague wellbeing and deliver sustained performance against target.	Sickness absence remains above target and survey results indicate limited improvement in wellbeing measures. Existing controls have not yet achieved sustained reduction in absence levels or demonstrable improvement in colleague wellbeing outcomes across the Trust	Establish clear governance, ownership, sustainable funding and delivery arrangements, supported by defined training requirements, access standards, utilisation measures and outcome indicators to enable effective monitoring and assurance. Owner: Anna Edgren Davies, supported by relevant control leads. Initial framework for People Function Senior Leadership Team review due: 30 November 2026.
Supporting Attendance Policy and guidance, agreed with Staff Side, set out the arrangements for absence management and enable line managers to take local action. Assurance processes	Policy requires updating	Complete consultation on the revised Supporting Attendance Policy, consider the consultation feedback and progress the final policy through the required approval route.

are implemented across Clinical Service Units (CSUs) and supported by the Operational Human Resources (HR) team.		Owner: Dominic Barnes. Consultation commenced; planned approval date: 31 December 2026.
The Medical and Dental template process for managing sickness absence has been implemented, including warranted variation for Clinical Service Unit (CSU)-specific arrangements where appropriate.	Management arrangements for resident doctors require clarification because short placements may limit proactive sickness management. Implementation has not yet reached full maturity across all Clinical Service Units (CSUs).	Complete implementation of the Medical and Dental sickness-absence standard across all Clinical Service Units, including clear arrangements for resident doctors. Provide assurance showing implementation status, any agreed local variation, compliance with the standard and outstanding corrective actions. Owner: Dominic Barnes. Implementation and compliance review due: 31 December 2026.
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.	There is insufficient integrated assurance that managers have the capacity, capability and confidence to apply attendance, stress-risk-assessment and wellbeing arrangements consistently. Training availability is understood, but uptake, application and impact are not yet evaluated consistently.	Establish proportionate assurance of manager capability through training uptake, application audits, case-quality review and feedback from managers and colleagues. Owner: Dominic Barnes and Anna Edgren-Davies. Baseline assurance report due: 31 March 2027.
A comprehensive range of wellbeing support mechanisms is available to colleagues, including Mental Health First Aiders (MHFA), Money Buddies, Chaplaincy services, Clinical Psychology support and dedicated post-incident support guidance. These arrangements are intended to promote	There is limited assurance regarding the awareness, uptake and effectiveness of existing wellbeing support resources across the Trust. Engagement with post-event support training has been variable between Clinical Service Units (CSUs), and the	Agree a Trust-wide post-event support operating model covering immediate manager-led support, appropriately timed debrief by a trained person and access to specialist intervention where indicated. The model will define ownership, sustainable

psychological wellbeing, provide early intervention and support colleagues following adverse or potentially traumatic events	cessation of fixed-term funding has created uncertainty regarding the future sustainability of training provision and delivery. Access to embedded psychology support remains inconsistent across services.	resource and funding, training requirements, equitable access, uptake measures and intended outcomes. Owner: Anna Edgren Davies. Operating model and funding decision due: 20 December 2026. First effectiveness report due: 9 April 2027.
	The colleague clinical psychology team does not have a robust system to record interventions and manage appointments, requiring clinical time to complete administrative activity.	Adult Therapies to review the clinical psychology provision, funding model and requirements for recording interventions and managing appointments and submit a recommended sustainable model. Owner: Nikki Hosty. Review and decision due: 31 March 2027.
Occupational Health (OH) provides advice to managers on fitness for work and reasonable adjustments to support effective management of sickness absence.	Case complexity is increasing, which is leading to higher demand for advice from the OH service.	The OH team are working more closely with the HR operational team to ensure that managers and colleagues are given appropriate advice and support from both teams. Management referral guidance for managers will be completed by December 2026 to improve the quality of referrals into the service and ensure that the OH team can meet the needs of managers. A hot house event to better understand what managers need from the OH service will be undertaken in October 2026. This will create

		an action plan for the service of improvements to better meet changing organisational need.
The organisational immunisation programme, including pre-employment and winter vaccination, is delivered in accordance with the United Kingdom Health Security Agency (UKHSA) occupational vaccination schedule for new starters. The Trust's flu-vaccination uptake compared favourably with other large acute trusts during the relevant reporting period.	The Trust is not currently compliant with the full UKHSA requirements, with a gap in tuberculosis (TB) vaccination for new and substantive colleagues.	The OH team are working with the IPC team to identify which roles require TB vaccination and the appropriate clinical delivery method, to start vaccinations by January 2027.
The Suicide Prevention Strategy has been updated, and postvention guidance is available for managers and affected colleagues.	Some managers may not be aware of the strategy and guidance and therefore not access it when needed.	Continue trust wide communications on the resources, including raising awareness through events including World Mental Health Day in October. Include the postvention guidance in the new LTHT leadership development framework which will be launched in January 2027.
A stress risk assessment process is in place to support the management of work-related stress.	Managers may not undertake individual and team stress risk assessment when required.	OH to include the process for completing stress risk assessments in the management referral guidance, to increase awareness of the process, for completion by December 2026. OH to train the HR operational team on appropriate use of stress risk assessments by December 2026. Managers provide assurance on the completion of team stress risk assessments as part of the annual Health and Safety

		Controls assurance cycle. When this is completed, undertake a review of the number undertaken and their quality, in order to identify any gaps in provision or process. Owner: Anna Edgren-Davies. Review due: 31 March 2027.
The Moving and Handling Policy is in place to support appropriate training and reduce musculoskeletal (MSK)-related sickness absence.	There is insufficient assurance that current moving and handling training and competency assessment are completed consistently across the organisation in line with legislative requirements.	Complete the review of moving and handling training, confirm legislative and organisational requirements, and approve a sustainable delivery model, including interim controls pending competent-person capacity. Owner: Anna Edgren-Davies. Appointment of competent person to undertake review: 31 March 2027.
	There is no permanent training facility for moving and handling key-trainer delivery.	Complete the review with Capital Planning and the organisational training-space review, and agree the preferred option, funding route and implementation plan for moving and handling key-trainer delivery. Owner: Anna Edgren-Davies. Options appraisal and decision due: 30 June 2027.
	There is no competent person in post to provide assurance of compliance with legislative requirements.	Confirm the recruitment position, accountable operational owner, planned appointment date and documented interim arrangements for maintaining competent advice and compliance assurance until a substantive competent person is in post.

		Owner: Anna Edgren-Davies. Position and interim assurance arrangements to be reported by 30 November 2026.

CRRO9: Risk of failure to deliver the LGI Site Development Project	C = 4 L = 4	16	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
											Target Score		Initial score	Current score		

Risk Description:

There is a risk that the LGI Development Site Project fails to deliver its objectives as a result of:

- 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:

- 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 Estates and Facilities

Date Added to CRR: May 2020
Last reviewed: April 2026
Next Review: November 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.

The Project currently reports into the Infrastructure Committee which was set-up in November 2024. The Trust has obtained professional advice on specific issues relating to the Innovation Village. 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.		
Guidance and Market Position 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. The LDS Project Team formally review the property market and investor position on a 6 monthly basis and report the findings to RIC.		
Stakeholder Engagement Engagement with Trust staff and external stakeholders is being undertaken to support the Project (on-going). Formal and informal discussion are ongoing with LCC, Leeds University and Leeds Beckett University regarding the Innovation Village.		

Frequent discussions with potential developers to assess continued interest in the Innovation Village. An improved relationship has been achieved with the Little Woodhouse Community Association.		
Mix of uses for the Innovation Village 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.		The Trust will influence the uses for the remaining LDS to be complementary to the delivery of HofF. 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.

CRRO10: Cyber-attack leading to potential loss of IT systems and/ or data	C = 4 L = 5	20	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
												Target Score			Initial & Current Score	

Risk Description:

- Redacted due to business sensitive information

Executive Lead: Chief Digital & Information Officer

Date added to CRR: May 2022
Last Reviewed: April 2026
Next Review: October 2026

Committee reviewed at:
DIT Committee

Controls	Gaps in Control	Further Mitigating Actions

CRRO11: Insufficient DIT resources to update the Trust IT estate to a minimally supported standard, maintain it, and meet demand for DIT led projects.	**C = 4** **L = 4**	16	**Very Low Risk**			**Low Risk**			**Medium Risk**		**High Risk**		**Significant Risk**			
			1	**2**	**3**	**4**	**5**	**6**	**8**	**9**	**10**	**12**	**15**	**16**	**20**	**25**
										Target Score				Initial & 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.

