NHS
The Leeds Teaching Hospitals
NHS Trust

Annual Report and Accounts

2025-2026

Contents

Overview

This section introduces the work of Leeds Teaching Hospitals NHS Trust (LTHT), one of the largest and busiest providers of health services in the country. We deliver acute and specialist services to people from Leeds, West Yorkshire and beyond.

The overview sets out the Trust's core mission and values, and highlights some of our strategic developments and achievements during the 2025/26 financial year.

Chair and Chief Executive's statement

Welcome to the Annual Report of Leeds Teaching Hospitals NHS Trust, reflecting on our financial year 2025/26. This has been a year of significant change, continued challenges and important progress for the Trust, our patients and the communities we serve. It has also been a year of transition in leadership for our Trust; and we are delighted to present our first Annual Report as Chair and Chief Executive of Leeds Teaching Hospitals.

As one of the largest teaching hospital trusts in the country, with more than 20,000 colleagues serving patients from Leeds, West Yorkshire and far beyond, our role is both broad and vital. Every day, our teams deliver high-quality specialist care, lead world-class research and innovation, educate the healthcare workforce of the future and work in partnership to improve health outcomes for the populations we serve. We are deeply grateful to all our colleagues for their professionalism, compassion and resilience throughout another demanding year for the NHS.

We know that while we have achieved a great deal, there are times when we have not got it right and patients and families have been let down by the care they have received. When this happens, we must listen, learn and improve. That commitment remains central to our organisation.

Improving our maternity and neonatal services has remained one of our highest priorities during the year. Following the publication of the Care Quality Commission reports for our maternity and neonatal services in 2025, we have continued to take action to strengthen safety, culture, staffing and leadership across these services. We have worked closely with colleagues and families to drive sustained improvement and to ensure the voices of patients and families help shape the changes we make. We recognise the significance of the forthcoming independent review into our maternity and neonatal services and are committed to engaging fully, openly and constructively to support learning and lasting improvement.

During the year, we also received a Care Quality Commission Well-Led inspection. External assurance is an important part of continuous improvement, and while recognising some areas of good practice, the inspection report also identified a number of areas where we could do better. We value the opportunity to reflect on our leadership, governance and culture as we continue to strengthen how we work as an organisation.

Alongside these important areas of focus, we are proud of the progress made across many aspects of our services. Our teams have continued to embrace improvement and innovation to enhance patient care, reduce waits and make better use of our resources and have delivered measurable benefits for patients and services. These include dermatology referral-to-clinic waits reduced from 38 days to 18 days, gynaecology triage backlog reduced by 59%, and waits in a specialist liver disease pathway fell from 9.5 months to just three weeks. Home-based treatment for stable dialysis patients also increased from 10% to 34%, improving patient experience while creating additional capacity. We were also proud to achieve accreditation as a British Society for Gynaecological Endoscopy (BSGE) Endometriosis Centre. This is the culmination of four years of hard work by the team to build an endometriosis and pelvic pain centre in Leeds and will enable the Trust to develop further to achieving excellence in endometriosis treatment.

This has also been another exceptional year for research and innovation. Leeds Teaching Hospitals remains at the forefront of pioneering new treatments, clinical trials and digital transformation. During the year, more than 14,500 participants took part in 1,365 active research studies across the Trust, with patients benefiting from access to some of the most advanced treatments and opportunities available anywhere in the NHS. We have continued to lead in areas such as cancer research, medical technologies and artificial intelligence, strengthening our reputation nationally and internationally.

We have also continued to invest in environments that support excellent care and improve patient experience. In November 2025 the Rob Burrow Centre for Motor Neurone Disease (MND) opened at Seacroft Hospital, made possible by the incredible support of Leeds Hospitals Charity, Kevin Sinfield, Leeds Rhinos and the wider Leeds communities. The landmark building is the first purpose-built centre dedicated entirely to MND care, research, education and holistic support. It will be a trailblazer for other centres around the country and has been designed with patients and families at its heart. We also welcomed the go-ahead for a new £32 million Elective Care Hub at Chapel Allerton Hospital, which will expand planned care capacity and help more patients receive treatment sooner.

Our partnership with the Royal Horticultural Society (RHS) took the next step as we opened the wonderful White Rose Wellbeing Garden at St James's University Hospital. The garden, designed by award-winning garden designer and RHS Ambassador Adam Frost, provides a restorative space to relax and reflect for those working in or visiting the hospital. The RHS Communities team continues to support the Trust with an annual programme of events and activities for colleagues to get in touch with nature and support their wellbeing.

We have also strengthened our commitment to tackling health inequalities. During 2025/26, we launched a new Health Equity and Public Health Strategy, setting out how we will embed fairness and inclusion in all we do and aligning closely with the Government's 10-Year Health Plan for England to shift from sickness to prevention. We know we have an important role in helping to create a healthier and fairer city and region. This work depends on strong partnerships, and we are proud of the progress made with colleagues across Leeds and West Yorkshire to improve services, reduce variation and support people to receive care closer to home wherever possible.

Our commitment to sustainability has continued to grow. We have refreshed our Green Plan, secured around £30 million of external investment in decarbonisation over the last five years and supported colleagues to develop greener care pathways that reduce waste, improve efficiency and lower our environmental impact. We remain determined to play our part in creating a more sustainable NHS for future generations.

We know that the quality of care we provide depends on the experience of the people who work here. Throughout the year, we have continued to invest in colleague wellbeing, leadership development, education and inclusion, taking onboard the findings from the Staff Survey and our CQC Well-Led inspection report. We want Leeds Teaching Hospitals to be a place where people feel respected, supported and able to thrive, because when our people thrive, patients benefit too.

Like all NHS organisations, we continue to face financial and operational pressures, rising demand and ageing estate challenges. We were disappointed by the delay to the new hospital development at Leeds General Infirmary (LGI) which was announced in January 2025, but we continue to work closely with national partners to explore every opportunity to improve our estate while remaining ready to progress our long-term plans. At the same time, we are pleased that wider developments are moving forward. In March 2026 Trust partners Scarborough Group International formally completed the acquisition of the Old Medical School on our LGI site in the latest milestones to transform it into a healthtech innovation hub.

Looking ahead, we do so with confidence and determination. Our new Trust Strategy for 2026–2029 has been shaped by the voices of colleagues, patients and partners. A major piece of work has also been undertaken to create a new set of values and priorities reflecting who

we are as a Trust today, at our best, providing the foundation for our new strategy. It sets out our ambition to deliver safe, high-quality care every time; to be an outstanding place to work; to strengthen partnerships; to lead in improvement and innovation; and to achieve excellent operational and financial performance.

We continue to play a strong role working alongside our partner organisations, such as the West Yorkshire Integrated Care Board (ICB) and West Yorkshire Association of Acute Trusts (WYAAT) and are actively involved in helping to shape and inform new ways of working as several of our partner organisation navigate significant periods of change. We also continue to work closely with our charitable partners, including Leeds Hospitals Charity who we would like to thank wholeheartedly for their ongoing commitment and support for our Trust and the people we serve.

This Annual Report captures only a small part of what our colleagues achieve every day. We would like to thank our patients, colleagues, volunteers, members, partners and supporters for the trust they place in us and the contribution they make to our success.

We are proud to lead this Trust at such an important time in its history. Together, we will continue to learn, improve and build a healthier future for Leeds and beyond.

Antony Kildare
Chair

Brendan Brown
Chief Executive

About us

Leeds Teaching Hospitals NHS Trust is one of the largest and busiest acute hospital trusts in Europe. The Trust provides healthcare and specialist services for people from the city of Leeds, the Yorkshire and the Humber region and beyond. We play an important role in the training and education of medical, nursing and dental students, and are a centre for world-class research, innovation and pioneering new treatments.

The Trust has a budget of more than £2.6 billion and over 20,000 colleagues. Last year, we delivered almost 1.9 million episodes of care, including close to 100,000 inpatient admissions, 1.4 million outpatient attendances, an increase of 140,000 from last year, and 364,000 attendances in our Emergency Departments.

Our care and clinical expertise is delivered from seven hospitals on five sites, all joined by our vision to be the best for specialist and integrated care.

Our hospitals

- Leeds General Infirmary (LGI)
- St James's University Hospital (including Leeds Cancer Centre)
- Seacroft Hospital
- Wharfedale Hospital
- Chapel Allerton Hospital
- Leeds Children's Hospital (LCH)
- Leeds Dental Institute

Our services

We are committed to providing our patients with the very best care across all our services.

Our services include:

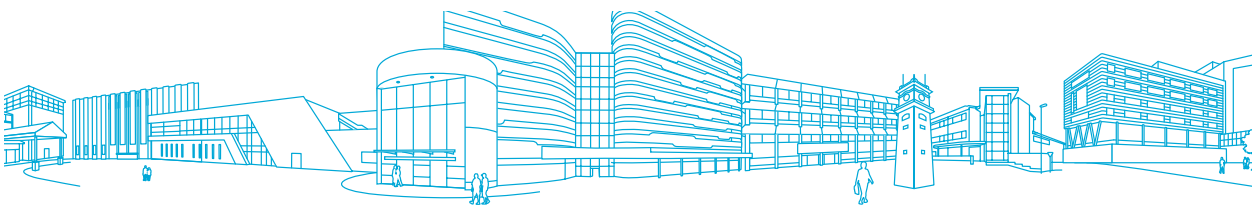
- High-quality, effective hospital services for our community in Leeds, such as two emergency departments, outpatients, inpatients, maternity and older people services.
- Highly specialised services for the population of Leeds, Yorkshire and the Humber, nationally and beyond.

This means that people in Leeds have access to some of the very best care in the country and benefit from a seamless provision of all services.

We operate a clinically-led structure, which means that doctors, nurses and other healthcare professionals make the decisions on how we run our services. Our clinical service units (CSUs) deliver our services and are led by a triumvirate team, including a clinical Director, a head of nursing or profession and a general manager.

Each CSU has its own clinical focus and is responsible for delivering the highest standards of quality, safety and financial performance for its service. Providing high-quality care and running effective services is very much a team effort.

