

Winter plan-Post Winter Review
Public Board
Thursday 30th July 2026

Presented for:	Information
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Previous Committees:	None

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

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

Risk Appetite Framework			
Level 1 Risk	Level 2 Risks	(Risk Appetite Scale)	Impact
Workforce Risk	Workforce Supply Risk - We will deliver safe and effective patient care through having adequate systems and processes in place to ensure the Trust has access to appropriate levels of workforce supply.	Cautious	Operating within
Operational Risk	Business Continuity Risk - We will develop and maintain stable and resilient services, operating to consistently high levels of performance.	Cautious	Operating within
Clinical Risk	Capacity Planning Risk - We will ensure that capacity is planned to meet the demand for elective and non-elective (acute) admissions to our hospitals, managing this risk to provide safe treatment and care to our patients.	Cautious	Operating within
External Risk	Partnership Working Risk - We will maintain well-established stakeholder partnerships which will mitigate the threats to the achievement of the organisation's strategic goals.	Cautious	Operating within

1. Summary

Overall, LTHT delivered a resilient plan over the winter of 2025/26 despite sustained operational pressure. Forecasting and mitigations enabled the Trust to improve cancer performance, Appendix 1, deliver the Emergency Care Standard against its submitted trajectory, Appendix 2, and achieve excellent ambulance handover performance, Appendix 3. The Trust also delivered the strongest frontline staff flu vaccination uptake among peer organisations, with a 9.7% vaccination improvement from last year. The principal winter challenge for 2025/26 was not an unexpected surge in demand, but earlier than planned influenza and prolonged operational pressure, particularly around patient flow, which reduced organisational efficiency and resulted in the Trust working at full capacity. This resulted in a significant level of crowding in the Emergency Departments with the subsequent clinical risk and mitigations escalated to the Quality Assurance Committee. Learning from this winter will be used in 2026/27 winter planning in conjunction which will be adapted to include NHSE requirements (normally published in early September.) It is expected the 2026/27 winter plan will be presented at Quality Assurance Committee on 20th August 2026 and Finance and Performance Committee on 26th August 2026 for review and then an update to the Trust Board on 24th September 2026. These dates may be subject to change should NHSE require earlier submission or additional information and actions.

2. Findings

Last year the Trust undertook a structured and evidence-based approach to winter planning; modelling demand and capacity across elective and non-elective inpatient pathways with phased mitigation plans for increased winter pressure in the form of admission avoidance and additional bed capacity. This plan was presented at Finance and Performance Committee on 25th September 2025 and tabled at Board for sign-off and submission to NHSE on 26th September 2025.

A fundamental review of 21 data sets and performance of constitutional standards, Appendix 4, reflection workshop on 18th May 2026 attended by an MDT of leaders, and a city system leader workshop on 6th July 2026 have been held and outputs will be used to inform 2026/27 winter planning.

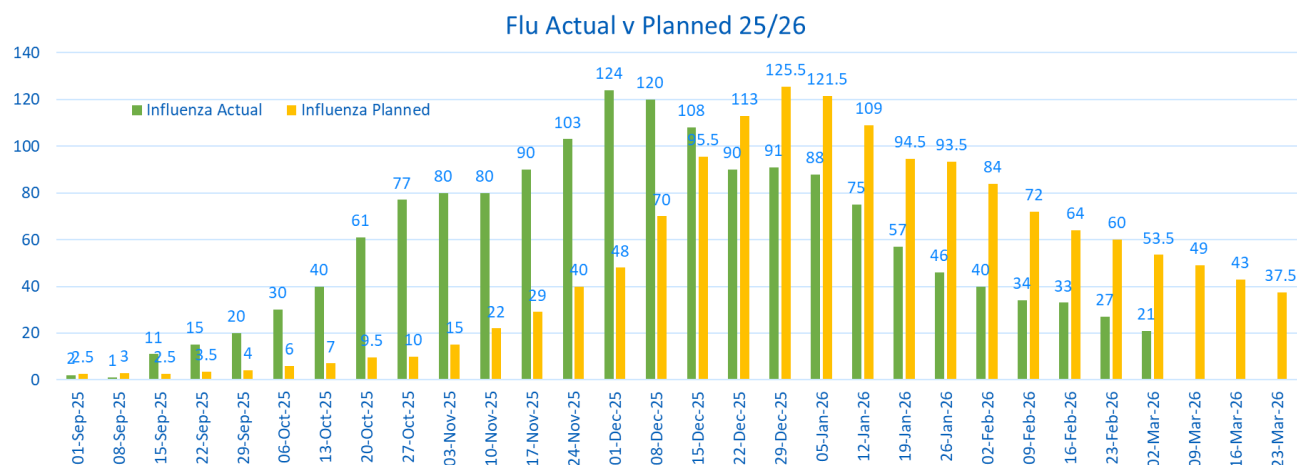
2.1 What went well

- Robust data-led planning and bed modelling with weekly tracking of key data sets through the winter period
- Early mobilisation when influenza arrived earlier than nationally and locally forecast
- Strong vaccination programme for staff and patients
- Sustained improvement in ambulance handover performance
- Emergency Care Standard maintained against improvement trajectory
- Elective services largely protected
- Continued improvement in cancer standards during winter