- **Applications**.
  - 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.

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

• **Infrastructure**. ○ 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.** • 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. • 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. Related to risk 10353**.**	

Controls	Gaps in Control	Further Mitigating Actions
Prioritisation Group meeting fortnightly to review and agree priority of new works.	Potential for Group not to be able to agree a priority, may require an escalation process. Insufficient resource in DIT to commence new projects.	- 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. -

		- Additional Revenue made available to DIT 26/27 for some additional resources to help address some of the backlog.
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.	Currently there is insufficient revenue resource to replace all vacant posts.	Vacancy control panel in place.
Upgrade of existing Server Operating systems where possible	Whilst work is underway to upgrade Server Operating Systems within the re-source 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 *Clostridioides difficile* infection, Methicillin Sensitive *staphylococcus aureus* (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: November 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, 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. 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. 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. 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	Documentation of staff immunisation assessment for childhood infectious diseases, such as measles and pertussis, is not comprehensively recorded for all existing staff. This means if there is an outbreak we do not have the information 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.	Occupational health is working to close the gap in information about immunisations for the highest risk areas i.e. ED and PED. To be completed by March 2026. To develop a plan for closing the gap for information about immunisations in other areas of the Trust guided by IPC by March 2026.

Virologists with an escalation plan to the Medical IPC Lead should there be a sudden rise in cases. Staff on the infectious Disease ward are trained and a process for providing mutual aid established. 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. Derogation of Mpox clade 1 on 1 March 2025 – no longer classed as a HCID Clinical teams have established the minimum number of staff to be trained in an outbreak response for HCID patient pathways New Laboratory Information System (LIMS) 'WinPath' for Microbiology and IPC implemented June 2025	Current number of staff trained in High Consequence Infectious Diseases (HCID) PPE would not support an outbreak response for mpox clade 1	CSU HCID staff training compliance is presented at OIPC gaps in training compliance still exist predominantly in E/D medical workforce. Escalation to DIPC, Medical IPC lead and chair of EPRR mutual aid to support a medical model of delivery being discussed with clinical director.
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 Updated surveillance software installed. ICNET Phase 3 Surgical Module delivery. LIM and ICNET integrated to support Surgical site infection surveillance module	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.	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.

HCAI reports generated weekly and circulated to clinical service units to monitor performance. IPC lead for surgery/anaesthesia appointed Dec 2023- this role to lead on improving infection prevention in pathways involving surgery and invasive devices. 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. 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	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. Transmission of vancomycin resistant enterococci within Trauma Related Services. Transmission of *Pseudomonas* in Adult Haematology	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 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. 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

Covid -19 testing and management incorporated into national respiratory guidance and National Infection Prevention and control manual (NIPCM) External audit of the HCAI performance data processes completed all recommendations adopted quarterly audit data compliant.		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
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.	Current offer for Aseptic non touch technique (ANTT) training does not meet Trust requirements	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.
Current national CPE guidance Implemented within Adults New National Carbapenemase Producing Enterobacteriaceae (CPE) guidance implemented in Leeds Children's hospital	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.	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.
Quality Improvement methodology adopted with a Trust wide HCAI collaborative and LIM.	Gaps in Learning from HCAI Patient Safety Incident Response Framework	Dyad medical and nursing/AHP leadership model to be implemented in all CSU's Relaunch of roles, responsibilities and process in autumn.
LTHT has implemented the National Infection Prevention and Control Manual (NIPCM) for England. National IPC Manual implemented plan re-aligned with HCAI Annual Commitment.	Gaps in National Infection Prevention and Control Manual (NIPCM) for England understanding identified during HCAI PSIRF process	Integration of NIPCM compliance into the new Trust Recognition of Innovation, Safe Care and Excellence (RISE) clinical accreditation programme for wards.

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.		
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. Refurbishment of NNU ahead of the planned BTLW agreed. Rapid action tender to scope building work commenced October 2023 Formalised cot numbers produced. L43 Ventilation plant requires replacement as part of asset management. Progressing with capital funding assessment. March 2024. L43 NNU external visit by NHSE and UKHSA occurred 5 June 2024. Awaiting evaluation report.	LGI NNU has experienced new outbreaks of infection related to practice and environment.	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. 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
Trust Water Safety Plan	Trust wide roll out of water safety plan requires infrastructure investment	Resource provided for two High risk areas, LGI NNU, and Adult Critical care J53/54
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. 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.	Rolling programme of whole ward HPV decontamination paused as current decant facility is providing winter bed capacity.	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

Rolling programme of HPV decontamination commenced where temporary access to vacant areas occurs. Hierarchy of controls completed by clinical teams which details controls, risks, and mitigations for Covid-19. All adult haematology en suite side rooms redesigned to reduce risk from water borne infection. All patients in adult haematology receive written information about reducing risk of infection related to water hygiene and safety. Antimicrobial stewardship in adult haematology including weekly patient screening Active *Pseudomonas aeruginosa* surveillance in all augmented care is in place, and regular multi-disciplinary *Pseudomonas aeruginosa* risk assessments and evaluation of probable water-borne infection is occurring in all augmented care units at LTHT. A multidisciplinary task and finish group has been formed to deliver an assurance programme for the trust based on the learning in haematology. IPC involvement in design, refurbishment, and new builds. Live bed state test phase completed		
Side Room Management eForm designed to facilitate oversight and optimise isolation of infectious patients and clinically appropriate stepdown of side-room available	Limited side room capacity in the unplanned pathway.	Live bed state side room delivery currently paused

Side room Management Eform report being generated to support CSU's to understand utilisation, compliance and improve patient flow. Side room capacity increased in ED, ARCU and Critical Care, with additional 12 side rooms across LGI, SJUH and CAH Feasibility study completed on the ability for 3 extra side rooms in Gledhow wing, namely J15,16 and J17 A further increase of 3 side rooms have been provided on J33 in December 2022. 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. 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. A monthly Trust-wide ventilation safety group has been established from September 2021 to provide monitoring,	Large parts of the estate have natural ventilation only.	Newly developed clinical ventilation safety group where risk assessment occurs.

oversight and assurance around our current ventilation and enhance the use of new technologies. Options appraisal identified opportunities to provide two Redi-rooms in Becket Wing to provide isolation with inbuilt mechanical ventilation. Portable air scrubbers provided following impact assessment by the clinical team and ventilation group. 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.		
Detection: Monthly surveillance monitoring and assurance through monthly Perfect Ward meetings and additional hand hygiene audits and ward assurance visits. IPC Leadership team continued to review the HCAI performance at Trust CSU and ward level. Consultant Microbiologists provided ward and CSU level review and feedback. HCAI assurance monitoring through the Perfect Ward expanded to include all national HCAI objectives by January 2022. IQPR expanded to include all national HCAI objectives by January 2022. Infection reporting has now been amended so all Klebsiella species are reported.	NHS oversight framework has been released and LTHT is red for MRSA and amber for CDI and E. coli	Quarter 1 performance and July/ August position statement presented at QAC 21 August 2025, due to escalating position key areas supported: 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. 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) 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)
Recovery and lessons Learned: Outbreak Management. Incident investigations. City wide Outbreak response group. CSUs manage individual HCAI case reviews, incidents, and Outbreak Meetings with support from Consultant Microbiologists, IPCT, Antimicrobial Pharmacists and DIPC/DDIPC. Successful recruitment to Microbiologist role. post holder commenced January 24 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. 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 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. Consultation between Medical IPC Lead, Clinical directors and medical directors to identify a process that will facilitate	Feedback of lessons from HCAI incidents to clinicians is variable across LTHT, in some areas learning may not be shared effectively. Not all CSU's have a designated Consultant Microbiologist to support.	HCAI PSIRF process now live across the Trust in bed holding CSU'S. 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 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. 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

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 DIPC requested a clinically led thematic review of HCAIs following an increase in cases in August to expedite learning. CSU thematic led review returns September 30, 2023. Review by DDIPC and Medical IPC Lead October- learning incorporated into the HCAI Annual Commitment report outs. 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.		decolonisation process to be supported by a fresh campaign October 2025.
Assurance: HCAI assurance is monitored through the Infection Prevention and Control Governance Structure. 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. Recruitment for Medical AMS lead role completed. Covid-19 assurance is monitored through the Trust OIPC group and IPC governance structure. Board oversight is provided through the Infection Prevention and Control Annual Programme and combined		

Board Assurance Framework, published by NHSE in May 2020. **Cross-ref: CRR04-** Integration of the IPC Annual programme and new Board Assurance Framework within the reset work streams completed, and CSU's are invited to provide an assessment of their position against the programme at the operational infection prevention and Control Group (OIPC) and HCAI group**. C**ontrol 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. Medical Workforce redesign completed. New Medical IPC Lead role appointed 1 September 2022. Review of current medical leadership to support the Medical IPC Lead completed recommendations adopted. Trust wide IPC Medical appointments made to AMS post September 2023 IPC Medical Anaesthetic and Surgical Lead December 2023 IPC Medical High Consequence Infectious Disease post February 2023 supporting wider IPC plan. Successful recruitment to Microbiologist role, December 2024. IPCN development plan in place. New JD to include AHP in approved. IPCT Successfully recruited too. Team now at full establishment	Consultant Virologist capacity limited- not all CSU's have a designated Consultant Microbiologist to support the HCAI reduction strategy	Review of virology IPC provision underway. Review of Microbiologist CSU alignment through workplan process.