It means we can attract specialists at the top of their disciplines and enables us to offer our patients the very latest in drug trials, therapies and treatments. Evidence suggests that for many complex conditions, patients will have a better outcome if they are seen by a specialist in a place with the best equipment and expert colleagues available.



Our mission, strategic priorities and values - The Leeds Way

Leeds Teaching Hospitals is committed to delivering the highest quality and safest treatment and care to every patient, every time.

Our Mission

To be an internationally renowned academic healthcare institution, working in partnership to deliver the highest quality, safe, effective and innovative care which improves outcomes.

This is underpinned by our
strategic priorities:

- Develop integrated partnership services
- Support and develop our people
- Focus on care quality, effectiveness and patient experience
- Deliver continous innovation and inclusive research
- Ensure financial stability

In 2014, our colleagues helped to define the values and behaviours we should work to so we can deliver our mission and strategic priorities. This has become known as The Leeds Way and forms the foundation of our culture, ethos and how we work every day.

Much has happened within the NHS and Trust since The Leeds Way was introduced, and in summer 2022, colleagues were invited to revisit and refresh the behaviours to better reflect how our colleagues feel we should interact with patients, each other and with partners. The values are shown on the next page.

Our Leeds Way Values

Patient-centred

We act with compassion, empathy and kindness towards those in our care and to each other.

We consistently deliver high quality, safe and dignified care, focusing on individual needs.

Fair

We seek to understand the perspective of others, respecting and embracing our differences.

We champion inclusivity by prioritising fairness and equality.

Collaborative

We are all one team with a common purpose and value the contribution of others.

We work in partnership with our patients, their families and carers, our colleagues and other providers.

Accountable

We keep our promises, agree clear expectations and will speak up to respectfully hold ourselves and each other to account.

We are true to our word and act with integrity and honesty with our patients, colleagues and communities.

Empowered

We empower our patients and colleagues to have a voice and make decisions, and are considerate of their choices.

We celebrate innovation, and we take personal responsibility for our learning.

In 2026 work commenced to review and refresh the Trust's values to reflect who we are now and to guide our approach for the future. In May 2026, The Trust Board approved a new set of values for the Trust for 2026/27:

Kind

Responsible

Open and Honest

One Team

At the time of writing this report work was underway to develop the behaviours that will underpin these values.

Our 7 Commitments

Along with the wider NHS, we know that there are big challenges facing all of our services, with many competing priorities. Working closely with our clinical teams and senior leaders, we developed what we call our annual 7 Commitments, first launched in 2023. Each year, these gave us clarity on what are the most important priorities to focus on over the year.

They were refreshed every year and align with our multi-year goals so that we can realise our strategic priorities and ultimately provide the highest quality specialist and integrated care.

The 7 Commitments for 2025/26 fell under seven headings:

Compassion: Recognise and act upon moments that matter to our patients.

Team: Support each other to act with kindness and compassion.

Resources: Make best use of our estate, equipment and digital assets.

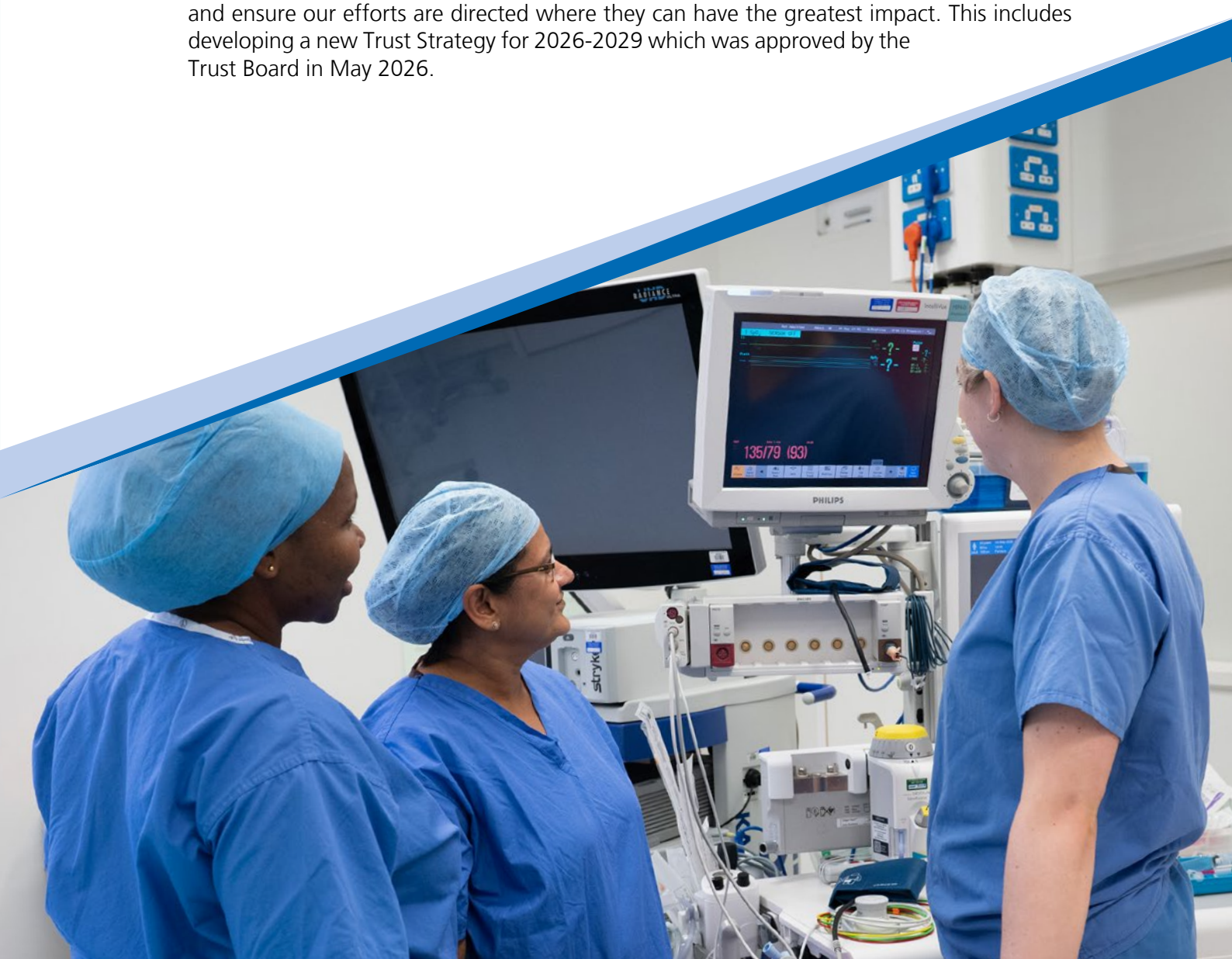
Finance: Support our staff to manage every £ wisely.

Quality: Be in the top 25% for patient experience and efficiency in Outpatients.

Care: Support our patients to get home a day sooner.

Sustainability: Reduce our carbon footprint by creating greener patient pathways.

At the end of 2025 in consultation with colleagues, we made the decision to dissolve the 7 Commitments for the remainder of the financial year to allow us to refine our collective focus and ensure our efforts are directed where they can have the greatest impact. This includes developing a new Trust Strategy for 2026-2029 which was approved by the Trust Board in May 2026.



The Leeds Improvement Method

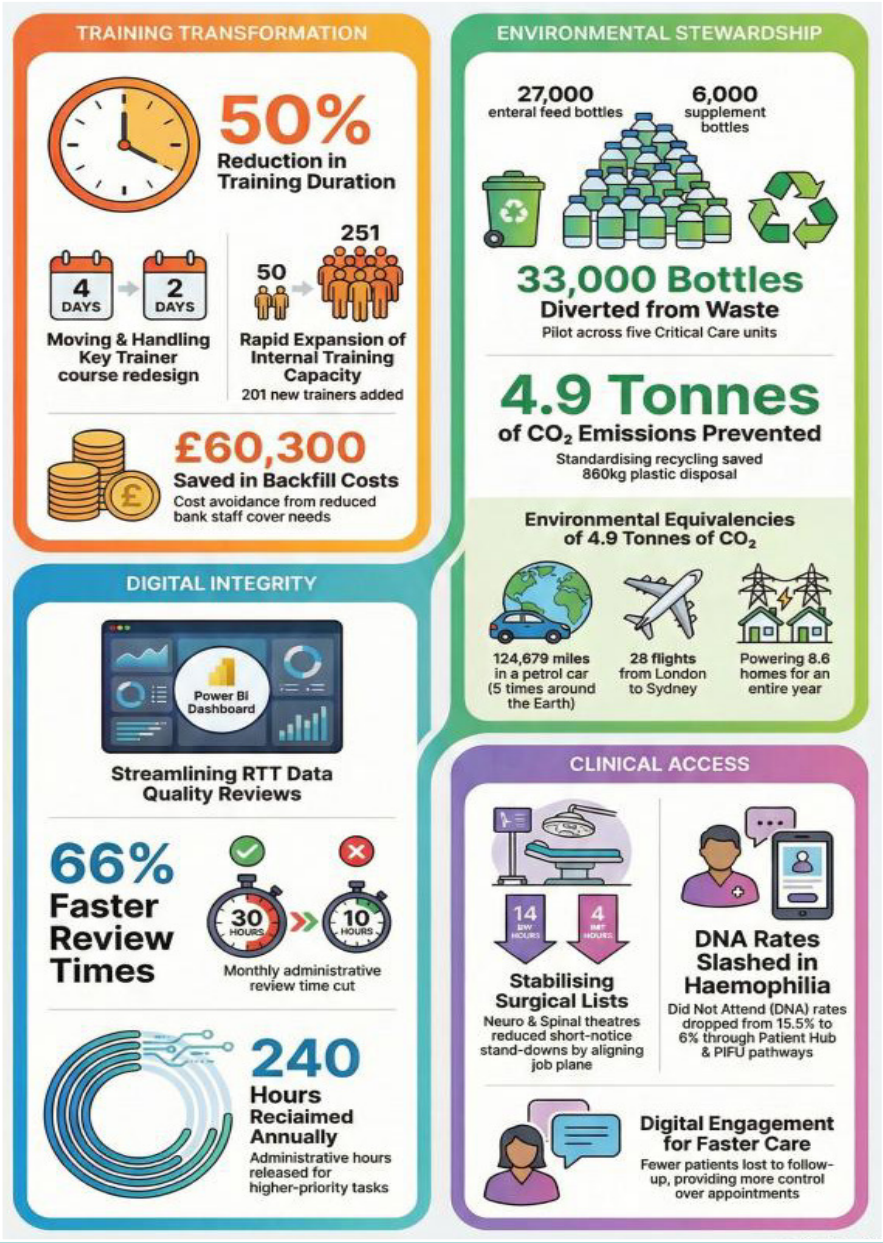
Leeds Improvement Method (LIM) remains the Trust's core continuous improvement and daily management ethos.