2.2 What the data tells us

Influenza peaked earlier than nationally and locally anticipated by approximately nine weeks requiring capacity to be opened ahead of schedule. The volume and shape of predicted occupied beds with influenza (Flu) was accurate. Figure 1.

Figure 1.



Emergency Department numbers of patients waiting for an inpatient bed exceeded forecast during this period, particularly at St James's Hospital. Whilst patients receiving corridor care in the Emergency Departments was not recorded during winter 2025/26 it is noted that volumes of patients in the department frequently outstripped cubicle provision.

Critical care step-down demand periodically exceeded assumptions. Length of stay and patients with No Criteria to Reside in hospital both increased through January–April, Appendix 5 and Appendix 6, indicating that discharge processes and patient flow, rather than absolute bed numbers, became the dominant operational constraint leading to congestion in our Emergency Departments.

2.3 What we learnt

Winter modelling and capacity planning for peak pressure points adds value and enables us to plan for additional bed capacity against trigger points; however, the organisation operates more efficiently when decisions are made earlier, escalation thresholds are predefined, accountability is explicit and operational disciplines are embedded every-day rather than only during periods of pressure. Improving patient flow and system triggers and actions throughout the year is the greatest opportunity to increase resilience and offer the best care. Overall, sustained system pressure exposed limitations in timing and responsiveness.

On this basis a 'summer plan for winter readiness' has commenced with agreed timeframes for completion and identified owners.

2.4 High level summary of summer actions

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

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

2.5 System agreed actions

- Strengthening escalation and decision-making in system flow including refining system governance, escalation routes and decision thresholds. Aligning with forthcoming system changes including ICB operating model and developing Leeds Provider Partnership.
In progress. Complete by August 2026
- 100-day proactive care test of change, testing and scaling up multi-neighbourhood proactive care and discharge model which commenced in July 2026.
In progress. Complete by November 2026
- Reduce the number of No Criteria to Reside inpatients in the hospital by improving intermediate care.
In progress. 2-year improvement trajectory agreed
- Quantify the benefit of the proposed city system winter capacity schemes.
In progress. Complete by end of July 2026

3. Quality and Performance Implications

Performance has been maintained and is described within the body of the paper. It is recognised the Emergency Departments were crowded during the winter months. The new corridor care definition and nationally mandated daily reporting provides a further marker of patient experience and quality of care for winter 2026/27. The summer work plan is focussed on reducing delays and improving timeliness of care for our patients. A paper will be presented on 20th August 2026 to the Quality Assurance Committee describing the plans to maintain quality of care during winter 2026/27.

4. Financial Implications

In 2025/26 an LTHT winter fund of £4.2 million was approved at executive level, allocated, tracked and spent by the Clinical Service Units to support increased staffing in the Emergency Departments, increased capacity across adults and children's services, and additional winter pathways and resources across the organisation. A new governance process was established last year with biweekly tracking of spend against each winter approved scheme and funds released when it was evident that the actions and associated costs were being incurred. The £4.4 million allocated for winter 2026/27 will follow the same governance process.

5. Risk

There are no material changes or impact to the risk appetite currently. Seasonal demand and capacity are described in corporate risks:

- CRRC10, High levels of occupancy and insufficient capacity and system flow, reviewed by risk committee March 2026 (due to be reviewed again in September 2026)
- CRRC4, Failure to achieve the ECS constitutional standard of 95% reviewed by risk committee on 2nd July 2026
- A newly described corporate risk, corridor care, which was approved through risk committee on 2nd July 2026.

6. Communication and Involvement

Learning is based on a multidisciplinary reflection session in May 2026 involving CSU teams and support services, followed by a Leeds city event in July 2026 with over fifty colleagues from Leeds organisations including third sector representation. This informed shared understanding and agreed future planning priorities for this year. There are two further events planned through North East and Yorkshire NHSE, the first on 28th July 2026 and the second planned as an in-person event in September 2026. Details to be confirmed.