CRRC4: Emergency Care 95% Constitutional Standard	C = 4 L = 5	20	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
									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, corridor care, increased infection risk and staff morale.

Executive Lead: Chief Operating Officer

Date Added to CRR May 2014

Last Reviewed: July 2026

Next Review: January 2027

Committee reviewed at:

		Finance & Performance Committee
Controls	**Gaps in Control**	**Further Mitigating Actions:**
Daily management and oversight of the hospital established including: ➢ 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 ➢ WYAAT repatriation policy agreement ➢ summary operation centre email sent to CSUs for organisational context and specific actions required When demand for inpatient beds outstrips capacity there is a suite of requested actions as per the LTHT	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.	Review of operational response guidance, use of surge and corridor care is being undertaken aligned to new national guidance and LTHT learning to date. City home First programme refreshed trajectory for the year with associated work plans mapped and will be tracked to measure success.

Operational flow guidance document for standard work against certain pre agreed triggers. -There is a Director on Point and clear Business continuity levels mapped, aligned to EPPR national framework with actions for recovery both internal to LTHT, cross city and region.		
Daily monitoring and reporting of 4-hour performance. Use of the National OPEL system with data feed to the RAIDR app for local and regional oversight of key ED pressures. Twice daily meetings held by the Urgent Care team to ensure capacity and demand met. 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	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%. RAIDR due to be decommissioned Absence of real time electronic bed state and real time bed and patient placement overview. Timeliness of bed allocation by CSUs to ED and Adult Critical care	ED team currently developing an improvement plan to ensure there are no gaps in control for the 2 hourly safety rounds. Understand the information flow in the absence of RAIDR prior to contract end (ICB system)- ICB region action. 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.

trajectories for annual improvements and the delivery of the actions the CSU described for this. Operational planning guidance trajectory to deliver 82% ECS by March 2027 continues to be monitored submitted with workstreams and measures to enable delivery developed and is monitored through the CSU service delivery framework. ED Patient 2 hourly safety rounds completed and recorded with assurance checks to be completed. Long waiting patients within the ED for more than 12 hours from bed request are escalated as per the patient flow guidance document. Daily, weekly and monthly reports are shared with tri team and director teams. Patients over 24 hours in ED reported on the weekly executive score card and through NHSE KLOE daily reports.	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 and when not complete at peak pressure periods Gap in control of the 2 hourly safety round compliance and 12 hours from decision to admit and 24 hours in department is not currently clinically reviewed outside the CSU.	Making Every Day Count 30 day Event across the Trust across June and July 2026 to embed daily rhythm and timeliness of discharge and reallocation of the hospital beds. Accountability structure evolving in June/July 2026 to align with the Integrated Accountability Meetings held monthly

Patients with mental health conditions with long waits for a mental health bed are flagged on the Daily Operation report within LTHT. There is an escalation process to LYPFT (mental health Trust) and ICB. All patients awaiting over 24 hours in the ED will be reported on the WTER document for SCC. Fortnightly group with LTHT urgent care team and LYPFT colleagues developed a dashboard with referral data that is reviewed together monthly.	There are insufficient mental health inpatient beds and services to meet demand and Length of Stay 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. Limited impact from current escalation process.	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 written confirmation of success of bid. Model of care for this service with clear lines off accountability being worked through a task and finish group. New SOP for care of patients with mental health conditions in ED, 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 now being embedded.
Alternatives to ED attendance and patient streaming in place to the most appropriate route via the Same	Same Day Emergency Care Units at times of inpatient bed availability	Community Proactive Care model aligned to the 10-year plan has begun with the

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. Primary Care Access Line in place to prevent unnecessary ED attendances where clinically appropriate and route to alternatives to ED.	pressure have patients placed in them overnight which impacts on their ability to function as admission avoidance due to space and staff.	community proactive care for identified at risk population cohorts beginning on boarding. Full roll out to the 10 000 identified Leeds population to be completed by June 2027
Business continuity plans in place for times of high acuity/ attendances to ensure safe patient placement when ED capacity is inadequate for demand. 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.	The estate footprint constraints within EDs specifically lack of surge space at LGI adult and children's ED and SJUH ED adults. Poor ergonomic flow across the ED footprints when ED occupancy is now reported through RAIDR and shows both sites at over 100% routinely and SJUH ED running at 140% plus.	Currently developing capital plans and bids by February 2026 to increase footprint and refurbishment aligned to NHSE model ED requirements.
Seasonal reflections and winter learning across the city completed as part of an annual plan including attendance to ED and ambulance conveyance avoidance schemes and their impacts.	Unpredictable activity levels and demand.	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.

CRRC5: 18-week RTT Constitutional Standard	C = 4	20	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
	L = 5								Target Score					Initial Score	Current Score	

Risk Description:
There is a risk that the Trust will not deliver 18-week RTT constitutional standard as a result of waiting list growth and reduced levels of activity combined with referral growth in some areas, and reduced levels of productivity across some specialities in outpatients, diagnostics and theatres.

This results in a poor experience for patients. There is a risk that some patients may experience harm, including deteriorating symptoms and condition and impacts on health and wellbeing while waiting for treatment. There is a reputational risk for the organisation and the risk of increased scrutiny and additional capacity being required at increased cost.

Executive Lead: Chief Operating Officer

Date Added to CRR: May 2014
Last Reviewed: September2026
Next Review: M**arch** 2027

Committee reviewed at: Finance & Performance Committee

Controls	Gaps in Control	Further Mitigating Actions:
The 2026/27 priorities and operational planning guidance requires NHS providers to achieve 7% improvements in RTT performance, 1st 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.	Some specialities are experiencing higher referral growth (LTHT up by 3% % overall) and will require significantly increased activity.	Theatre, Diagnostic and Outpatient productivity schemes are well established and are increasing levels of productivity across pathways.
Clinical validation of all follow-up patients waiting beyond anticipated review date requested to determine if patient suitable for discharge, conversion to PIFU, requiring of urgent review or able to wait. Robotic Process Automation (RPA) supports the administrative validation of the entire RTT waiting list and is further supported by targeted clinical validation	Validation does not deliver any additional capacity in areas where backlog continues to grow. Volume of patients means that capacity to undertake reviews is limited and may require cancellation of clinics	CSUs are aiming to increase the number of PIFU protocols in place as part of their follow up action plans to reduce the number of patients waiting beyond their follow up due date. This is further supported by: - the roll out of GIRFT: Further Faster handbooks across 15 specialties.

		- Patient led validation using patient hub to support targeted clinical validation at those patients who do not wish to be seen - RPA automations to streamline validation - e-Outcomes implementation - Improved Clinic Utilisation -
Administrative validation of the total waiting list (TWL) is being supported by the use of an external partner to reduce TWL, identify and improve data quality and deliver the PNP (Patient Not Present) programme.	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 the FDP to improve validation opportunities
Implementation of telephone and video conferencing facilities have enabled non-face-to-face appointments to be delivered.	Not suitable for patients where investigation or examination is required. Virtual activity does not clock stop as many patients RTT pathways as face-to-face activity.	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. 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 CSUs are progressing actions through their follow-up improvement plans to increase the use of non-face-to-face appointments, where clinically appropriate. This includes greater use of telephone and video consultations to

		support additional follow-up capacity and reduce the number of patients overdue for their follow-up appointment.
Triage of referrals enables identification of some patients at risk of harm if appointments are delayed.	Quality of referrals from GPs can vary. Primary Care collective action may reduce uptake of Advice and Guidance	Delivering easier access to consultant opinion for GPs ahead of referral through enhanced advice and guidance systems Focus on increasing and streamlining Advice and Guidance process as part of national changes to ERS
IAM performance trajectories are linked to planning guidance to focus on key outcomes. 65-week & 52-week delivery trajectories agreed with each CSU.	Demand variation from winter modelling / Covid modelling will impact elective delivery. Some specialties have larger waiting lists and / or more constrained capacity to deliver planning guidance requirements.	LTHT Winter Plan approved to manage capacity through anticipated spikes in non-elective demand and to protect elective capacity. Director of Operations, Medical 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. Service Delivery Accountability Meetings and/or Integrated Accountability Meetings held monthly between DOP and CSU team to provide traction on service delivery and actions to deliver or bring back to trajectory. Additional support identified and recovery actions agreed.