It empowers colleagues at all levels to lead meaningful change, ensuring that those closest to the work are at the heart of our efforts to deliver safe, high-quality care and a better environment for our people. Over the 2025/26 year, we have evolved our operating model to align with the national NHS IMPACT domains, positioning systematic improvement as the cornerstone of our organisational delivery.

The Kaizen Promotion Office (KPO) supports LIM by leading Trust-wide improvement initiatives and delivering education and training. This enables teams to identify and eliminate waste, improve efficiency and deliver greater value to our patients.

Impact and Achievements in 2025/26

A high-level summary of LIM's key successes, showcasing operational efficiency, digital innovation, and enhanced patient access through embedded systems and culture.



LIM in action: highlights from 2025/26

Operational improvements

During the 2025/26 year, the Leeds Improvement Method (LIM) served as the Trust's primary engine for converting strategic vision into **measurable operational delivery**, using data-driven decision-making to enhance patient flow and access.

Key operational achievements include:

Dialysis care redesign: The Peritoneal Dialysis team increased home treatment for stable patients **from 10% to 34%**, which **avoided 80 hospital attendances** in three months and allowed the service to absorb a **9% increase in demand** without extra resources.

Enhanced outpatient efficiency: Medical Dermatology reduced referral-to-clinic lead times **from 38 to 18 days**, creating **117 additional weekly appointments**.

Reduced backlogs and waiting times: Gynaecology saw a **59% reduction in triage backlog** with waits **dropping from 14 to 5 weeks**, while the **Liver Disease Early Detection Clinic** reduced referral-to-treatment times **from 9.5 months to three weeks**.

Environmental stewardship: Standardised recycling in Critical Care diverted **33,000 bottles** from waste, **preventing approximately 4.9 tonnes of carbon emissions** annually.

Blood-borne virus (BBV) testing: Testing uptake increased significantly, with relative **increases of 39.5%** at St James's Emergency Department and **14.8%** at Leeds General Infirmary. Repeat testing in frequent attenders **fell by 24%**.

Radiology reporting efficiency: The implementation of standard work led to an **88% reduction** in returned radiology reports.

Patient involvement in care: In Elderly Medicine, structured medication reviews **rose from 0% to 75%**, with **74% of patients now actively involved** in shared decision-making regarding their medication changes.

Education and training

The Trust's commitment to building improvement capability is reflected in the high quality of its programmes.

Key education and training achievements include:

High training satisfaction: 97% of participants reported they would recommend the training.

Leadership development: We launched bespoke **Business Manager cohorts**, where **28 managers completed training** that included delivering a live improvement project, ensuring that learning translated directly into measurable service change.

Inclusive learning: intermediate LIM training was redesigned this year to enhance accessibility. This included specific adjustments to **support colleagues with neurodiversity**, utilising adapted materials and enhanced facilitation to ensure improvement skills are accessible to all.

Coaching for improvement: A new coaching offer was developed, empowering clinical leads to run regular clinics that **support frontline teams** in testing and sustaining their own improvement ideas.

Maternity and Neonatal Services

We are deeply sorry to families who have been harmed while receiving care in our maternity and neonatal services. However, we recognise that apologies are not enough, and families deserve answers, honesty and meaningful change.

As an organisation we are truly committed to making lasting improvements in the care that we offer by listening to the concerns and experiences shared with us. We recognise we have not always got this right.

Over the last year we have been working to address concerns about our services which have been raised by families and external organisations.

The Care Quality Commission visited our maternity and neonatal services in winter 2024/25 and the reports were published in June 2025. The CQC rated the Trust's maternity services as inadequate and neonatal services as requires improvement.

These reports highlighted some significant areas where we need to improve our maternity and neonatal services. We worked to take urgent action to deliver immediate improvements and developed a comprehensive improvement plan.

In March 2025, NHS England's Maternity Safety Support Programme also visited the Trust and in July 2025 issued a report which identified a number of recommendations for improvement. These recommendations were also incorporated into the Trust's improvement plan, and significant steps have already been taken to address improvements needed.

In September 2025, it was announced that Leeds Teaching Hospitals NHS Trust would be one of 14 hospital trusts included in a rapid, independent, national review of maternity and neonatal services, being independently chaired by Baroness Amos.

The following month, the Secretary of State for Health announced that there would be an independent review into Leeds' maternity and neonatal services and Leeds Teaching Hospitals NHS Trust would therefore not be included in the national review. In March 2026, Donna Ockenden was announced as the chair of this independent review.

The Trust is committed to working openly and honestly with the review team to identify further improvements and provide harmed families with answers.

There has understandably been significant scrutiny of the Trust's maternity and neonatal services over the past year. The Trust has worked to put in place a structured programme of improvements, setting up a Perinatal Improvement Assurance Committee as a sub-committee of the Board, and reporting monthly to NHS England through the Integrated Quality Improvement Group.

Significant investments have been made in the maternity and neonatal workforce, facilities and equipment. We recognise there is still a great deal more to do, and we are committed to making real and lasting changes to provide safe and compassionate care for all our families.

Building the Leeds Way

In July 2024, the Government began a review of the New Hospital Programme to ensure its long-term sustainability. The review concluded in January 2025, when it was confirmed that all schemes would proceed through phased investment. It was announced that Leeds Teaching Hospitals was placed in Wave 2, meaning construction of the new hospital at Leeds General Infirmary will not begin until 2033-2035, with all development paused until 2030.

Throughout 2025/2026, work continued to engage with national and regional stakeholders to explore, identify and consider all opportunities to deliver much-needed improvements to our hospital services and wider hospital estate across the Trust while remaining ready to commence our new hospital as soon as possible. Engagement has continued with the New Hospitals Programme Team.

Working with partners

Regional and local partnerships

Leeds Teaching Hospitals NHS Trust is a key partner within the West Yorkshire Health and Care Partnership, the Integrated Care System (ICS) serving a population of over two million people. The partnership is facilitated by the West Yorkshire Integrated Care Board (ICB), which operates at both system and place levels, including Leeds, working alongside NHS organisations, local authorities, primary care, Healthwatch and the voluntary, community and social enterprise sector to improve health, care and wellbeing outcomes.

During 2025/26, the ICB began transitioning towards a strategic commissioner and system convenor model. This shift places greater emphasis on setting outcomes, allocating resources and providing oversight, while enabling providers to take on increased responsibility for service planning and delivery.

In Leeds, this transition has been reflected in the strengthening of place-based arrangements through the Leeds Health and Care Partnership. Over the year, partners worked collaboratively to establish more formal, provider-led governance, including the development of the Leeds Provider Partnership. This partnership is intended to take on future delegated responsibility for population health, supported by a Joint Committee currently operating in shadow form ahead of full implementation in April 2027.

These arrangements are designed to support more structured, transparent and accountable collective decision-making by providers, aligned with the ICB's strategic commissioning role. Through this approach, the Trust and its partners are working together to:

- Contribute to the delivery of Leeds' ambitions as a healthy, growing, thriving and resilient city, working in a 'Team Leeds' way.
- Understand and respond to the health and care needs of the Leeds population.
- Deliver more integrated neighbourhood health, support and community services, focused on priority areas to improve outcomes for local people.

Key achievements in 2025/2026 include:

- Contributing to the establishment of formal governance arrangements for the Leeds Provider Partnership, strengthening accountability and enabling provider-led decision-making during the shadow year.
- Developing a Partnership strategy to be incorporated within the organisation's 2026–2029 strategic planning framework.

West Yorkshire Association of Acute Trusts (WYAAT)

Leeds Teaching Hospitals NHS Trust is one of six acute trusts within the West Yorkshire Association of Acute Trusts (WYAAT), which plays a central role in supporting delivery of the West Yorkshire Health and Care Partnership's ambitions. During 2025/26, WYAAT completed a comprehensive Service Review and Case for Change, recognising that the current model of acute service delivery is unsustainable in the context of rising demand, workforce constraints, health inequalities and financial pressures.

The review sets out a clear direction for the future, building on WYAAT's Five-Year Strategy (2024–2029) and focusing on the national shifts from hospital to community, treatment to prevention, and analogue to digital. It identifies priority opportunities to improve access, outcomes and productivity through greater collaboration, including integrated neighbourhood health models, expanded use of surgical hubs and community diagnostic centres, networked and specialised clinical services, and more efficient shared corporate functions.

In 2025/26, WYAAT began progressing priority areas identified in the review, including elective recovery, pathology, imaging, neurology and aseptics, alongside strengthened governance arrangements to support collaborative delivery. Implementation will continue through 2026/27 and beyond, with Leeds Teaching Hospitals playing a key role in delivering specialised services and supporting system-wide improvement for patients across West Yorkshire and Harrogate.

Leeds Academic Health Partnership (LAHP)

The Trust continues to be a key member of the Leeds Academic Health Partnership (LAHP). The partnership brings together local NHS organisations, the West Yorkshire Health and Care Partnership, Leeds' universities, Leeds City Council, Leeds City College, the regional economic enterprise partnership, industry and third sector partners. LAHP also owns the "Health Innovation Leeds" brand which is used as an umbrella brand to market the capabilities of Leeds partners nationally and internationally to industry and other inward investors. This brand has successfully been used by Leeds Teaching Hospitals in partnership with the University of Leeds and Leeds Beckett University to leverage £1.6m from the West Yorkshire Combined Authority to create the "Health Innovation Leeds Incubator", a support programme for West Yorkshire's HealthTech Businesses to help bring the most promising HealthTech innovations into use in clinical services for patient benefit and economic growth.