7. Impact on Equality & Health Inequalities

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

Key areas of note are:

The proportion of patients who attend an Emergency Department who live in areas recorded as being in the IMD (Index of multiple deprivation) profile 1 (most deprived) was recorded as approximately 38% for SJUH which is a 2% reduction on the previous winter and 33% for LGI. This is similar to the previous winter period. Increasing attendance rates in this group are attributed to chronic health conditions that worsen over the winter months and require more intensive management compounded by damp housing and lack of heating.

Whilst LTHT has a higher-than-average deprivation group who attend the Emergency Departments, in order to maintain equity at the point of attendance, we would prioritise based on clinical urgency, whilst continuing to working across system boundaries to reduce health inequalities through system programmes of work.

The city influenza vaccination programme was aimed at those with higher chronic disease, risk and deprivation. Our inpatient influenza vaccination rate had increased by 80.3%

through implementing a new process, led by our medicine management colleagues. The city vaccination rate for influenza improved against the previous year with notable improvement in high clinical risk groups, people with identified learning disability, 2- to 3-year-olds and pregnant women.

8. Publication Under Freedom of Information Act

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

9. Recommendation

The Board are asked to note the contents of the report, and the process to reviewing the 2025/26 winter plan through use of a multi-source review and identification of learning opportunities.

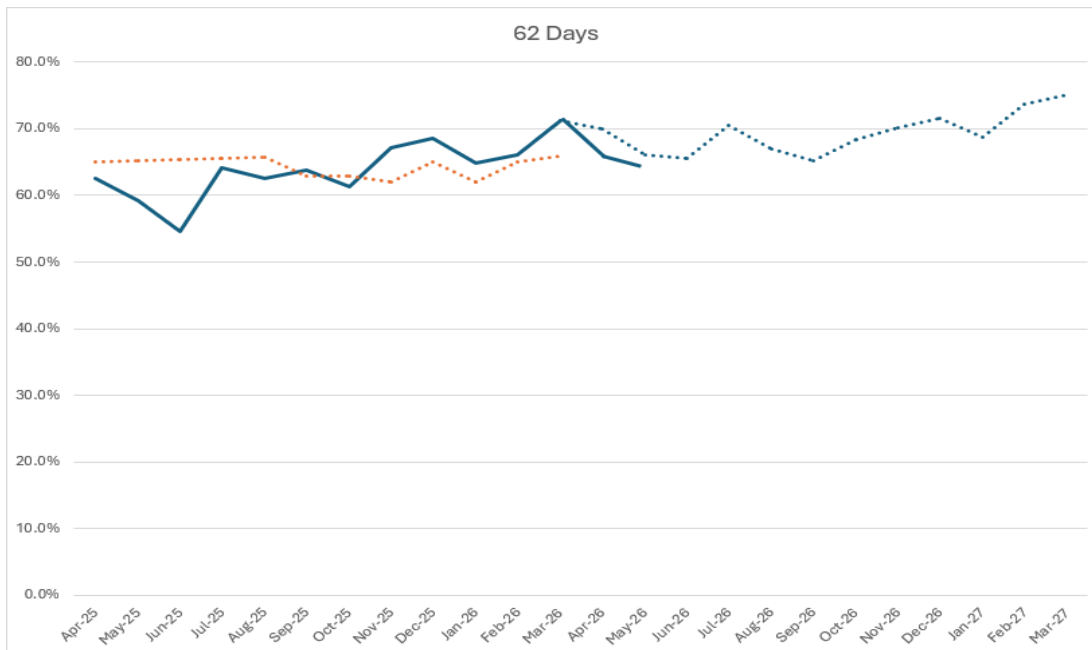
The Board is asked to note the findings, support earlier planning, endorse improved escalation and decision-making frameworks, and support strengthened system-wide alignment.

10. Supporting Information

Supporting information is included as appendices

Appendices

Appendix 1. Cancer performance actual versus national trajectory



Appendix 2. Emergency Care Standard

	May -25	Jun- 25	Jul- 25	Aug -25	Sep -25	Oct -25	Nov -25	Dec- 25	Jan- 26	Feb- 26	Mar-26
Trajectory NHSE	75.7 %	76. 5%	76. 9%	78. 2%	76. 2%	74. 5%	74.1 %	73.7 %	74.5 %	73.5 %	78% National March challenge
LTHT ECS Performance	76.5 %	76. 8%	79. 1%	78. 4%	76. 3%	75. 1%	74. 1%	73.7 %	74.0 %	74.8 %	78.6%
Peer Ranking Against 10 Peers	3	5	3	3	2	3	2	3	3	3	3

Please note the January 2026 ECS was as a direct result of one day of increased LGI attendances (an additional 200 patients) due to the impact of black ice and bad weather.