Single points of access in some specialties will allow onward referral of routine activity to AQP's spreading burden across providers	AQPs will be subject to same restrictions on activity as LTHT.	Go live of CDCs (Community Diagnostic Centres) will increase funded capacity for some specialties particularly in imaging and physiological assessments/tests. Planned expansion of CDC capacity across 7 days continues to be developed. 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. 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	Absence of standardised system/approach to support the capture, recording and reporting of advice and guidance into EPR prevents roll-out to all specialties. Primary Care collective action may reduce uptake of Advice and Guidance LTHT Digital infrastructure to support the national roll out	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.
Advanced or on-the-day allocation of theatre, critical care, ward and staff capacity to areas of greatest clinical risk.	Prioritises clinically more urgent patients and so does not improve RTT position. There is insufficient capacity in specialties that are prioritised to reduce risks: • Cardiac surgery • Max Facs surgery • Endocrine surgery • Neuro surgery • Plastic surgery • ENT surgery • Paediatric surgery Delay of the BTLW programme reduces planned expansion of theatre capacity at the LGI	Additional Business cases being developed to expand theatre capacity at the LGI within existing estate which includes: - 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. The approval of the CAH theatre expansion business case will provide additional Orthopaedic and Neurosurgical capacity from late-2028 onwards. The Paediatric operating capacity remains constrained by workforce (anaesthetics) and estate. A business case for Children's Hospital theatre expansion (6 day working) is in development.
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	The process approved is time consuming and requires forms to be completed manually and uploaded to PPM+.	

be repeated every 3 months for patients who have waited over 52 weeks.		
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. There is currently minimal capacity for paediatric elective activity at tariff in the Independent Sector	CSUs prioritising access to the Independent Sector to support most at risk specialities. The ICB has supported limited volumes of patients to IPT to the Independent Sector for non-admitted and admitted activity in Orthopaedics. The ICB have not supported General Surgery, Plastics, and ENT/PENT in their recurrent use of the IS.
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 or not available due to local pressures and constraints.	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.

		Further discussion with WYAAT COOs has reiterated the need for mutual support to be offered to LTHT where very long waiters are most concentrated.
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 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 (not yet established) to explore the impact of delayed step downs on critical care and elective capacity which results in on day cancellations. Plans required to reduce step down delays or expand ACC capacity to prevent further cancellations at the LGI.
The Speciality Theatre Utilisation Group, and Outpatient P & T Programme within the Transforming Services Programme are 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 / Average Case per session / DNA/WNB rate /	Impact of unplanned pressures on elective bed base Willingness of clinicians to do extra work due to pension / tax issues. Capacity to focus on improvement work alongside operational pressures.	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. A specific Theatre productivity and efficiency target developed to deliver an increase in list

cancellation (patient and hospital) rates / advice and guidance provision		utilisation and cases per session by individual specialities and theatre suite linked to the activity plan. A specific Outpatients productivity and Transformation PID for 2026/27 developed to deliver increases in advice and guidance, e-outcomes, clinic utilisation and activity (Focusing on reducing the number of patients who are overdue for their follow-up appointment.). Each project will reassess productivity expectations in line with required activity targets for delivery of RTT improvement requirements in 2026/27
Standardisation of processes relating to RTT recording and monitoring	Historic tools (Patient Tracking List and associated reports) are still available for use and have known errors relating to incorrect exclusions and poorly defined logic to attribute pathways at a specialty level.	Provision of Pathway Advisory Group to support decision making for correct recording of RTT pathways where the WYAAT Elective Access Policy does not provide sufficient detail Provision of Trustwide Standard Operating Procedure for RTT Validation Implementation and continual improvement of Federated Data Platform RTT module as primary tool for validating RTT patients Creation of additional reports for monitoring patients incorrectly excluded from the PTL and manual additions to central returns

CRRC6: 2WW, 31 Day and 62-Day Cancer 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					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, and complex diagnostic pathways.

This results in a poor patient experience. Some patients may experience harm, including deteriorating symptoms and condition and impacts on health and wellbeing while waiting for treatment. There is a reputational risk for the organisation and the risk of increased scrutiny and additional capacity being required at increased cost.

Executive Lead: Chief Operating Officer

Date added to CRR: May 2014

Last Reviewed: July 2026

Next Review: January 2027

Committee reviewed at: Finance and Performance Committee

Controls	Gaps in Control	Further Actions Planned:
Operational plans to meet the waiting time standards set out in the NHS Constitution (2012), monitoring against the following standards: • 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	Seasonal variation in capacity requirement. Demand control Clear oversight of pathways spanning multiple services and CSUs and IT	DIT project as part of PPM decommissioning to move towards automation and tracking by exception where possible. Timeframes currently unknown.

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 out • A 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 • A maximum of 31 days from decision to treat to treatment (first definitive or subsequent)	systems to support proactive management of individual patients and risk.	Further development and sharing of power bi tools to provide oversight.
Cancer Operational Delivery group established to support collaboration, shared ownership and drive improvements in the challenges that impact all pathways eg pathology, radiology, data.	Real time data to identify delays in patient care to support proactive management	DIT project as part of PPM decommissioning to move towards automation where possible. Timeframes currently unknown.
Trajectory to delivery for 26/27 submitted and supported by the Cancer Alliance for all of the cancer standards.	The 62 day trajectory delivers 75.1% by March 2027 with the expectation that further improvement will be delivered over the subsequent 2 years.	Leeds Cancer Centre has developed proposed trajectories to delivery at pathway level these will be signed off by services and monitored via weekly oversight and the IAF process.

	The constitutional standard is 85%	Pathology trajectory (and plan) in place to deliver 7 day turnaround. Pathology specific PTL supported by the LCC
Medical Director of Operations for Cancer in post alongside a revised Cancer Board and pathway level deep dives led by the clinical teams to strengthen clinical leadership.		.
Clinical and Strategic Cancer Boards have been introduced to enable Clinical/Operational teams to escalate key challenges for support.		Leadership meetings regularly with GM for Cancer, Lead Cancer Nurse, MDOP and DOP around progressing actions outside of meetings.
Continued focus on pathology turn around times across cancer pathways	Turn around of samples within 7 days (Trust standard) is currently not achieving	Significant improvement to 8 days trun around time on average for urgent biopsies. Variation remains at tumour site level.

		Additional LC agreed for cell path to support focused work at pathway level. Equipment replacement programme to commence over 26/27 to reduce the time a sample is in the lab through increased automation. Y3 investment in the pathology business case has been brought forward into Y2 to expedite improvement (funded non recurrently by the Cancer Alliance).
Recovery plan in place for the skin backlog position – significant reduction despite increased seasonal demand.	The backlog has reduced but this has not yet delivered an improvement in the % of patients treated within 62 days	Specific pathway review project to be commenced facilitated by the LCC following the methodology of the recent LGI and Lung reviews.

		Weekly oversight meeting with the Director of Operations. Learning from peer organisations (Royal Free visit)
MDT Review to explore opportunities to make decisions outside of MDT where clinically appropriate to avoid unnecessary delays to pathways led by MDOP	This is dependent on the move to PPM+ and the functionality of the opportunity described to move to automation of information available to inform decisions and actions.	LCC working with DIT to support the timely transition to PPM+ for MDT management.
Harm reviews undertaken for patients waiting longer than 104 days.	Delays in treatment for patients waiting longer than national standard. Harm reviews for patients who were treated after day 104 are completed by MDT leads for each pathway	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.

The Trust maintains and publishes timed pathways, agreed with the local commissioners and any other Providers involved in the pathway, taking support from the WY&H Cancer Alliance for key areas	Referrals from other providers do not always occur in a timely manner to support delivery of 62 performance. LTHT capacity does not match the demand to deliver treatment within 62 days specifically in relation to surgical capacity for some tumour sites	A review of demand for cancer surgery by tumour site compared with the current capacity is being undertaken by the LCC. This will be shared with CSUs and Corporate Operations teams to inform conversations around allocation of capacity. Services are flexing capacity according to clinical need and delivering additional activity to manage demand.
Delivery against generic pathway milestones (NHSE guidance)		The 26/27 trajectories will be underpinned by trajectories at pathway level to deliver the generic pathway milestones where appropriate.