This year, the LAHP brought together Leeds' complex £40m National Institute of Health Research (NIHR) infrastructure, aligning partners behind a clear, compelling narrative to national funders and showcasing this collective strength during the HM Treasury visit. The LAHP also ensured learning from systems engineering for multiple long-term conditions (SEISMIC) was maximised, supporting its application in the design of new neighbourhood health models. Building on this, we strengthened partnerships and contributed to a successful bid to the NIHR Inequalities Challenge for cardiovascular disease, with Leeds leading one of nine national collaborations.

Leeds Innovation Partnership (LIP)

The Trust is a key member of this partnership, which aims to foster innovation in Leeds and drive the development of an Innovation Arc for the city. Set across 150 hectares of the city centre, this is one of the largest regeneration schemes in the north of England, reinforcing Leeds as a nationally and internationally recognised centre for research, innovation, investment in digital and healthtech and new business growth.

Despite the disappointing news about the delay in building work on the new hospital we remain committed to the Innovation Arc and in October 2024 the Scarborough Group officially acquired the Old Medical School on the site of Leeds General Infirmary. They are developing the building to support health tech innovation activity around Leeds Teaching Hospitals' Innovation Pop Up, alongside start-ups, established industry players, academic institutions, government initiatives and community organisations.

Leeds Anchors Network

Anchor institutions are large, typically non-profit, public-sector organisations whose long-term sustainability is closely linked to the wellbeing of the populations they serve. The Leeds Anchor Network (LAN) brings together the city's largest employers - including NHS trusts, Leeds City Council, universities, public utilities, and further education colleges - to focus on areas where they can collectively maximise impact and scale their anchor activity.

Leeds Teaching Hospitals has been an active member of the network since 2018, with our approach coordinated through an internal steering group. In 2026, we undertook our fourth Inclusive Anchor Progression Framework assessment, supported by a comprehensive baseline exercise reviewing progress across key domains, including sustainability (environment and assets), procurement, and employment. This drew on input from lead officers across the Framework's five dimensions: employer, procurement, environment and assets, service delivery, and corporate and civic.

Overall, our benchmarked performance remains moderate to good, with notable progress since 2021. In particular, the procurement dimension has strengthened significantly, highlighting our key role in supporting local suppliers and embedding social value within procurement processes.

Cancer Alliance

Leeds Teaching Hospitals NHS Trust works collaboratively with the West Yorkshire & Harrogate (WY&H) Cancer Alliance. For the financial year 25/26, WY&H Cancer Alliance showed an improved performance for the Faster Diagnosis Standard (28 Days) and 31 Day metrics and was named as the top Alliance in England for the Faster Diagnosis Standard in March 2026 (with a performance of 83.2%).

The Alliance has also supported the operationalisation of various programmes - including the establishment of the Lung Cancer Screening Programme in Leeds, starting in September 2026. This means the people of Leeds will be able to access opportunities to detect lung cancer at an earlier stage, which is a key component of the National Cancer Plan published in January 2026 to identify cancers earlier.

Wharfedale and Harrogate

In partnership with Harrogate and District NHS Foundation Trust, Leeds Teaching Hospitals continues to work collaboratively to review and maximise the use of resources at Wharfedale Hospital. This collaborative approach enables additional elective activity to be delivered away from acute hospital sites, supporting efficiency, improving patient experience and contributing to system-wide elective recovery. As well as shared ambitions for the use of Wharfedale Hospital, we continue to work with Harrogate as well as other WYAAT organisations on areas where mutual support may be beneficial.

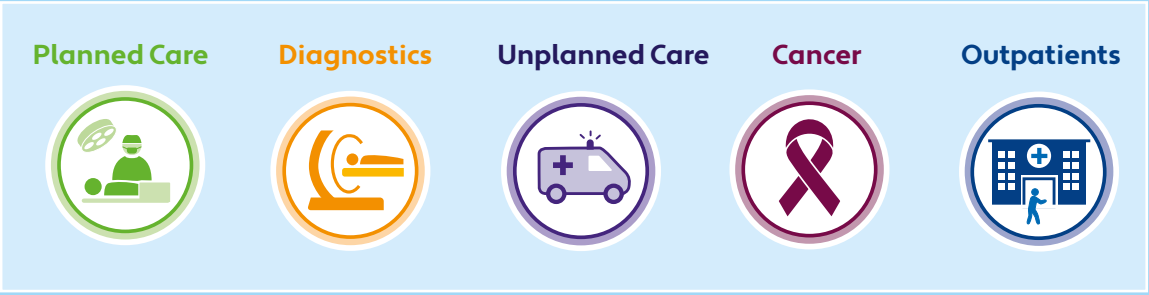
West Yorkshire Integrated Care Board

During 2025/26, the West Yorkshire Integrated Care Board (ICB) continued to work with partners in Leeds to improve health outcomes, reduce inequalities and drive recovery across key priority areas. From a Leeds perspective, this included progress on elective recovery, urgent and emergency care, cancer and mental health access, and continued improvements in primary and community services. The ICB supported citywide initiatives to improve access to women's health services through women's health hubs and to strengthen intermediate care and discharge arrangements, including through the HomeFirst Programme. Progress was also made in system enablement, including shared digital and diagnostic infrastructure, supporting more efficient and joined up care.

Looking ahead, the ICB is increasingly operating as a strategic commissioner and system convenor, with greater responsibility for service planning and delivery sitting with providers. In Leeds, this is being taken forward through the development of place based provider partnerships named the Leeds Provider Partnership, which will enable more integrated, provider led planning, effective use of resources and improvement in population health outcomes which will have delegated authority in April 2027.

Operational transformation

Our Operational Strategy is an ambitious plan to achieve our vision to provide the highest quality integrated and specialist care, delivered in a supportive environment that develops our people and produces optimal outcomes for our patients. The Trust has implemented a number of initiatives to improve efficiency and support pathway changes including:



Elective Surgical Hub

During 2025/2026, Wharfedale Hospital achieved GIRFT accreditation as an Elective Surgical Hub, with utilisation improved by more than 5%, and investment has been secured for two new theatres at Chapel Allerton Hospital for 2027/2028. Looking ahead to 2026/2027, the key opportunity remains reducing avoidable cancellations and lost case-time, supported by GIRFT guidance. Achieving utilisation and throughput levels comparable with peers will increase capacity, reduce waiting times, and continue to strengthen outcomes and patient experience.

Diagnostics

During 2025/2026, we made considerable progress in improving the way diagnostic tests are used and delivered across Leeds. Our Diagnostics Demand Optimisation (DDO) Programme has focused on ensuring patients receive the right test, at the right time, in the right place. By reducing the number of tests that offer limited clinical value, we have been able to free up capacity, reduce waiting times and improve the overall patient experience.

Engagement from colleagues across the city has been incredibly positive, with more than 140 improvement ideas submitted. Early results have already shown a reduction of up to 50% in the use of some tests, alongside marked improvements in radiology efficiency and quicker access for patients who need diagnostic investigations.

There are now three operational Community Diagnostic Centres (CDCs) for Leeds. Our three CDCs at Seacroft, Beeston and Armley offer of a range of cardio-respiratory tests, radiology tests and blood tests. The three sites have collectively delivered 115,586 tests between April 2025 to March 2026 which is an increase of 8,646 tests on the 2024/2025 position. Funding has been secured to expand the CDC at Seacroft and deliver increased activity which will be delivered mid-year 2027.

Unplanned care

Our Emergency Departments have improved performance and are better than most in the country in delivering the four-hour Emergency Care Standard and average ambulance handover time.

A pilot for 'call before you convey' category 3 and 4 ambulance patients from care homes was agreed across Yorkshire Ambulance Service and Leeds Teaching Hospitals with the purpose of not conveying some patients to A&E if they could safely be better cared for via a virtual ward or community geriatrician support. This aims to reduce disruption to frailer people and their family/friends whilst releasing ambulance time on the road. This initiative is now live.

Cancer

A number of improvements have been delivered across the cancer transformation programme during 2025/2026:

Pathway review meetings: CSUs and services have taken a different approach to transformation programmes by adopting a model that focuses on pathway working. Bi-monthly sessions have brought together key individuals from all aspects of pathway delivery to identify and explore critical challenges in order to understand how all elements of the pathway need to work in unison to deliver the cancer performance standards. Pathways that have been initially chosen to undergo this approach for 2026/2027 are Lower GI, Skin, Gynae, Head & Neck and Lung.

MDT streamlining: Review of the MDT process has taken place with opportunities provided to teams to identify Standards of Care (SoC) and efficiencies within their pathways. Two SoC's have been developed and established within MDTs to reduce waiting times for patients on a protocolised pathway with others in the pipeline. Other MDT's have reviewed the types of discussions taking place in the meeting and removed administrative tasks from the MDT.

Digital transformation: Digital developments continue to move MDTs and tracking from PPMv1 to PPM+ providing clinical teams with the opportunity to review and make decisions outside of MDTs (based on SoCs in place) delivering discussions of the right patients at the right time. The transition to PPM+ will also enable the MDT team to 'track by exception', allocating valuable resource to be focussed on progressing patients through pathways rather than tracking all patients unnecessarily.

Outpatients

One of our goals for 2025/26 was to make our services easier to use and provide a better patient experience. We wanted to reduce waiting times, make it simpler for people to attend their appointments, and ensure that those who need to be seen most urgently are prioritised.

We listened to patient feedback and redesigned our appointment letters to make them clearer and easier to understand. All letters now have a standard layout and are available in digital format, large print, and on paper. With the help of our expert patient volunteers, we created "easy read" versions of letters, simplified the wording and added clearer directions to help patients and visitors find their way around our busy hospital sites.

We have reduced the proportion of patients waiting over 18 weeks for their first appointment by 1.3% and provided over 9,000 additional new appointments.