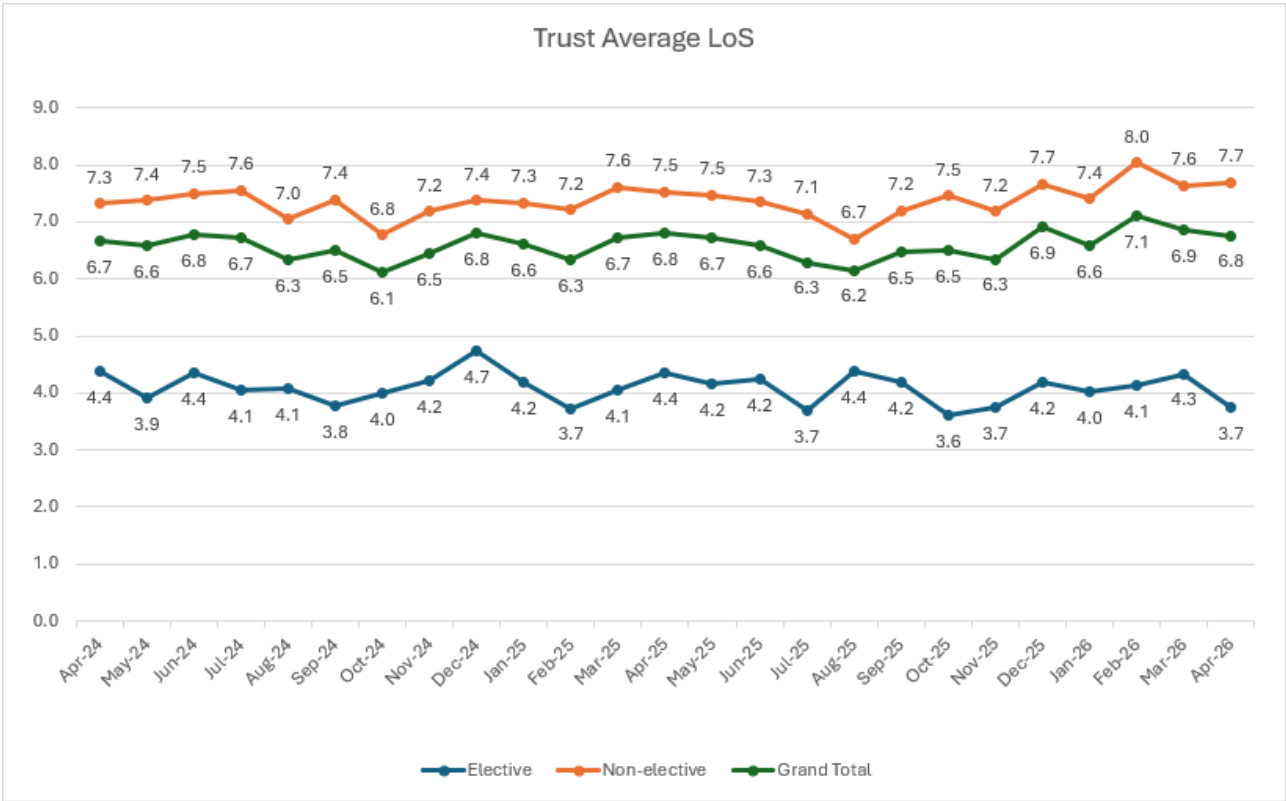
Appendix 3. Ambulance handover

		Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
Average ambulance handover time at LGI	2024/25	00:16:17	00:16:16	00:16:56	00:16:42	00:17:08	00:16:52	00:17:04	00:16:58	00:17:37
	2025/26	00:14:42	00:14:56	00:15:40	00:15:38	00:15:24	00:13:55	00:13:59	00:14:18	00:13:21
National Benchmarking Against 183 Hospitals		8	12	12	10	14	12	11	8	4
Average ambulance handover time at SJUH	2024/25	00:22:17	00:22:25	00:24:52	00:22:45	00:23:19	00:22:37	00:22:50	00:23:06	00:23:30
	2025/26	00:17:43	00:18:48	00:19:02	00:17:31	00:18:15	00:15:50	00:16:21	00:16:49	00:16:03
National Benchmarking Against 183 Hospitals		32	49	49	30	47	37	39	42	31
Overall Ambulance Handover Time	Trajectory	00:19:30	00:20:00	00:20:00	00:20:00	00:20:00	00:18:00	00:20:15	00:20:19	00:20:54
	Delivery	00:16:23	00:17:03	00:17:31	00:16:42	00:16:59	00:14:58	00:15:16	00:15:39	00:14:52

Appendix 4. Data set reviews

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

Appendix 5. Length of Stay



Appendix 6. No Criteria to Reside inpatient snapshot