Appropriate management of cancer referrals	2ww referrals have continued to increase	Focused work at pathway level to understand referral trends and themes – development of alternative pathways in collaboration with primary care eg IDA in lower gi to support appropriate referrals
MDOPs and DOP supporting the breast pathway to navigate a significant gap in the radiology workforce.	Significance workforce gaps remain primarily as a result of sickness. The reporting of breast screening imaging Is within the required timeframe as a result of significant additional activity being provided by bank staff. There is currently an unacceptable wait from a screening scan being reported to the patient being seen in an assessment clinic.	The radiology service has sought advice from SQAS regarding the best way to communicate the delay to assessment clinic with patients who are impacted. There is a weekly meeting between the breast surgery team and the radiology team chaired by the DOP/MDOP to monitor the position and ensure appropriate clinical prioritisation. Patients with imaging that is highly suspicious of cancer are prioritised into next available appointments. There is clinical prioritisation of the available capacity.

	This is expected to recover over summer to within the required timeframe There is a risk that radiology will be unable to provide a radiologist for some MDTs over summer	Radiology and oncology working group to develop a sustainable service model in September when the assessment position is recovered. Mutual aid is being sought to support MDTs. Flexible 'mini' MDTs at a different point in the week are being explored to avoid delays to patient pathways where possible.
Oncology programme of work to reduce delays for outpatient clinic appointments. Funding agreed (£2m) to support recruitment into the oncology service to respond to continued increasing demand	Opportunity to reduce follow up demand (mitigate growth and create new capacity) is dependent on realising opportunities delivered by e-proms	Agreement to expedite the e-proms opportunity within oncology outside of the Trust e-proms programme.

CRRC7: Failure to achieve 28 days cancelled operations Constitutional Standard	C = 4 L = 4	16	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
									Target Score					Initial & 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: September 2026
Next Review: March 2027

Committee reviewed at: Finance and Performance Committee

Controls	Gaps in Control	Further Mitigating Actions:
To support CSU's in their adherence to this constitutional standard work has been focussed on strategies which minimise the risk of on-day cancellation through the provision of post-operative facilities and services which meet the care needs of patients through: - Day surgery as norm - Higher observations/enhanced care and recovery - Theatre productivity & efficiency - Patient preparation, assessment and optimisation - Effective scheduling and planning Updates against these are provided through the Theatre Productivity Improvement Board, Strategic Theatre Utilisation Group & Specialty Theatre Improvement Groups.	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 Accountability Meetings and Integrated Accountability Meetings used to support the daily management of CSU KPIs and delivery of the 28-day constitutional target for CSUs. Monthly validation of 28 cancelled operations and breaches to be supported by I&I and Performance teams.
Addressing the avoidable reasons for cancelled operations to reduce the number of last-minute cancelled operations which	Gaps in scheduling, planning and communication processes all contribute to the volume of	Regular audit and review of cancelled operations. including regular review via Specialty Theatre Improvement Groups.

are then subject to the 28-day constitutional standard which are, in order or volume: - 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	operations cancelled on the day including: - Pre-assessment processes - Providing patient's reasonable notice - Reminder/confirmation processes - Adherence to 6-4-2 - Surgical and anaesthetic review of operating lists Impact of Theatre productivity and utilisation plan causing increase in on-day cancellations for 'ran out of theatre time'.	Reset of pre-assessment services to ensure patients are comprehensively reviewed and confirmed fit for surgery. Use of peri-operative medicine strategies (SU4S, PHR) to prepare patients for surgery. Standardised procedure for the confirmation and reminder services provided to patients about their surgery and surgical dates. Process of surgical and anaesthetic lockdown, in line with 6-4-2, of agreed operating lists prior to day of surgery. Implementation of GIRFT standards and best practice guidance in relation to the above.
Prompt starts for all elective theatre lists to automatically send for patients requiring inpatient or day case capacity. All ACC SJUH patients are automatically sent to theatre and Priority 1-4 patients at LGI are automatically sent to theatre	Co-ordination of theatre/ ward and critical care capacity does not always align leading to greater risk of cancellations. Not all Critical Care patients can be automatically sent for	Daily circulation of planned TCIs and previous cancellation status the day prior to surgery. Re-launched 1st start standards in areas with high incidence of on-day cancellation to minimise risk e.g. cardiac surgery; paediatric surgery.
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. 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.	Critical Care capacity can change overnight due to staffing absence or high numbers of unplanned admissions and result in on day cancellations	Further work on the collaborative scheduling of patients requiring High Observations Beds to replicate the processes in Adult Critical Care. 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.

Daily email prompt to CSUs highlighting their 28-day breach risks. 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. 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.		

CRRC9: Failure to achieve 6 weeks diagnostics test Constitutional Standard.	= 4 L = 4	16	Very Low Risk				Low Risk			Medium Risk		High Risk		Significant Risk			
			1	2	3		4	5	6	8	9	10	12	15	16	20	25
										Target Score					Initial & 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: July 2026

Next Review: January 2027

Committee reviewed at:

Finance & Performance Committee

Controls	Gaps in Control	Further Actions Planned:
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.	Targeted work required between CSUs to manage competing demands for paediatrics to reduce long waiters (i.e. patients waiting >13 weeks) and sustain delivery.

Inclusion as a key service delivery metric in the refreshed Integrated Accountability Framework. Bi-weekly oversight meeting (GM and DOP) with radiology focus on US MRI and CT Use of additional LTHT staffing hours, or independent sector staffing to mitigate breach position where such staffing available	Ultrasound recruitment and additional payment are in place, lack of applicants to new roles. Limitations in skill sets of independent sector and insourced Sonographers.	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 weekend is being explored as an LTHT more sustainable option. 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. The position is stable. A sustainable approach is being explored to resolve the gap in control of LTHT skilled staff for this. This requires a workforce restructure, which has been defined and proposed.
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	Lack of visibility of status of Inpatient requests and investigations due to patient's level information being held and booked on several	Review of Radiology consultant workforce on going to ensure resilience to manage fluctuations in demand.

for inpatient diagnostics e.g. Leader on Point contact.	different systems (ICE, PPM, CRIS, TMS)	Detailed capacity and demand analysis to be undertaken to ensure correct scanner capacity available. Business case submitted to increase overnight staffing levels on acute CT scanners at SJUH and LGI. This will provider safer staffing and ensure a more robust Inpatient overnight CT service.
A power BI dashboard has been developed to provide oversight and support operational management of diagnostic waiting time in radiology		Embed use of dashboard across Radiology team as key way to manage KPI's

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 and managed via CSU and Trust governance structures.	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.	Developing a process for clinical validation of non-admitted diagnostic breaches to identify patients at risk of harm from a delay
To Ensure we have a sufficiently trained workforce available to meet the demands of our patients	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.	. Continued review of further Insourcing and outsourcing opportunities across Radiology.

	Not all CSUs have completed workforce plans for growth in service demand. Modelling out of workforce plans for diagnostic services in line with 2026/2027 activity growth from CSU requiring use of diagnostics.	Recruitment strategy in place within radiology. Development of workforce plans as per the 2026/2027 activity planning and trajectories.
Equipment replacement programmes and maintenance.	Funding availability to replace equipment or gain additional equipment for continuation of provision of service. Breakdown of equipment requiring the cancellation of patients.	MRI capacity and demand review highlights need for additional scanning capacity. . MRI relocatable modular unit approval to accommodate demand for current year, with Capital bid developed for potential funding available for 2x MRI scanners at CDC. Continued review of Insourcing and outsourcing opportunities across Radiology with quality and cost efficiencies considerations.

		Managing conversations with contract providers of equipment to ensure responsive turnaround time for repairs. MES for all radiology equipment being reviewed and considered by the Trust

CRRC10: High occupancy levels and insufficient capacity and flow across the health and social care system causing impact on patient safety, outcomes, experience and reputational damage	C = 4 L = 4	16	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
											Target Score			Current Score		Initial Score

Risk Description:
There is a risk 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 and patients residing in hospital when they are medically optimised to be discharged; impacting on patient safety, outcomes, experience and delivery of constitutional standards. As a consequence, patients may be cared for in areas that are not designated for this, including corridors, further impacting on patient safety, outcomes, experience and the organisations reputation.

