

Medium Term Planning Framework (MTPF) Submission
Trust Board
26 March 2026

Presented for:	Information Assurance
Presented by:	Jenny Ehrhardt – Director of Finance Tim Hiles – Chief Operating Officer Suzanne Dunkley – Chief People Officer
Author:	Robert Hakin - Director of Healthcare Planning Chris Ellison - Deputy Director of Finance Alison Wilkinson - HR Transformation Lead
Previous Committees:	Trust Board – 25 September 2025 Trust Board – 27 November 2025 Finance and Performance Committee – 28 January 2026 Trust Board – 29 January 2026 Extraordinary Board – 11 February 2026

Link to Strategic Objective	Focus on care quality, effectiveness and patient experience
Link to Provider Capability Assessment	Governance, risk and regulatory
Link to CQC Well-led Statement	Governance, Management and Sustainability
Regulatory Impact	None

Key points	
This paper provides an overview of the NHSE Medium Term Planning submission for LTHT, specifically the performance, finance and workforce elements relating to 2026/27 and summary level for subsequent years. The Board is asked to receive the information contained within this paper, noting the assumptions and risks identified.	Information
It is recommended that the Trust Board agrees that it has sufficient assurance on the assumptions and risks within the 2026/27 plan.	Assurance

Risk Appetite Framework				
Level 1 Risk	(✓)	Level 2 Risks	(Risk Appetite Scale)	Impact
Workforce Risk	✓	Workforce Retention Risk - We will deliver safe and effective patient care, through providing a supportive culture, training, development and H&WB to our staff to retain the appropriate level to continue to meet the patient demand for our clinical services	Cautious	Moving Towards
Operational Risk	✓	Business Continuity Risk - We will develop and maintain stable and resilient services, operating to consistently high levels of performance.	Cautious	Moving Towards

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	Moving Towards
Financial Risk	✓	Financial Management & WRP - We will deliver sound financial management and reporting for the Trust, aiming to at least break even, with no material variances to forecast.	Cautious	Moving Towards

1 Summary

The Trust Board has previously received updates on the NHSE Medium Term Plan Framework and the Trusts Medium Term Plan in September 2025, November 2025, January 2026 and February 2026.

The Trust Board granted approval in February 2026 for the 'final' Medium Term submission on 12 February 2026, and this paper sets out specific performance, finance and workforce elements of the plan with relevant phasing detail for the 2026/27 revenue plan.

As presented in the previous update to the Board, the February plan submission was compliant for finance as the plan for each of the three years was breakeven inline with the 'Plan Limit' set by NHSE but was not compliant on all performance expectations or the bank and agency ceilings.

The Trust has received feedback on the February plan submission, and an extra submission date was added for 18 March 2026 for all organisations as part of a national 'realignment event'. The Trust is submitting plans with minor amendments to address data quality issues, cancer trajectories, sickness targets and financial phasing adjustments, however none of the changes are expected to impact the performance, workforce or financial plans approved at the February Board. A verbal update will be provided at the Board.

In addition, contracts have not yet been signed with Commissioners, with active conversations ongoing alongside agreeing indicative activity plans. Whilst a realistic level of funding to deliver the activity plans has been included in the plan submission, until contracts are signed there remains a level of risk. A verbal update on progress since submission will be provided at the Board.

2 Activity and Performance Summary

2.1 Activity Plan

Following the agreement of our RTT performance aim we are able to set our overall Trust activity plan as shown below:

POD	25/26 FOT	Demographic Growth 26/27		Non Demographic Growth 26/27		Activity to meet constitutional standards		Total Growth	
		Activity	%	Activity	%	Activity	%	Activity	%
Day Case	105,684	618	0.58%	634	0.60%	0	0.00%	1,252	1.18%
Elective Inpatient	24,358	146	0.60%	146	0.60%	284	1.20%	576	2.36%
Non-Elective Inpatients	344,848	7,012	2.03%	0	0.00%	0	0.00%	7,012	2.03%
Other	4,713,159	80,740	1.71%	0	0.00%	0	0.00%	80,740	1.71%
Outpatient First*	478,423	6,074	1.27%	0	0.00%	0	0.00%	6,074	1.27%
Outpatient Follow-ups*	909,809	11,788	1.30%	0	0.00%	0	0.00%	11,788	1.30%

* – Whilst demand driven plans for outpatients suggest a 3.8% increase the Trust expects to mitigate this growth, especially in follow up outpatients, with service transformation.