A new booking tool has reduced the time needed to make appointments by 60% and expanded the choice available to patients. We have also introduced a new report to help services prioritise clinically urgent follow up patients and trialled new ways of contacting patients on waiting lists, which we plan to expand across more services in 2026/2027.

These actions have contributed to a 6% reduction (around 4,500 people) in the number of patients waiting for definitive treatment in Outpatients. We have also focused on reducing concerns and complaints related to contacting departments and appointment waiting times, leading to a 7% reduction in those enquiries to our Patient Advice and Liaison Service.

In 2026/2027, we will continue to focus on making things easier for patients to access healthcare at our hospitals. Our priorities will include modernising our outpatient services using technology to improve the quality of interactions with our clinicians, improving the process for cancelling or changing appointments, and providing extra support for people living in the most deprived areas of the city, so that everyone can access the healthcare they need.

Health equity

Background

Health inequalities are the systematic, unfair, and avoidable differences in health across the population, and between different groups in society. Health equity is when everyone has a fair chance to be healthy. It is the absence of the inequalities that arise due to the conditions in which we are born, grow, live, work and age.

Health inequalities directly impact our services, people's need for healthcare, how people access healthcare, people's experiences of care, and outcomes from treatment.

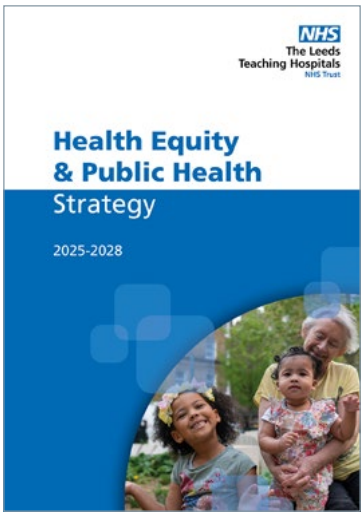
Health Equity & Public Health Strategy

A new three-year Trust Health Equity & Public Health Strategy was developed in April 2025, building on our previous progress made. Our vision is to embed equity at the heart of everything we do and to maximise the Trust's contribution to improving health equity within the populations we serve. We recognise that there are lots of things that impact health inequalities beyond the control of an acute Trust, but that we do have an important role in improving health equity through our role as a service provider, health system partner and anchor institution.

The role of Leeds Teaching Hospitals in improving health equity:

A provider of clinical services	A partner within local health systems	An employer and anchor institution
Providing high quality care and addressing inequities through ensuring equitable access, an excellent experience, and optimal outcomes.	Working with partners (including with communities and the third sector) to address inequities within the health system and society.	Maximising social value through employment, procurement, environmental impact, facilities and building the Leeds Way.

Health inequalities are complex, persistent, long-standing issues that require a multipronged approach to improvement. Although we want to get to the stage that our clinical and preventative programmes are equitable, there are foundational elements and enablers that need to be strengthened to support this. This is why we organise our work around our priority building blocks, shown in the diagram on the next page.



Our priority building blocks for improving health equity:

Our Approach

Tackling health inequalities requires a clear understanding of our populations' demographics. To ensure we are addressing the diverse needs of our population requires us to work in partnership at all levels. Our partnerships across Leeds and West Yorkshire are a particularly important part of our work to tackle inequalities. Leeds is a 'Marmot City,' and we share the ambition collectively with our partners to make Leeds a fairer and healthier city.

Last year, the Trust played a key role in the formation of the Leeds Healthcare Inequalities Oversight Group which continued to develop throughout 2025/26. The group focuses on the systems and processes we need to develop as a city to embed equity into the heart of healthcare. Examples of collaborative work include a focus on equity in our waiting lists, equality and health inequality impact assessments and developing a new Health Equity Index for the Leeds health and care system. This is a strategic tool for measuring and embedding equity in healthcare performance. Using the index will: help simplify the interpretation of health equity data for individuals, teams and the Trust; it will help empower our workforce to build equity into business as usual; and strengthen our assurance processes around how we are addressing health inequalities.

Our Health Equity & Public Health Strategy highlights focal areas of inequality and their impact on health, including the life expectancy gap, and provides guidance on who and where we need to target in order to narrow the health gap we know exists. This includes a focus on: people living in the most deprived areas; people who experience poorer health outcomes e.g. inclusion health groups; and on our workforce. This supports Core20PLUS5, which is NHS England's framework for tacking healthcare inequalities.

Progress and Reporting

As a Trust, multiple teams continue to work hard to improve access, experience and outcomes for our communities most at risk of health inequalities. It is impossible to capture the breadth and depth of this work but an overview of initiatives and programmes delivered in 2025/26 can be reviewed in our February 2026 Health Inequalities and Public Health Annual Update Report (www.leedsth.nhs.uk/wp-content/uploads/2026/04/Health-Inequalities-Public-Health-Update-Report-Feb-2026.pdf). As evidenced in this comprehensive report, we have many of the fundamentals in place to address health inequalities, but there are further opportunities to embed and scale up our work going forwards. Of particular importance is to strengthen how we identify, understand and measure health inequalities.

In 2025/26, action on how we measure and report on health inequalities has progressed. For example, a new Health Equity Integrated Quality and Performance Report (IQPR) has been developed and will be published every quarter from early 26/27. The purpose of the Health Equity report is to provide an overview of the Trust's performance and quality of service delivery and to systematically monitor, assess and report on disparities in healthcare access, experience and outcomes across different population groups.

The reports will provide data disaggregated by ethnicity, sex and deprivation for the following Trust indicators:

- Emergency Care Standard
- A&E 7-day Re-attendance
- Cancer Diagnosis
- Length of Stay
- Cancelled Operations
- Waiting Lists
- Outpatient Missed Appointments
- Workforce Demographics
- Complaints

Both the Health Equity IQPR and Health Equity Index are ways to enable and facilitate our transition from high level ambition, as set out in the Health Equity & Public Health Strategy, to transparent and data-led accountability across the Trust.

The Trust is required to publish health inequalities data in line with the duties outlined in NHS England's statement on information on health inequalities (www.england.nhs.uk/long-read/nhs-englands-statement-on-information-on-health-inequalities). It should be noted that other types of trusts (e.g. community and mental health) and Integrated Care Boards (ICBs) have different reporting duties under the statement. These sources together provide a fuller picture of health inequalities in our city and region. A summary of the core measures set out by NHS England, where available, can be found in Appendix 2.

Achievements: the year in review

April 2025

We shone the light on the vital work of our admin teams in our Celebrating Admin Awards ceremony which coincided with Administrative Professionals Day. Colleagues were nominated in six categories and judges faced a real challenge in selecting the winners from so many worthy entries. Teams across the Trust also celebrated administrative colleagues in their own way with a series of mini events.

May 2025

We received two new DEXA scanners at Leeds General Infirmary and Wharfedale Hospital to improve the diagnosis and treatment for patients at risk of osteoporosis. The advanced technology provides earlier detection, resulting in faster treatment and better outcomes for patients. The additional scanning capacity also enables us to scan around an additional 3,000 patients per year.

We took away two awards at the Student Nursing Times Awards reflecting the Trust's commitment to educational excellence for nurses of the future. Highlighted as a 'true changemaker and rising star' Siofra McKeon Erskine won Apprentice Nurse of the Year, and our Digital Information Technology Nursing Team won Student Hospital Placement of the Year.

June 2025

We launched the pioneering Centre for Emergency Care and Global Health (CENT-EC Global) to revolutionise emergency care locally, nationally and globally through the power of technology, innovation and international collaboration. The launch event was held at the Thackray Museum of Medicine.

Dr Agam Jung, Consultant Neurologist and Director of the Leeds Motor Neurone Disease (MND) Service at Seacroft Hospital was named winner of the Kate Granger Outstanding Contribution Award at the 2025 Yorkshire Choice Awards. She was praised for her warmth, compassion and dedication to developing MND care and research.

July 2025

Leeds became only the fourth centre in the UK to offer a new treatment which can dramatically reduce pain for cancer patients. The procedure, called percutaneous cervical cordotomy, is available to eligible palliative care patients and enables permanent relief to the affected side of the body whilst still enabling patients to move and walk freely afterwards.

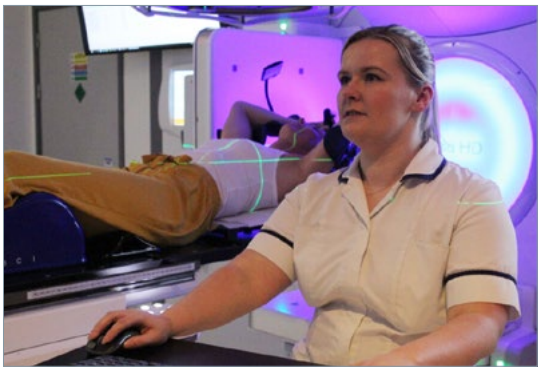
We celebrated the accomplishments of our colleagues at the 10th anniversary Time to Shine Awards when we welcomed 500 colleagues to a wonderful awards event at the Royal Armouries. There were 10 categories spotlighting the incredible work delivered by individuals and teams throughout the year, with hundreds of nominations received overall showcasing achievements across the length and breadth of the Trust.

August 2025

Our Community Diagnostic Centre in Armley marked a milestone after carrying out more than 10,000 tests since opening in September 2024. The tests offered include ultrasounds, electrocardiograms, blood tests, blood pressure checks, sleep studies and spirometry testing. The centre means patients don't have to travel to the city's larger hospitals for these tests and can book these closer to where they live.

September 2025

All breast cancer patients at Leeds Cancer Centre are now able to benefit from radiotherapy treatment without the need for permanent tattoos on their body. This is thanks to an additional £600,000 of funding from Leeds Hospitals Charity enabling the Trust to offer Surface Guided Radiotherapy (SGRT) treatment systems from Vision RT to all patients, which also provides more accurate and safer treatment.



Helen Tooby, a Well Child Tracheostomy Nurse Specialist at Leeds Children's Hospital was named winner of the Well Child Nurse Awards at the star-studded 2025 Well Child Awards. The award was in recognition of her ability to combine clinical excellence with heartfelt empathy, guiding families through some of their most overwhelming moments.