Cross-referenced to Corporate risks **CRRC4, CRRC5, CRRC6, CRRC7, CRRC8, CRRC9, CRRC11**.

Executive Lead: Chief Operating Officer

Date Added to CRR: September 2015
Last Reviewed: September 2026
Next Review March 2027

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 Directors on Point with clinical support from site managers. Corridor care standard operating procedure established	Fully operationally implemented Live bed state not in place – limited real time admission and discharge data to support understanding of all available capacity. Acute internal medicine and elderly care patients wait a disproportionate time in ED for an inpatient bed 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. Data collection of the number of patients experiencing corridor care for 45 minutes or over in the Emergency Departments is running as per NHSE requirement and this figure is reported daily in the national sitrep. Heatmap of corridor care use by hour is used to support understanding of pressure points and impact of improvements or challenges.

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 established to work with and provide support to discharge coordinators. 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.	efficiency not currently met- plan for a central model review	An operational delivery task force from key multi-disciplinary leaders with 3 key objectives for each main site has been established. Key areas of focus include: 1.Right size the medical bedbase 2. Develop an improved flow model that decongests Same Day Emergency Care Units Across the organisation 3. Devise a centralised patient flow model that improves timeliness of patient placement The Operational Response Guidance has been reviewed and agreed through corporate Operations and will be presented at Weekly Executive Board which hosts all CSU senior representation.
Agreed Full Capacity Protocols (FPC) for surge and corridor care implementation capture and assurance process measures. <u>This includes utilisation of the plan.</u> Daily submission of corridor care data captured and submitted on the NHSE sitrep from 1st May 2026 Monthly report provided to the Quality & Safety Assurance Group (QSAG) for assurance on the Trust response to eradicating corridor care by 2029 issued by NHSE. Structure established to ensure a weekly review of the longest waiting patients with No Criteria to Reside to	Insufficient space and staff to meet expected surges if inpatient numbers increase above expected population growth. 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. Overall patient experience and potential for patient harm impacted by use of corridor care.	Track the frequency of FCP implementation against the triggers and impact it had for assurance and further understanding. Online form developed and currently being tested through the operations centre. Review the NHSE corridor care reduction requirements including director level ownership of long stay patient reviews and design an approach to deliver and track this. Review the demand and capacity bed model by CSU to understand opportunity and pressures for each CSU bed base to configure their bed base.

ensure timely escalation of patients and to identify suitable alternative pathways that will result in earlier discharge. 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 Protected elective capacity at SJUH, CAH and Wharfedale Hospitals to support elective (planned patient) capacity.	There was a city trajectory to reduce the number of inpatients with No Criteria to reside in hospital to no more than 160 - trajectory not met. 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.	To confirm what beds are protected and which can be offered for other specialities to support best use of estate and people and timeliness of care. Winter planning in progress based on information currently available.
Tactical: Alternatives to admission- Established Same Day Emergency Care unit 7 days per week. Primary Care Access Line receives calls for primary care colleagues, GPs and ambulance services to navigate as clinically appropriate away from ED and admissions to a series of rapid access clinics, specialist advice of a consultant, SDEC or assessment area - Nationally recognised for its success	SDEC's across the organisation will host overnight inpatients when the organisation is under significant pressure and demand outstrips capacity.	Review of the SDEC's and assessment areas business continuity plans, Decision Management Tools and triggers with learning from winter pressures to ensure resilience and continuity of provision. Call before you convey test of change for ambulance conveyances from care homes in Leeds with a category 3 or 4 (lower acuity) showing greater use than expected and is now being embedded into practice.

Developed Virtual Ward for respiratory and frailer adults to support admission avoidance and early discharge and alternative care for lower acuity admissions Developed Home Telemetry ward to support early discharge and monitoring from a patients own home/bed rather than a hospital bed where clinically appropriate.		
Strategic: Established Leeds urgent community response group with delivery of 2-hour community response 8am till 8pm to avoid ED and admission conveyance. Neighbourhood Health, Adult Programme Board launched. 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.	Risk of system service resilience and delivery due to the financial pressures and cost reduction requirements.	Agreed trajectory to reduce No Criteria to Reside (NC2R) patients over the next 2 years to 160. Weekly tracking and dashboard against trajectory being developed for the SRO's of the intermediate care group.

CRRC11: Patients presenting with mental health conditions waiting for long periods in the emergency department and acute admission pathway	C = 4 L = 4	16	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
									Target Score			Initial Score		Current Score		

Risk Description:
There is a risk that 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: September 2026
Next Review: January 2027

Committee reviewed at:
Quality Assurance Committee

Controls	Gaps in Control	Further Mitigating Actions
A joint triage model incorporating a member of the ALPS team was introduced from the week commencing 30/03/2026. This initiative aims to strengthen front-door assessment processes and support timely clinical decision-making through closer collaboration between teams.	Current staffing levels within the ALPS team may limit the ability to provide a consistent 24/7 service. Ongoing workforce planning and review of staffing models will be required to support sustainable service delivery and maximise the impact of the enhanced triage model.	Monthly operational meetings are held with LYPFT to review performance, identify emerging concerns, and develop collaborative solutions. This forum supports joint decision-making, strengthens inter-organisational relationships, and promotes continuous service improvement across patient pathways.
The Mental Health Triage and Risk Assessment Tool has been reviewed to ensure the identification of immediate needs and appropriate escalation of medium and high-risk concerns. Associated actions have been amended to reflect operational and staffing pressures while continuing to provide a safe and effective response for this vulnerable patient cohort.	The control relies on availability of workforce capacity and timely escalation pathways	Ongoing audit and outcome monitoring of compliance of usage of the forma and compliance with the associated actions
A formal escalation process is in place through the CSM team for patients experiencing prolonged delays while awaiting specialist mental health assessment or admission. This is achieved via a live PPM+ custom list. This ensures that delays are actively monitored, risks are escalated appropriately, and	Hospital capacity pressures and competing admissions can limit opportunities to expedite mental health placements. In addition, patients requiring mental health assessment often present with complex physical health	

multidisciplinary partners are engaged to support timely progression of care and improve the patient experience.	needs, necessitating input from multiple specialties and contributing to extended care pathways.	
Monthly operational meetings with LYPFT are undertaken to review incidents, identify emerging trends, and jointly address patient pathway challenges, supporting continuous improvement in care and patient experience.	Capacity and operational pressures within LYPFT remain outside the control of LTHT. LYPFT balance demand across organisations, which may impact its ability to consistently meet LTHT service requirements.	A GIRFT review has been undertaken to understand delays within mental health pathways and identify recommendations for improvement. Where operational challenges persist, issues are escalated and discussions between organisations to drive resolution and system-wide improvement.
A standing agenda item is maintained within the Urgent Care Governance Forum to review Datix incidents and reportable events relating to patients experiencing prolonged delays in mental health assessment, admission, or onward referral. This provides routine oversight of patient safety risks, facilitates the identification of themes and trends, and supports the timely implementation and monitoring of corrective actions.	This provides a retrospective assurance rather than preventing delays in real time. Relies upon consistent reporting	

CRRC12: Corridor care in Emergency departments and in ward areas	C = 4		Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
	L = 5								6Target Score					15Current Score	20	

Risk Description:
Patients being cared for in corridors impacting on patient harm and poor patient experience including lack of privacy and dignity and staff morale. National daily reporting of patients in corridor impacting on reputational damage and CQC concerns. Failure to eliminate corridor care as mandated by NHSE due to insufficient Emergency Department (ED) cubicles and footprint, insufficient available inpatient bed capacity and lack of system flow.
Cross referenced to Corporate risks: **CRRC10 CRRC4**

Executive Lead: Chief Nurse

Date added to CRR:
Last Reviewed:
Next Review:

Committee reviewed at:

Controls	Gaps in Control	Further Actions Planned:
Operational: Daily management and oversight of the hospital established including: ➢ 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 ➢ WYAAT repatriation policy agreement ➢ summary operation centre email sent to CSUs for organisational context and specific actions required	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. Fully operationally implemented Live bed state not in place – limited real time admission and discharge data to support understanding of all available capacity. Acute internal medicine and elderly care patients wait a disproportionate time in ED for an inpatient bed Patient flow and discharge co-ordinators hosted by CSU's. Devolved model does not enable standard work and maximum	Review all areas previously categorised as Corridor care against the newly published NHSE guidance and re-categorise as appropriate in order to maximise bed base and surge capacity. Review of operational response guidance, use of surge and corridor care is being undertaken aligned to new national guidance for corridor care reduction and will include LTHT learning to date. City home First programme refreshed trajectory for the year established with associated work plans mapped and will be tracked to measure success. Review the demand and capacity bed model by CSU to understand opportunity and pressures for each CSU bed base to configure their bed base.