2.2 Core Standards

This activity plan would deliver the following constitutional standards performance.

Standard	26/27		27/28		28/29	
	Target	Planned	Target	Planned	Target	Planned
RTT	77%	73.4%	84.5%	78.7%	92%	87.5%
52 wks	<1%	<1%	<1%	<1%	<1%	<1%
Cancer 28*1	80%	80.6%	80%	81.8%	80%	81.8%
Cancer 31	94%	94.0%	95%	95.5%	96%	95.5%
Cancer 62	80%	75.0%	82.5%	73.0%	85%	73.0%
6wk Diag	94.6%	94.6%	96.8%	96.8%	99%	99%
4Hr ED*2	82%	82.0%	N/A	80.4%	85%	81.4%
Amb Handover (mm:ss)	19:00	18:00	18:30	18:28	18:00	18:00

*1: Cancer standard target requires 'maintaining 80%, LTHT currently predicts only March 27 would be >80%

*2: In 2026/27, 4-hour performance is judged on a single month (March 2027). In 2027/28 and 2028/29, performance is measured as a year-round average, reflecting a shift from a point-in-time target to sustained performance across the full year. Our ambition improve performance from a patient perspective (overall average waits will be shorter) but does not meet the constitutional requirement.

This shows that the Trust would not meet three of the main constitutional standards. The rationale for these is as follows:

- RTT – As described previously to the Board the Trust is unable to deliver the required activity growth to meet RTT performance, this has been communicated to NHSE and local ICB colleagues. This remains a discussion point with NHSE and a verbal update will be given at the meeting.
- Cancer Treatment – The West Yorkshire Cancer Alliance has developed a compliant trajectory for cancer performance across West Yorkshire and LTHT is aligned to this trajectory. However, as we receive late referrals from neighbouring Trusts they would need to overdeliver on their performance to allow for LTHT to meet an individual organisational performance. NHSE have been notified of the cancer alliance position and currently support the submission.
- 4 Hour ED – Due to increasing demand it has not been deemed feasible to deliver the requested improvement, however the Trust is showing an increased performance from our baseline.

2.3 Financial

2.3.1 Revenue

The Trust has submitted a breakeven revenue plan in-line with the 'Plan Limit' set by NHSE. Table 1 below details the Income and Expenditure plan at summary level and Chart 1 details

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the 2026/27 bottom line plan phasing and WRP required per month, with the phasing largely driven by the increasing WRP delivery as the financial year progresses as was the case in 2025/26.

Table 1: Summary Income and Expenditure plan

Category	2026/27	2027/28	2028/29
	£m	£m	£m
Operating income from patient care activities	1,860.4	1,918.1	1,972.0
Other operating income	313.1	312.1	319.3
Total income	2,173.5	2,230.2	2,291.3
Pay Expenditure	-1,250.6	-1,284.1	-1,316.0
Non-Pay expenditure (including non-operating and technical)	-922.9	-946.1	-975.3
Total expenditure	-2,173.5	-2,230.2	-2,291.3
Plan Surplus/(deficit)	0.0	0.0	0.0
<i>Memo - WRP</i>	95.0	95.0	95.0

Chart 1: 2026/27 Plan and WRP phasing



Delivery of the planned surplus in month 12 requires £6m WRP delivery from changes to annual leave usage.