October 2025

The White Rose Wellbeing Garden was officially opened at St James's Hospital, created by The Royal Horticultural Society (RHS) and designed by award-winning garden designer Adam Frost. The garden provides a restorative space to relax and reflect for those working in or visiting the hospital, as well as a venue for workshops delivered by the RHS to support colleague wellbeing.

We celebrated 25 years of paediatric liver transplants in Leeds with an event at the Royal Armouries, bringing together colleagues, past and present, patients, families and supporters, and reflecting on the courage and generosity of organ donors. Since the service was commissioned in 2000, nearly 450 children have received life-changing transplants in our hospitals.

November 2025

The Rob Burrow Centre for Motor Neurone Disease was officially opened at Seacroft Hospital five years after a dream was first shared between rugby league legend Rob Burrow and his consultant Dr Agam Jung. The centre will be a beacon of hope, compassion and innovation for those affected by MND. The centre received a Royal visit later in the month from HRH The Prince of Wales.

Leeds hand transplant patient Kim Smith was featured in a powerful new Sky News documentary following her journey from becoming a quadruple amputee following sepsis, to receiving a life-changing donor hand eight years later. The transplant was carried out in Leeds by our exceptional multi-disciplinary team led by Consultant Plastic Surgeon Professor Simon Kay OBE.

December 2025

We became the first hospital trust outside of London to introduce the latest, state-of-the-art robotic technology to treat liver and kidney cancers. The new Epione robotic guidance system allows clinicians to accurately locate and destroy cancerous tissue without the need for invasive surgery. The system also supports shorter hospital stays, reduces disruption to patients' wellbeing and allows us to manage more cases.

January 2026

Children and young people with cancer receiving treatment at Leeds Children's Hospital became some of the youngest in the UK to benefit from home or 'ambulatory' chemotherapy, an alternative to being admitted to a hospital ward. Receiving their treatment at home means patients can be more comfortable, better rested and distracted from their treatment whilst easing the burden on parents and carers.

February 2026

We recommitted our pledge to support the Armed Forces Community by re-signing the Armed Forces Covenant. The Covenant outlines the commitment to supporting both patients and colleagues to ensure they are not disadvantaged by their service. The following month the Trust received reaccreditation of our gold status as a Veterans Aware Trust.

March 2026

Our Leeds Centre for Endometriosis and Pelvic Pain gained national accreditation from the British Society for Gynaecological Endoscopy (BSGE). The accreditation was awarded in recognition of the team's high standards of care, clinical expertise, patient-centred approach and commitment to research and innovation, and positions Leeds among the top hospitals in the UK for endometriosis treatment.

You can find out more about the Trust's work at www.leedsth.nhs.uk or by following us on Facebook and Instagram.

Notable visits

Our work attracts regional, national and global interest and we are always delighted to share it with visitors.

Over the year, we updated visitors on the new Rob Burrow Centre for Motor Neurone Disease and showcased the exciting work being done at our Innovation Pop Up.

Visitors were also keen to hear about other great work going on across the Trust with colleagues receiving visits in areas including Oncology, Radiotherapy, Clinical Research and Endometriosis.

Last year we had too many visitors to mention individually, but they included:

- HRH The Prince of Wales

- Karin Smyth MP, Minister of State for Health (Secondary Care)
- Sir Alec Shelbrooke MP for Wetherby and Easingwold
- Hilary Benn MP for Leeds South
- Dr Penny Dash, Chair of NHS England
- Clare Matterson, Director General of the Royal Horticultural Society
- Jamie Jones-Buchanan, Chief Executive of the Leeds Rhinos
- Tanya Curry, Chief Executive of the MND Association

Section 1

Operating and financial review

Section 1 - Operating and financial review

1.1 Performance analysis

The purpose of this section is to describe how well the Trust delivers services to its patients against a number of key national measures. The standards for delivery are set out in the NHS Constitution, although there are also a number of pertinent measures within the NHS System Oversight Framework. Interim measures are also defined in the annual NHS Priorities and Operational Planning Guidance. The key measures within the NHS Constitution are:

a. Referral to Treatment Times (RTT) - how long our patients wait to begin treatment after being referred to our services,

b. Emergency Care Standards (ECS) - how long our patients wait for treatment,

c. Diagnostic Tests - how long our patients wait for tests,

d. Cancer - how long patients with cancer wait for a diagnosis and treatment.

Within each section the key measures of performance are shown. These are measures that we report on nationally, which enables comparison with other NHS trusts. These measures are reported to our Finance and Performance Committee and Trust Board. Our ability to deliver on these measures can be impacted by numerous factors, such as workforce, estate issues and increasing requirements for healthcare from a growing and ageing population. These are recorded in the Trust's risk register, along with controls and mitigating actions to manage the risk and are reviewed at the Risk Management Committee.

Our performance

During 2025/26 we have again needed to increase the number of patients who were diagnosed and treated within our services to allow us to reduce waiting times for patients. During the year we delivered 1,402,604 outpatient appointments, which is an increase of 140,000 appointments on our 2024/2025 activity. In addition to this we have performed 306,707 procedures within an outpatient setting, which represents a 5% increase on our 2024/2025 position, and we treated 102,738 patients as a day case or elective inpatient, representing a 13% increase.

364,084 patients attended our Emergency Departments (EDs) during the year representing an increase of 1.5% over the course of the year.

We have focussed during the year on ensuring that we use our capacity productively. We have sought to ensure that patients are treated in the most appropriate environment and that they do not remain in hospital for longer than necessary.

Our services report on these measures through service delivery contracts to ensure that there is a clear line of reporting and accountability as to the levels of service we deliver for our patients. Oversight and assurance continue via reporting to the Finance and Performance Committee and to the Trust Board.

Referral to Treatment Times (RTT)

The 2025/26 operational planning guidance required trusts to improve the percentage of patients waiting no longer than 18 weeks for treatment to 65% nationally by March 2026 with every Trust expected to deliver a 5%-point improvement as well as reducing the proportion of people waiting over 52-weeks for treatment to less than 1% of the total waiting list by March 2026. Reducing waiting times for patients remains part of our plan to recover towards the constitutional standard of delivering care within 18 weeks of a referral being made.

In April 2025, the starting position for total 52-week risks was 2,355 with the Trust reducing this to 1,302 patients waiting at the end of March 2026.

Nationally, for treatments within 18 weeks of referral to our services, Leeds Teaching Hospitals ranks 36th out of 118 trusts.

We have continued to reduce the total waiting list this year and will continue to reduce this as we move into 2026/2027. The total waiting list size at the end of March 2025 was 89,091 with a closing position in March 2026 of 85,339, a reduction of 3,752, which equates to 4.3% reduction.

We have continued to manage our most urgent procedures in line with guidance developed by the Federation of Specialty Surgical Associations, which categorises procedures as requiring treatment within specified time bands. This means that those patients deemed to be less urgent experience longer waits for care. Prioritisation of patients according to clinical need is important in reducing the risk of patients deteriorating during any waits for treatment. The Trust also undertakes reviews of patients experiencing longer waits to determine whether patients have come to harm as a result. These reviews are reported to the Quality Assurance Committee and to the Board.

Emergency Care Standard (ECS)

The 2025/26 Priorities and Operational Planning Guidance required ECS to be delivered at 78% by March 2026 and a higher proportion of patients admitted, discharged and transferred from emergency departments within 12 hours across 2025/26 compared to 2024/2025. ECS delivery for March 2026 was 78.6% at Leeds Teaching Hospitals. For the same time last year ECS delivery was at 79.3%. The Trust delivered above the England national average for March 2026 which was 74.9% and ranked 36th for ECS delivery out of 118 Trusts, which is a change from March 2025 when the Trust ranked 21st out of 118 Trusts.

Attendance levels in our emergency departments remained high in 2025/2026 with a total of 364,084 attendances for the year across all our departments representing an increase of 1.5% compared to the year prior. Average attendances for 2025/2026 were 30,340, up from 29,903 in 2024/2025.

The Trust is also committed to supporting Yorkshire Ambulance Service (YAS) improve its Category 2 ambulance response times to an average of 30 minutes across 2025/2026 and within Leeds our mean time is 24.11 minutes. This is an ambulance metric, and we have played a crucial role in releasing the ambulance crews back onto the roads to support YAS delivering a timely response to their calls.

Diagnostics

Diagnostic performance for 2025/2026 delivered 93.2% which was an improved position on 2024/2025 with a national ranking of 22nd out of 118 Trusts.

There was no national planning guidance target for the Diagnostic standard in the national planning priorities for 2025/2026 however the Trust made the decision to continue with an internal target to ensure ongoing improvement in the diagnostic standard. We have seen challenges with capacity and staffing in some areas, and this has resulted in patients waiting longer than six weeks for diagnostic tests in some areas.

To reduce waits for diagnostic tests we have increased capacity within the Community Diagnostic Centre at Seacroft on a Sunday for CT scans, added additional capacity for Ultrasound, and installed new accelerator software on MRI scanners. Funding has been secured for ongoing development of the CDC at Seacroft and development of future pathways to be delivered mid-year 2027.

Cancer

The national requirement was to improve performance against the headline 62-day standard to 75% by March 2026.

Since October 2023, all patients on a pathway for a first cancer treatment are included in this standard, which previously only monitored new GP referrals, and upgraded patients (incidental findings of suspected cancer, usually initiated by a secondary care consultant) were excluded. For 62-days, we delivered 71.2%, with a national ranking of 66th out of 118 Trusts for Cancer 62-day performance.

The number of patients who have waited over 62 days from GP referral to treatment reduced to 153 at the end of March 26 from a high point of around 350, with 36 patients

waiting over 104 days. Consistent delivery of the 31-day decision to treatment standard in radiotherapy and Systemic Anti-Cancer Therapy and improvements in the time to surgery has supported the improvement in delivery against the 62-day standard.

Improved oversight of the 28-day backlog is now in place to anticipate and proactively respond to risks at pathway level going forward. Reducing pathology turn-around times has been a significant contributor to improving delivery against the 28-day standard and this work will continue into 2026/2027.