Intentional Rounding of patients to maintain safety by reducing harm and ensuring privacy and dignity is maintained ➢ 2 hourly patient safety checks for patients in ED ➢ Intentional rounding for patients in corridors on wards ➢ Portable call bells in place for all patients placed in corridors ➢ Dignity screens available ➢ Patient risk assessments in place ➢ Daily spot check assurance audits undertaken by corporate nursing team 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. There is a Director on Point and clear Business continuity levels mapped, aligned to EPPR national framework with actions for recovery both internal to LTHT, cross city and region.	efficiency not currently met- plan for a revised model	Review of digital enablers for patient placement and flow including Live bed state. Progress estates work within the emergency departments in order to increase the cubicles with bed headed services. On-going assurance checks and escalation of non-compliance with risk assessments
Tactical: Established and developed alternatives to admission to include SDEC, Primary Care Access Line (PCAL), Virtual wards	SDEC's across the organisation will host overnight inpatients when the organisation is under significant pressure and demand outstrips capacity.	
Strategic: Intermediate Care redesign (called Home First 2 programme) collectively understood with a programme	Data and programme management gaps due to ICB changes will need to be supported by system partners	HomeFirst2 programme review has established a new agreed trajectory to reduce by a further 100 No Criteria to Reside (NC2R) patients over the

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.		next 2 years currently running at 250 patients. City Gold was established and improvement trajectory to reduce the NC2R this year shared.

CRRF1: Failure to deliver the financial plan for 2026/27	C = 5 L = 4	20	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
							Target Score								Current Score	Initial Score

Risk Description:
There is a risk that the Trust does not achieve its planned control total in 2026/27. This would have the following impacts:

- External intervention, reducing the Trust's autonomy and imposing decision-making
- Reducing the internal funding for the Trust's ambitious Five-Year Capital programme, leading to:
  - Limiting the capital programme/not replacing equipment
  - Relying on external sources of funding
  - Cash 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: Chief Finance Officer

Date added to CRR: November 2020
Last reviewed: August 2026
Next Review: February 2027

Committee reviewed at:
Finance and Performance Committee

Controls	Gaps in Control	Further Mitigating Actions
Yearly Board approved medium term financial plan (2026-29). The Board agree the medium-term plan, including Income and Expenditure position and four-year Capital Plan. The Board are sighted on risks to delivery of the plan through a quarterly risk range and executive agreed mitigation plans	• Changing National Payment System (Payment by Results). • No reason to reside issue is not resolved. • Restrictions on capital allocation due to funding formula.	• Turnaround Executive meetings Chaired by Chief Executive oversee delivery of the Trust's Waste Reduction Programme, and overall financial plan • Close monitoring of activity-based income, underpinned by strong contract negotiations at the start of the year • Capital Planning Group puts increasing focus through the year on strength of programme managers forecasts and ability to complete. Confidence levels and risks are specifically addressed. • Executive review of Backlog work. Development of an in-house mitigation plan.

		• Detailed review of underlying cost base and associated savings plans. • Regular updates to the Executive Team and Finance and Performance Committee including Exec lead on financial risk and associated mitigations. • Regular communication with ICS and Region 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	• Regular updates to the Executive Team and Finance and Performance Committee including Exec led financial mitigations. • Regular communication with NHSE to identify and adapt to changes.
Quarterly Fundamental Review of the Trust's Financial Position to Finance and Performance Committee setting out the risk range of the in-year financial position and executive owned mitigations		• 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 CFO and Deputy CFO which in turn feed into Integrated Accountability Framework CSU meetings, and Turnaround Executive, chaired by the Trust CEO	Waste reduction is not delivered in full	• 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	• Development of in-house mitigation plan • Regular updates to the Turnaround Executive and Finance and Performance Committee including Exec led financial mitigations • Support to be sought from external parties where appropriate (eg funding for mutual aid)

Operation of the Integrated Accountability framework with: • Monthly Clinical Director signed off forecasts and a RAG rating against CSU agreed Control Totals • Turnaround Executive, including the Chief Executive and other Executive Directors, for oversight of the delivery of the financial plan including waste reduction	None	• Regular updates to the Executive Team and Finance and Performance Committee including Exec led financial mitigations. • Further escalation of underperforming CSUs to Exec-led intervention
Contracts for income agreed in line with current NHS payment mechanism.	National Variable Payment System (Payment by Results). The cultural shift required moving from the Aligned Incentive Payment system to Variable Payment System (PbR). Insufficient capacity in the coding team impacting on the implementation of PbR. Impact of organisational change at NHS E and ICB. Awareness and understanding of the financial impact of changes in funding and delivering required operational performance in a fixed elective funding envelope.	• 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 • 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	• Working with other Trusts to identify, share and implement good practice. • Use of the PWC grip & control review findings alongside 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	• Strong relationships with Regional Team • Discussion with and support from other Trusts who have already had to access emergency cash.
Progress against the four-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 capital need eg 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			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
	L = 5					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:

- Reducing the internal funding for the Trust's ambitious Five-Year Capital programme, leading to:
  - Limiting the capital programme / not replacing equipment / not replacing Estates assets / not replacing Digital assets
  - Greater reliance on external sources of funding
  - Potential non-compliance with regulatory requirements
- Increased clinical risk due to inability to replace capital assets within agreed replacement schedules, address critical maintenance backlogs, and invest in infrastructure across the capital programmes.
- Inability to invest in required strategic developments to support clinical services either in development or in improving productivity.
- Reputational damage, as the Trust fails to invest in equipment, estate and digital infrastructure to support service development.

Executive Lead: Chief Finance Officer

Date added to CRR: May 2023
Last reviewed: August 2026
Next Review: February 2027

Committee reviewed at:
Finance and Performance Committee

Controls	Gaps in Control	Further Mitigating Actions
The Trust has adopted a risk-based approach to the prioritisation of internal capital funding via the annual refresh of the four-year capital plan. Progress against the four-year plan is overseen by the Capital Planning Group including specific prioritisation for the MSE, BME and DIT programmes.	• 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.	• Refresh of the approach to medical equipment through PWC advisory report in early 2026/27. • 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.
Development of in-house mitigation plan allows for the Trust to respond to changes in funding allocations or utilise slippage in other Trusts.	• Restrictions on capital allocation due to funding formula – • 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.	• 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 NHS England region team to assess and mitigate risks • Regular communications with New Hospitals Programme to assess and mitigate risks • Programme leads have developed contingency schemes to utilise any additional capital availability on a risk-based approach.
External funding opportunities monitored closely with bid and applications submitted wherever possible	• 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	• 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 4-year Capital programmes are developed based on funding availability, including external, operational capital allocation and internal funding.	• 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.	• Cash management is in place with the cashflow forecast reported to the Finance & Performance Committee. • The cash risk is reported and monitored within the Finance team. • 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.

	• Application of funding has been impacted with accounting standard changes – leases now included in CDEL.	• 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	• Availability of capital and revenue allocations impacts on the affordability of operational capital investment.	• 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			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
	L = 4								Target Score			Initial Score		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: Nov 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 CQC Fundamental Standards – Breaches of Regulation(s) in Maternity and Neonatal Services	C = 4 L = 4	16	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
									Target Score			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.

There is a risk the trust will face further and more severe enforcement action from the Care Quality Commission (CQC) if the trust does not embed and sustain improvements to achieve compliance with the current enforcement action and breaches of Regulation 12: Safe care and treatment; Regulation 15: Premises and equipment; Regulation 17: Good governance and 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: July 2025
Last reviewed: September 2026
Next Review: December 2026

Committee reviewed at:
Perinatal Improvement 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. Monthly perinatal briefing meetings with staff. Bi-weekly virtual briefing events 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 Director of Nursing.	Capacity of maternity and neonatal senior leadership team to host listening events with staff.	
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. Monthly HRG report reviewed at NHSE Integrated Quality Improvement Group (IQIG). Maternity Escalation Policy developed Maternity Escalation Policy and Operational Pressures Escalation Levels Framework		
Regulation 12 Safe Care and Treatment Findings and recommendations published in the National Maternity Investigation, announced by Health Secretary in June 2025, to examine 12 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 published 30 June 2026. Findings and recommendations published in the Nottingham Maternity Investigation (Ockenden) 24 June 2026. 10-Point Plan setting out immediate actions to be implemented in 100 days published by NHSE 30 June 2026.	Capacity of maternity and neonatal senior leadership team to implement recommendations set out in the report and 10-Point Plan set out in the letter from NHSE.	Recommendations to be reviewed with CSU leads and Executive Directors to identify where resources and support is required (31 July 2026). Recommendations in the report to be incorporated into perinatal improvement plan (31 August 2026).
Regulation 12 Safe Care and Treatment Trust participation in Leeds Maternity and Neonatal Independent Review, announced by Health Secretary in October 2025.	Capacity of maternity and neonatal senior leadership team to participate in independent review whilst delivering services and improvements.	Additional senior leadership support provided to CSU, including Director of Operations (Corporate Operations) and Director of Nursing.