As mentioned above, 2026/27 contracts have not yet been signed with Commissioners, with active conversations ongoing alongside agreeing Indicative Activity Plans. Whilst a realistic level of funding to deliver the activity plans has been included in the plan submission, until contracts are signed there remains a level of risk. A verbal update on progress since submission will be provided at the Board.

2.3.2 Waste Reduction Plan

The approved plan includes a waste reduction requirement of £95m in each year. As in 2025/26 there is no ability to generate additional elective payment therefore all areas of the Trust must focus on cost reduction to ensure delivery of the WRP programme.

The planning assumptions were communicated in a letter to Clinical Directors and Executive leads for non-clinical CSUs in November, requesting plans for 2026/27 to be built up for the

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3% tactical target, equating to £41.7m, and issuing a support pack for ideas generation. This was followed up by additional communication in early March of the total WRP allocation. Table 2 below details the 2026/27 WRP target by theme.

There are a number of enablers to support a further allocation to CSUs for example the PWC grip and control recommendations, NHS Model System, CSUs working together to release further opportunities. A small element is planned to be retained centrally for technical schemes. It is highlighted that for next financial year this is extremely limited given the non-recurrent and technical measures planned to achieve the 2025/26 financial plan.

Table 2: 2026/27 WRP target by theme

WRP theme	£m
CSU Tactical 3%	41.7
Working Together Tactical 1%	13.9
Cross cutting schemes currently identified	16.7
Annual Leave accrual	6.0
Central Technical schemes	5.0
To be identified	11.7
Total	95.0

CSUs have undertaken a significant amount of work to develop their WRP plans to date. At the time of writing, for CSUs gross schemes identified are £30.0m and risk adjusted £16.1m. The work to deliver cross-cutting schemes is overseen through the Turnaround Executive meetings, with further work required across the Trust to deliver those schemes and develop schemes to fill the current £11.7m unidentified gap. Finance and PMO colleagues continue to work with CSU colleagues to identify further opportunities as well as CSU challenge through the Integrated Accountability Framework.

As has been the case for many years, all WRP schemes will have a Quality and Equality Impact Assessment completed.

2.3.3 Capital

The Medium Term Plan submission included the Trust's 4-year Capital allocation as detailed in Table 3 below (excluding PFI lifecycle replacements and donated/grant funding as these do not impact on the Trust CDEL allocation).

In addition, a Digital fund has recently been communicated by NHSE which the Trust has submitted initial bids for. Further detail will be shared with the Board at an appropriate time.

The Executive team is working through the detailed allocation of the capital programme to individual schemes. Monitoring of the capital programme will continue through the Trust's Capital Planning Group, and the Trust will continue to work with the ICB on the ICS capital allocation through the ICS Capital Working Group.

Table 3: Capital allocation

LTHT allocation	2026/27 £m	2027/28 £m	2028/29 £m	2029/30 £m
Operational Capital	42.1	43.6	44.9	48.5
Estates Safety Fund (PDC)	10.0	10.0	10.0	10.0
Maternity and LGI BLM mitigations (PDC)	10.0	5.0	10.0	10.0
Return to Constitutional Standards (Elective) – CAH (PDC)	18.7	11.2	0.0	0.0
Return to Constitutional Standards (Diagnostics) – Seacroft CDC (PDC)	12.0	0.0	0.0	0.0
Urgent and Emergency Care – UEC (PDC)	1.3	3.5	16.0	32.0
Mental Health, Learning Disability and Autism (PDC)	1.0	1.0	0.0	0.0
Total	95.1	74.3	80.9	100.5

2.3.4 Cash

Delivery of the 2025/26 financial plan to start 2026/27 with a strong cash position is fundamental. Achieving the 2026/27 financial plan of breakeven, including full delivery of the waste reduction plan, would result in a projected cash balance at the end of March 2027 of £81.8m. Thus, delivery of the plan would result in no requirement for revenue cash support.

Changes in 2025/26 to revenue cash support have resulted in a much more stringent assessment and approval process, therefore continued focus on the cash position is required. In particular, delivery of the revenue plan, phasing of the capital programme and phased delivery of the Waste Reduction Programme will have a significant bearing on the cash position and the potential need for cash support. The requirement to access cash support comes with additional scrutiny in several areas.