In March 2026 Leeds Teaching Hospitals ranked 27th out of 118 Trusts for Cancer 28-day performance.

1.2 Improving quality

Our aim is to provide outstanding care, ensuring we treat every patient as an individual, deliver the best outcomes and the best experience. This ambition informs our values, underpins our goals and is reflected in our culture of continuous improvement.

Quality and safety are an integral part of the Trust Strategy 2024-26 and our vision to provide the highest quality specialist and integrated care. Our Patient Safety and Quality Strategy 2024-27 sets out how we will develop our patient safety culture, learn from incidents and change the way we investigate through implementing the Patient Safety Incident Response Framework (PSIRF).

Our quality improvement programme remains key to addressing patient safety challenges: we have continued with our collaborations and the achievements are set out in our Quality Account 2025/26. The Leeds Improvement Method (LIM) has continued to provide a framework to address safety improvements and we have revised and updated our Improvement Strategy.

We have continued to work with our external stakeholders and regulators to ensure that we provide safe care to all our patients in the face of sustained pressures across the healthcare system. We will continue to embed The Leeds Way values and our People Priorities, creating a positive culture where staff feel engaged in the work that they do. We are extremely proud of our staff who have focused on providing safe care and improving quality for our patients and taking the time to support and care for each other. We continue to listen to and empower our patients and the public in order to understand the value of services and how we can improve.

We have continued to work with our clinicians, managers, staff and local partners at Leeds Health and Care Partnership, NHS West Yorkshire Integrated Care Board, and Healthwatch Leeds to build on our improvements and identify our priorities for 2026/27.

Further information on key improvements in the quality of care and patient safety, the Trust's performance against national standards, goals agreed with commissioners and our plans for 2025/26 is summarised in our Quality Account, published in June 2026.

1.3 Finance review

The financial year ending on 31 March 2026 has been another challenging year for the Trust with the continuing impact of industrial action, on-going impact of inflation resulting from events worldwide, and the changes in leadership in the Trust.

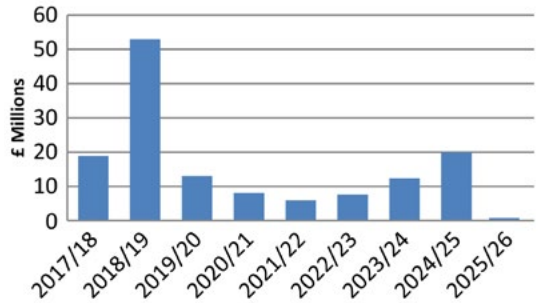
During 2025/26, the Trust commissioned PwC to review the effectiveness of its financial controls. The recommendations from the report are being monitored by the Trust Executive Teams through bi-weekly turnaround meetings. These actions have contributed to the achievement of the delivery of the financial position for 2025/26 and lay foundations for further delivery in 2026/27.

Despite these ongoing pressures the year has seen continued strong financial results. The Trust's Finance corporate support unit, encompassing Finance and Procurement, has been integral to the Trust's delivery of a waste reduction programme of £89m and enabling investment in frontline services. Highlights from 2025/26 include:

- Achievement of our final financial plan through delivery of a small revenue surplus, which is the ninth consecutive year of surplus (see table 1);
- Significant level of capital investment of £104m (see table 7);
- Delivery of a mitigation and Waste Reduction Programme of £89m;
- Cash balance of £134m;
- The Procurement Team has successfully completed the NHS Procurement re-accreditation assessment achieving a score of 98%;
- The Procurement Team have achieved re-accreditation for the Customer Service Excellence standard;
- At the Annual Healthcare Financial Management Association (HFMA) Awards, the Costing Team won the 'Addressing health inequalities' award for their work with maternity colleagues in developing an innovative PLICS maternity analyser, which has helped drive a reduction in smoking at time of delivery rates. The Finance Team were highly also commended for the Havelock Award for training and development recognising the work done on training for non-finance colleagues; and
- The Trust previously achieved Level 3 accreditation (the highest level) under the One NHS Finance Towards Excellence framework, which is re-assessed every three years. Re-assessment took place in March 2026 and the Trust has been awarded Level 3 accreditation for a further three years to May 2029.

None of this would have been possible without the tremendous contribution of all members of staff across the Trust, not least those in the Finance corporate service unit.

Table 1: Adjusted retained surplus/(deficit)



Income and expenditure summary

One of the Trust's strategic goals is financial sustainability, with the Trust Board setting a breakeven plan for 2025/26 a clear measure of success against this goal in addition to meeting the statutory duty to achieve breakeven.

Financial sustainability is important because it allows the Trust to maintain a level of autonomy within the NHS Oversight Framework and demonstrates our good governance in balancing the financial requirements with the need to deliver high quality patient care, supporting the performance requirements. Further, whilst the financial rules within the NHS to some extent restrict the Trust's ability to invest cash surpluses generated from delivering at least a breakeven revenue position in capital expenditure, financial sustainability gives more flexibility for the Trust in this area and reduces the risk of cash availability. Capital expenditure is used to maintain and improve our estate, purchase medical equipment and develop our digital infrastructure to provide modern healthcare to our patients in safe surroundings.

The Trust has delivered a small adjusted financial performance surplus of £39k. The performance contributed to the West Yorkshire Integrated Care Board (ICB) achieving the forecast agreed with NHSE for 2025/26.

For 2025/26, the majority of the income received by the Trust under commissioner contracts was fixed. The main variable elements to the income received into the Trust related to elective activity and NHS England commissioned drugs and devices. The Trust performance in elective delivery and the outpatient sprint within the final quarter of the financial year secured additional funding from ICBs and NHS England Specialised Commissioning based on the commissioner allocations increasing.

Table 2 on the next page illustrates the income received over the year from different sectors.

Table 2: Income received from different sectors

	2017/18 Actual £000	2018/19 Actual £000	2019/20 Actual £000	2020/21 Actual £000	2021/22 Actual £000	2022/23 Actual £000	2023/24 Actual £000	2024/25 Actual £000	2025/26 Actual £000
NHS England	498,293	515,025	589,857	619,924	702,831	816,560	817,726	895,744	491,656
Integrated Care Board	522,806	543,232	588,855	652,340	778,854	772,150	816,412	913,276	1,444,400
Non-NHS: Private Patients	5,857	4,907	5,535	3,706	3,845	1,437	1,386	1,502	3,011
Other income from patient care activities	7,266	20,448	8,739	6,234	7,375	8,337	9,647	12,464	12,604
Other operating income	204,045	252,235	221,754	314,591	235,040	245,504	255,345	301,740	316,604
Total operating income	**1,238,267**	**1,335,847**	**1,414,740**	**1,596,795**	**1,727,945**	**1,843,988**	**1,900,516**	**2,124,726**	**2,268,275**

The significant reduction in 2025/26 in NHS England and offsetting increase in Integrated Care Board income relates to the delegation of the majority of specialised activity to ICBs which started from 1 April 2025.

For 2025/26, included in "Other operating income" above is £7.0m in respect of donations from a number of charities and organisations who generously support our services by funding equipment purchases, research activity, specialist staffing or environmental enhancements. The Trust is grateful to all the charities from which it receives support.

The Leeds Hospitals Charity is the official charity partner of the Trust. It has continued to raise funds on our behalf and works closely with our staff to raise the profile of our services.

Table 3 below gives a summarised breakdown of expenditure during 2025/26.

Table 3: Summarised breakdown of expenditure

	2017/18 Actual £000	2018/19 Actual £000	2019/20 Actual £000	2020/21 Actual £000	2021/22 Actual £000	2022/23 Actual £000	2023/24 Actual £000	2024/25 Actual £000	2025/26 Actual £000
Employment related costs	702,958	745,032	830,372	924,569	985,758	1,088,351	1,126,477	1,238,950	1,338,304
Drug costs	178,445	188,170	200,947	237,243	266,116	285,106	301,554	326,296	343,918
Clinical supplies and services	155,889	153,668	156,404	164,594	182,293	191,325	205,857	237,951	252,256
Premises	42,348	54,594	68,597	78,021	74,831	70,769	66,035	66,340	68,637
Other operating expenses	172,962	117,297	113,883	363,776	189,850	136,191	157,567	244,222	281,954
Total operating expenses	**1,252,602**	**1,258,761**	**1,370,203**	**1,603,609**	**1,698,848**	**1,771,742**	**1,857,490**	**2,113,759**	**2,285,069**

For 2025/26:

- The expenditure position has increased due to an increase in costs from inflation, drugs costs and staffing costs.
- Employment costs have increased during the year by £99m, reflecting a £93m increase in substantive pay costs and a £6m increase in bank and agency costs. The substantive increase includes the nationally agreed pay awards of £42m, increases to National Insurance of £22m relating to the Secondary Class 1 Employers rate increasing from 13.8% to 15% alongside a reduction in the Secondary threshold, and increase in employer pension contributions of £10m, with the balance reflecting planned investment in services and successful recruitment to key frontline roles.
- To achieve the revenue position, the Trust delivered a mitigation and waste reduction programme of £89m, of which £45.3m came from programmes across our clinical service units individually and working together on savings opportunities. The balance was delivered through various Trust-wide programmes such as increased productivity schemes managing activity growth within the cost base, research and innovation, length of stay initiatives, commercial and private patient income, reducing independent sector spend, bank interest received from higher cash balances and other cost base reviews. These programmes were and continue to be, built on the principles of our Leeds Improvement Method, which seeks to identify and remove wasteful practices, procedures or delays which impede great patient experience.

The two charts below give some further information on where our income comes from and how we use it to deliver our full range of services to patients.