	Terms of Reference and scope of review not yet published.	Programme Director, team and infrastructure established to lead the response to the Leeds Maternity and Neonatal Independent Review (30 September 2026) and provide support to CSU(s).
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 submitted 20 August 2025.		
Regulation 12 Safe Care and Treatment **Regulation 17 Good Governance** Maternity and neonatal services: perinatal improvement plan. Evidence Review Panel established June 2026 to provide assurance that actions have been completed. Perinatal Improvement Action Group (PIAC) established June 2026.	Oversight of different workstreams and improvement plans (MSSP, CQC).	Oversight of perinatal improvement plan provided by Programme manager, working in conjunction with CSU leads and MIAs.
Regulation 12 Safe Care and Treatment **Regulation 17 Good Governance** Maternity Safety Support Programme (MSSP) – monthly Integrated Quality Improvement Group (IQIG), to provide oversight of improvement plan and assurance. Support from Maternity Improvement Adviser(s) (MIA) and neonatal Improvement Adviser(s) (NIA). Actions developed in response to review of MIS year 5 and 6. MIA review of MIS year 5 and 6 to inform improvement plan. Discretionary funding application approved by NHSR for funding to support improvements and compliance with MIS safety standards (September 2025). Equality Diversity and Inclusion (EDI) diagnostic undertaken 1-2 July 2025.	Capacity to deliver improvements. Maternity Incentive Scheme (MIS) year 5 and 6 reviewed by MIA and not achieved.	Support provided by MSSP – 2 members (MIA) of MSSP commissioned to provide direct support to improvement programme.

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.	Variable compliance re management and storage of medicines.	Daily compliance checklists.
Regulation 15 Premises and Equipment Revised process for the monitoring, procurement and maintenance of equipment required to provide safe care, including CTG machines. Process for the oversight of estate jobs that require completion, including escalation.	Availability of equipment	A review of the total number of CTG machines available and required for the service undertaken.
Regulation 15 Premises and Equipment Infection Prevention and Control (IPC) guidelines and audit programme. Environmental cleaning and audit programme. HCAI report to Quality Assurance Committee.	Variable compliance re infection prevention and control.	IPC review of infection prevention and control practices, overseen by IPC Sub-Committee.
Regulation 15 Premises and Equipment Quarterly audit of neonatal cot-side resuscitation equipment against 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.	Capacity to manage regulatory requests alongside improvement work. Gaps in senior leadership provision.	Additional leadership capacity and support provided to the maternity and neonatal teams, including Medical Director Operations, Director of Nursing.

Trust response setting out improvement actions and how these will be measured and monitored, for assurance.		
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.
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. Communications team oversight of direct communications received through the Chief Executive e-mail address.	Capacity to manage all enquiries following publication of CQC inspection reports (maternity and neonatal services) 0n 20 June 2025.	PALS support to CSUs in the handling of enquiries 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 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. Monthly Governance pack shared across CSU (email and hard copies).	Full MDT attendance to represent all areas to review patient safety incidents/PMRT.	Review of governance infrastructure and support included in perinatal improvement plan.
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.	Additional capacity to provide support to CSUs in the management of FOIs and SARs to be provided by IG (30 September 2026).
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.	Ability of non-clinical, specialist and management midwives to complete their	Recommendations in the National Maternity Investigation report related to staffing to be

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 Improvement Assurance Committee. NHSE 10-Point Plan following publication of the National Maternity Investigation report (June 2026) – staffing.	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.	incorporated into perinatal improvement plan (31 August 2026).
Regulation 18 Staffing Standard Operating Procedure (SOP) – escalation and management of gaps in medical rotas. 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.	Gaps in consultant and resident doctor rotas.	Long-term consultant locum posts (2) appointed.

CRRE2: CQC Registration – breaches of Regulation(s) Well-led	C = 4 L = 4	16	Very Low Risk			Low Risk			Medium Risk		High Risk		Significant Risk			
			1	2	3	4	5	6	8	9	10	12	15	16	20	25
									Target Score			Initial Score		Current Score		

Risk Description:
There is a risk 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: Director of Corporate Affairs

Date added to CRR: Nov 2025
Last reviewed: August 2026
Next Review: December 2026

Committee reviewed at:
Quality Assurance Committee
PIAC
Board

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. Integrated Accountability Framework Meeting 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.	From initial diagnostic review of complaints process, long term complaints improvement plan to drive cultural changes to capture, investigate and critically learn from patient feedback – deliver by June 2027. Established new Patient Experience and Engagement Group reporting to QAC. R
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 to support CSUs preparation for CQC inspection.	Associate Director – Compliance and Regulation appointed to provide additional leadership capacity, July 2026.
Regulation 17 Good Governance Inspection letter from CQC (Well-led) published 20 June , full report published 25 Sept 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 reviewed at Improvement Steering Group established in November 2025. Monthly progress reporting to IQIG, building assurance and compliance aiming to remove enforcement notice.

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 Executive Improvement Steering Group chaired by Chief Executive.		Associate Director – Compliance and Regulation appointed to provide additional leadership capacity, July 2026.
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 (self-assessment red rated). NHSE issued red rating in March 2026
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 was delivered on the management and review of risks and risk registers In June 2026, with refreshed resources provided. Pilot work taking place with a small number of CSUs to refresh risk registers and use of 4th Edition of the Risk Appetite Framework – to build ongoing maturity and application of risk assessment, escalation and assurance of mitigations. CSU Quality Assurance Group framework 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.	Exec Director portfolios and accountabilities reviewed. Trust Board reporting and Cttee structures reviewed and approved at 26 November 2025 Board meeting and implemented from 1 January 2026. Board development programme approved at March 2026 Board on going focusing on listening, learning, curiosity, just culture and psychological safety. Q1 2026-27 NHS Alliance conducted phase 1 of external Well-led review – to report to 24 September 2026 Board meeting.
Regulation 17 Good Governance Patient safety incident reporting process, weekly review of incidents by CSU. Process for reviewing all patient safety	CSU understanding of the principles of the Patient Safety Incident Response Framework (PSIRF) variable, including application of	PSIRF maturity self-assessment undertaken in July 2026 and shared with WYAAT for benchmarking purposes.

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.	methods and tools to undertake patient safety incident investigations.	
Regulation 17 Good Governance Monthly reports (by exception) to Risk Management Committee, focusing on key risks, controls and mitigating actions, reporting to Board. Risk Appetite Framework 4th edition (June 2026)	CSU management of risk registers variable – changes to CSU leadership.	Board Workshop 26 March 2026 on the management and review of risks and risk registers. Revised Risk Appetite Framework published in June 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 People 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. Review of FTSU completed and all actions from the Well-led plan completed. Annual Report by FTSU Guardian received at 30 July 2026 Board, alongside Executive Assurance Report. Ongoing assurance via People Cttee Guardian now attending People Improvement Performance Meetings FTSU Guardian additional resources with recruitment for 1 WTE
Regulation 17 Good Governance Board leadership visit programme.	Programme does not cover all areas or focus on 24/7 care provision.	Board leadership programme revised for 2026/27 with more visits including out of hours and weekends. New process of quarterly reporting to 30 July 2026 Board meeting.
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, aligned into one action plan, approved at 27 November 2025 Board. Ongoing work lead by People Function for Belonging & Inclusion, underpinned by approval of

		revised Trust Strategy and Values at 28 May 2026 Board meeting. Completion date for Belonging & Inclusion Plan April 2027 with assurance overseen by People Committee.
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.	Detailed review of mandatory training and compliance carried closure of the original plan and replacement with boarder Mandatory and Priority Learning Improvement Plan to strengthen the control environment, governance, reporting and assurance mechanisms which was approved at 11 June 2026 People Cttee and on-going oversight for delivery.