2.4 Workforce

2.4.1 Whole Time Equivalents (WTEs)

The workforce plan by WTE is set out in table 4 below.

Table 4: WTE plan

Category	2026/27	2027/28	2028/29
	WTE Worked	WTE Worked	WTE Worked
Substantive staff WTE	19,290.40	19,414.32	19,455.10
Bank staff WTE	715.00	681.00	649.00
Agency staff WTE	103.00	83.00	70.00
Total staff WTE	20,108.40	20,178.32	20,174.10
<i>Memo – WRP required</i>	-468	-633	-598

Achievement of the workforce plan across the three years includes delivery of 1,699 WTE worked reduction relating to WRP schemes. In total the net workforce position is expected to be relatively flat as per the table above due to funding for cost pressures and service developments to deliver the performance expectations and funded business cases such as the Chapel Allerton Elective Hub and the CDC expansion at Seacroft.

In total across the three years the 1,699 WTE reductions associated with the WRP plan equates to an average of c2.8% per annum. From a national perspective, the average

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workforce reductions from the February plan submissions are 2.2% in 2026/27, 3.7% in 2027/28 and 5.0% in 2028/29. The Trust has received informal challenge on the scale of our workforce across the three years, given this context.

Work is ongoing to ensure that the Trust commences 2026/27 with an aligned WTE position for finance and workforce as a result of appropriate action.

2.4.2 Bank and Agency

As previously advised, in 2025/26 the guidance contained an expectation of a 30% reduction in agency spend and 10% reduction in bank, however due to the level of reductions delivered in previous years the Trust set plans at 5% reduction in each.

The 2026/27 guidance set out a more direct approach on targets to reduce temporary staffing expenditure, with each Trust set a limit for both bank and agency expenditure in 2026/27 to 2028/29, which is pre-populated in the Trust planning returns. Performance against the limits will be monitored at individual Trust level not across Systems. All Trusts are expected to remove agency spend by 2029/30.

Model Hospital data shows the Trust is currently in the lowest quartile for bank (i.e. lowest opportunity) and second lowest for agency spend. Additionally, due to significant work reducing bank and agency in previous years, there is less opportunity to further reduce this by the NHSE expected levels and the Trust is planning to reduce overtime spend by transitioning to Bank. The Trust submission therefore included a reduction of Agency spend by 10% and Bank spend by 5%.

3 Risk

During the development of our annual planning the Trust has kept a risk register to ensure we are working to mitigate and material risks to plan delivery, this is contained below.

Risk Title	Description	Impact	Likelihood	Score	Key Mitigations
Quality Challenges (Maternity & Neonatal)	Ongoing quality issues, including maternity & neonatal review findings, may affect performance, workforce stability, finance and regulatory assurance.	5	4	20	Strengthened quality governance, enhanced oversight, targeted investment, external review actions, workforce support.
Impact of Well-Led Review on Planning Engagement	Ongoing well-led review may affect the organisation's ability to fully engage in planning and implement changes at pace.	5	4	20	Strengthened leadership engagement, improved comms, executive oversight, clearer planning governance.
Financial Risk: Inflation, Tariff & Underlying Deficit	Underlying deficit (–£59.4m) and tariff/inflation misalignment increase risk of not meeting financial expectations.	5	4	20	WRP (£95m), contract alignment work, non-pay controls, productivity opportunities (theatre, outpatient, diagnostics).
No Reason to Reside Patients	Inability of the Leeds system to deliver improvements in the current NRTR patient cohort impacting operational delivery and financial sustainability.	4	4	16	System working groups in place, review investment and focus on action plans.
Capital Availability Constraints	Uncertainty on NHSE capital availability (estate safety, diagnostics, digital) may limit transformation and constrain elective/urgent care delivery.	4	4	16	Scenario planning, prioritised capital pipeline, alignment to national programmes (Estates Safety Fund, Return to Constitutional Standards).
Workforce Reduction Deliverability	Achieving required workforce reductions in 2026/27 may be undeliverable while maintaining safe staffing and service resilience.	4	3	12	CSU workforce planning sessions, skill-mix redesign, productivity improvements, targeted protections for high-risk areas.
Ability to Deliver Required Bank & Agency Reductions	NHSE-mandated reductions (30% agency / 7.5% bank) may not be achievable due to service pressures and clinical risk.	4	3	12	Tightened controls, "bank-first" model, strengthened rostering, job planning optimisation, system mutual aid.
Uncertainty in Payment Mechanism / Contracting Flows	Lack of clarity in commissioner contract offers and payment mechanisms increases financial risk and complicates planning.	4	3	12	Continued negotiation with ICB/NHSE, transparent assumptions, close alignment via planning meetings and timeouts.
Lower-than-Anticipated Delivery of Constitutional Standards (winter impacts)	Operational pressures (flu, industrial action, bed availability) may reduce performance against RTT, ED, diagnostics, and cancer standards.	3	4	12	Winter escalation plans, additional capacity where possible, system coordination, targeted productivity improvements.
Elective Activity Growth Deliverability	Required increases in elective/daycase activity (to support RTT and WL reduction) may not be achievable under current estate/workforce constraints.	4	2	8	Theatre productivity, outsourcing opportunities, waiting list modelling, enhanced job planning and scheduling.
System Changes Reduce Opportunities for Shared Delivery	Ongoing system-level changes may reduce opportunities for collaborative delivery of trajectories.	3	2	6	Continued engagement with Leeds system, provider collaboration, joint demand/capacity reviews, data sharing.

The MTPF will support the Trust in moving towards our risk appetite for the following level 2 risks:

- Workforce Retention Risk - We will deliver safe and effective patient care, through providing a supportive culture, training, development, and H&WB to our staff to retain the appropriate level to continue to meet the patient demand for our clinical services
- Business Continuity Risk - We will develop and maintain stable and resilient services, operating to consistently high levels of performance.
- 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.
- Financial Management & WRP - We will deliver sound financial management and reporting for the Trust, aiming to at least break even, with no material variances to forecast.

4 Communication and Involvement

The plan has been developed over several months led by a multidisciplinary weekly working group to ensure triangulation between workforce, activity and finance, which reported to the Executives periodically.

Data sharing was undertaken across all organisations in Leeds and the ICB to ensure system wide triangulation, including weekly acute specific and system wide review meetings.

Internal communication significantly increased from previous years due to changing nature of annual plans:

- Initial conversations around WRPs took place in September with clinical services
- Activity plans shared across clinical services
- 24 November initial figures presented to Executive Management Team
- CSU engagement meeting held in December 2025, individual CSU planning meetings held in January with follow up meetings in February 2026.
- Additional meetings are being held with specific CSUs in March 2026 regarding theatre scheduling to deliver the activity and performance plans.

5 Improving Health Equity

A Quality Impact Assessment and Health Equity and Equality Impact Assessment is being developed aligned to this full submission.

The delivery of this plan will have a significant and positive impact on quality aligned to delivery of the improvement targets against national metrics. The workforce and finance plans are aligned to the improvement plans within Maternity and Neonates. The activity plans are being developed with CSU involvement and there needs to be a focus on transformation to develop new ways of working to enhance outcomes for patients and populations. The assessment also identifies assurances around EQIA processes for WRP and robust governance around workforce planning. The risk section of this document describes some of the key risks and mitigations that are also described in the Quality Impact Assessment.

Overall, the assessment indicates no adverse impacts on protected characteristic groups or populations experiencing health inequalities, with the scheme expected to make a positive contribution by improving access and reducing variation. The assessment confirms that quality, safety and equity considerations have been embedded throughout planning.

Key Points

- No negative impacts identified for any protected characteristic group, including age, disability, race, sex, pregnancy/maternity, religion or sexual orientation.
- No negative impacts identified for groups experiencing health inequalities, such as people living in deprived areas, those with low literacy, digital exclusion, carers, or socially isolated groups.
- The scheme is expected to support reductions in inequalities in access, outcomes and experience.
- Engagement work and operational planning have incorporated population health data, deprivation indicators and expected demand growth across Leeds.
- Monitoring is recommended, including tracking activity and outcomes by ethnicity and deprivation, to ensure benefits are realised and inequalities are reduced.

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- Engagement with the CSUs has identified a theme relating harder to reach patients and DNA rates-this has been noted as an action to inform outpatient transformation plans.

6 Publication Under Freedom of Information Act

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

7 Conclusion and Recommendations

It is recommended that the Trust Board agrees that it has sufficient assurance on the assumptions and risks within the 2026/27 plan.

8 Supporting Information

Appendix 1: Income and Expenditure Plan 2026/27

Robert Hakin
Director of Healthcare Planning
Chris Ellison
Deputy Director of Finance
Alision Wilkinson
HR Transformation Lead
19/03/2026

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Appendix 1: Income and Expenditure Plan 2026/27

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000
Income													
Operating income from patient care activities	155,034	155,034	155,035	155,036	155,036	155,036	155,036	155,036	155,036	155,036	155,036	155,036	1,860,427
Other operating income	25,569	25,529	25,528	26,029	26,029	26,009	26,338	26,338	26,338	26,452	26,452	26,452	313,063
Total Income	180,603	180,563	180,563	181,065	181,065	181,045	181,374	181,374	181,374	181,488	181,488	181,488	2,173,490
Expenditure	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000
Pay costs	-104,680	-105,214	-105,144	-103,277	-104,376	-105,358	-104,599	-104,914	-104,794	-105,017	-104,765	-98,476	-1,250,614
Operating expenses excluding employee expenses	-75,054	-75,555	-75,098	-73,694	-72,274	-72,104	-72,284	-71,809	-72,096	-71,988	-71,602	-71,815	-875,373
Operating Expenditure Total	-179,734	-180,769	-180,242	-176,971	-176,650	-177,462	-176,883	-176,723	-176,890	-177,005	-176,367	-170,291	-2,125,987
Operating Surplus/(deficit)	869	-206	321	4,094	4,415	3,583	4,491	4,651	4,484	4,483	5,121	11,197	47,503
Finance income	321	321	321	321	321	321	321	321	321	321	321	321	3,852
Finance expense	-2,055	-2,056	-2,054	-2,054	-2,053	-2,051	-2,051	-2,050	-2,050	-2,048	-2,047	-2,053	-24,622
PDC dividend expense	-1,156	-1,156	-1,156	-1,156	-1,156	-1,156	-1,156	-1,156	-1,156	-1,156	-1,156	-1,156	-13,872
Net Finance Costs	-2,890	-2,891	-2,889	-2,889	-2,888	-2,886	-2,886	-2,885	-2,885	-2,883	-2,882	-2,888	-34,642
Remove capital donations/grants/peppercorn lease I&E impact	-210	-210	-210	-210	-210	-210	-210	-210	-210	-210	-210	-210	-2,520
Remove PFI revenue costs on an IFRS 16 basis	3,070	3,070	3,070	3,070	3,070	3,070	3,070	3,070	3,070	3,070	3,070	3,076	36,846
Add back PFI revenue costs on a UK GAAP basis	-3,930	-3,933	-3,933	-3,933	-3,933	-3,933	-3,932	-3,932	-3,932	-3,933	-3,932	-3,931	-47,187
Adjusted financial performance surplus/(deficit)	-3,091	-4,170	-3,641	132	454	-376	533	694	527	527	1,167	7,244	0
Waste Reduction Programme	4,357	4,357	4,357	7,204	7,204	7,204	8,639	8,639	8,639	9,588	9,463	15,350	95,000