Table 4: Where each £1 comes from

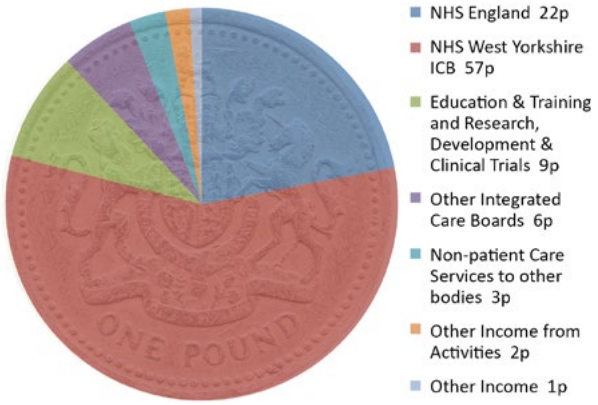
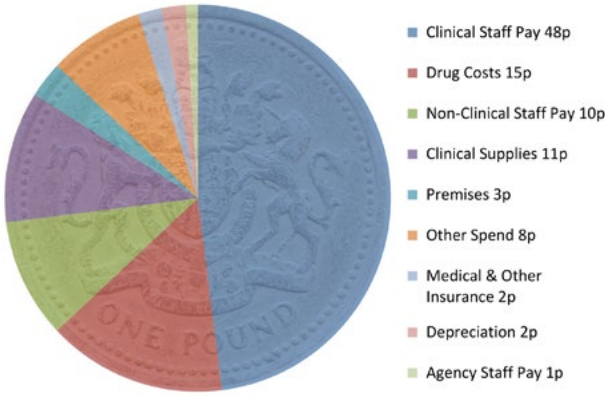


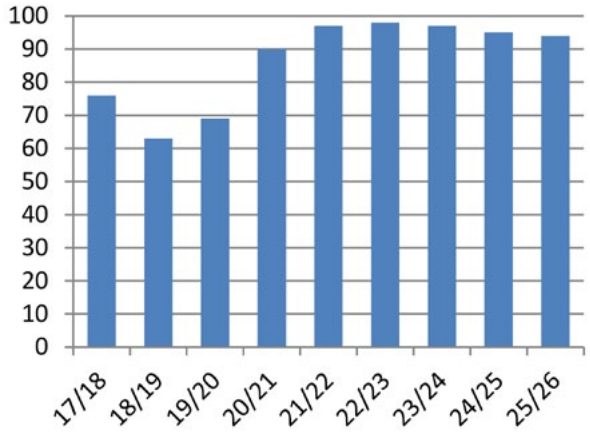
Table 5: How each £1 is spent



Better Payments Practice Code

Despite ongoing pressures, the Finance team have been able to maintain a high-level percentage against the Better Payments Practice Code, achieving 94% for the number of non-NHS invoices paid within 30 days. The table below shows the improvement over the past few years. In challenging economic times, it is particularly important to support our suppliers and local businesses by ensuring prompt payments are made to them so it is particularly pleasing to see the continued high level achieved.

Table 6: Better Payments Practice Code performance %



It is also pleasing to note that no late payment of commercial debt charges have been incurred during the year. If interest had been levied under the terms of the Public Contract Regulations on the small number of invoices that were not paid within terms, the maximum liability would have been £335k (24/25-£617k) - money which if incurred would no longer be available for patient care.

Capital investment

In 2025/26, capital expenditure was £105m, in part thanks to the Trust's previous years' surpluses. The Trust has been able to invest in its operations such as the Rob Burrow MND centre at Seacroft, the Electronic Health Record, elective theatres and estates. The table and graph below show how, the Trust has been able to build and sustain our level of capital expenditure over the last seven years.

Table 8: Capital investment

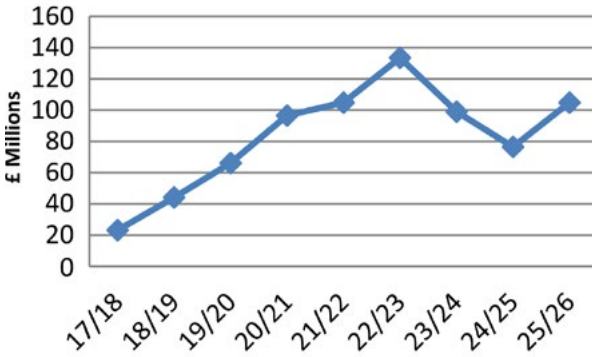


Table 7: Capital investment

	2017/18 £000	2018/19 £000	2019/20 £000	2020/21 £000	2021/22 £000	2022/23 £000	2023/24 £000	2024/25 £000	2025/26 £000
Building and Engineering	10,633	28,440	29,061	39,587	27,135	39,943	44,674	33,601	77,403
Medical and Surgical Equipment	7,286	8,963	22,978	16,434	23,607	10,415	9,703	14,636	13,665
Information Technology	5,210	6,746	14,110	20,048	40,059	44,770	21,579	17,785	9,793
Building the Leeds Way				14,092	14,002	35,786	11,311	10,723	
COVID-19				6,396					
Leased Assets						2,606	11,761	-245*	3,998
Total	**23,129**	**44,149**	**66,149**	**96,557**	**104,803**	**133,520**	**99,028**	**76,500**	**104,859**

*The negative figure in 2024/25 is as a result of the re-measurement of the Cardiology managed equipment service contract following a change in capital/revenue split of the contract.

Capital expenditure during the year included the following higher value schemes:

	£000
Estates Safety Fund – improving our buildings	12,045
MND Centre Seacroft	3,904
Electronic Health Record	2,836
WYAAT Pharmacy Aseptics	2,089
Data centre expansion	1,775
Pathology LIMS	1,470
Linear accelerator replacement	1,324
End user computer rolling device replacement	1,141
Elective theatres, Chapel Allerton	1,125
Chilled water tertiary supply, SJUH	1,026

Looking to the future

The national priorities and the most recent operational planning guidance setting the financial and operational performance expectations for the next three years highlight the continued challenge for the NHS to improve access to timely care for patients, increasing productivity, driving reform and living within allocated budgets.

Further, the ongoing changes across NHS England and Integrated Care Boards, alongside the refreshed National Oversight Framework indicate the scale and pace of reform expected. The Trust will enter 2026/27 with a healthy cash balance but will continue to monitor this closely during the year.

The financial position in 2026/27 will be impacted by the continued financial pressures across the NHS, continued higher inflation due to worldwide events, the uncertainty around industrial action from several staff groups and further stretch on operational performance expectations within a flat cash funding environment. As a result of the above it is clear that there is going to be huge financial pressure in the system in 2026/27. The Trust is working to deliver its plan of a balanced financial position.

Capital investment for 2026/27 is planned at £109.2m. While some risk to delivery of the full programme from inflation and supply chain concerns must be acknowledged, there is every reason to be confident of another high-level year of expenditure on our infrastructure.

The factors outlined above result in an uncertain outlook for the finances of the Trust. However, the Trust's history of delivering strong financial and operational performance alongside high quality patient care, its history of identifying waste reduction, and strong partnership working put it in the best possible place to meet these challenges. The Finance and Procurement team will support colleagues across the Trust to manage every pound wisely.

1.4 The NHS Constitution

NHS organisations like Leeds Teaching Hospitals are required by law to comply with the NHS Constitution, a document that establishes the principles and values of the NHS in England.

The Constitution sets out rights to which patients, the public and colleagues are entitled and pledges that the NHS is committed to achieve. It also describes the responsibilities that patients, staff and the public owe to one another to ensure the NHS operates fairly and effectively.

The Trust takes all reasonable steps to ensure the requirements of the NHS Constitution are met. Where patients are referred by their GP for consultant-led treatment the Trust aims to deliver this within 18 weeks or, where they have been referred to a cancer specialist, within two weeks.

In areas where we continue to face challenges due to system-wide issues we cannot resolve alone, we continue to work with our partners and commissioners to put plans in place to manage them.

We are committed to providing high-quality, safe care to all our patients and we will continue to work across the Trust so that we can meet the guidelines set out in the NHS Constitution.

1.5 Future direction

The Trust will maintain its focus on providing comprehensive hospital services for the people of Leeds and specialist healthcare for patients in the city, across West Yorkshire and beyond. Our vision remains to provide the highest quality specialist and integrated care, driving our mission to be an internationally-renowned healthcare institution – working in partnership to deliver the highest quality, safe, effective and innovative care that improves health outcomes. We anticipate a continued shift from analogue to digital, from treatment to prevention, and from hospital to community – changes we are already building into our strategy and operational plans.

The Trust operates within a complex and challenging environment at every level. Nationally, NHS reform, evolving political priorities and shifting public perception continue to shape the landscape, alongside financial and operational performance pressures and regulatory scrutiny. At a regional and city level, ICB reforms and changes to strategic commissioning are reshaping how services are planned and delivered. In response, our strategy is to focus on the experience of our colleagues and the quality of the services we provide whilst engaging positively and constructively with those who influence how we work, ensuring we remain an active and willing partner in shaping the future of health and care across our region.

Our strategy

We have a new Trust Strategy for 2026-2029. This has been developed through collaboration with colleagues, patients, and system partners to reflect real experiences and insights, and is built around a number of core priorities. Our purpose, to deliver safe high, quality care for patients every time, will be supported by these priorities

People: Creating a culture where colleagues feel respected, trusted and supported to grow, with investment in wellbeing, leadership and professional development.

Partnerships: Deepening collaboration across Leeds, West Yorkshire and beyond to share expertise, standardise pathways and serve our communities as a responsible anchor institution.

Improvement & Innovation: Embedding research, innovation and digital transformation in clinical practice to keep Leeds Teaching Hospitals NHS Trust at the forefront of world-leading healthcare.

Performance and achievement: Achieving top-quartile operational and financial delivery by 2029, underpinned by strong governance and transparent, data-driven decision-making.

The support and engagement of our workforce remains crucial to everything we do. We are committed to investing in our people, listening to colleagues and patients alike, and ensuring that the Trust's direction and culture are shaped by those who know it best.

People

Partnerships

Improvement & Innovation

Performance & Achievement

Partnerships

The Trust plays a significant role in improving health and care across the broader region. As an important partner within the West Yorkshire Health and Care Partnership and at a local level through the Leeds Place Partnership, we work alongside partners to share expertise, tackle health inequalities and ensure that patients receive care as close to home as possible.

Leeds Teaching Hospitals is committed to working in ever closer collaboration with healthcare providers and statutory partners across the Leeds Place. The Trust is part of actively building a new Provider Partnership model within the Leeds Place that will align governance and decision making across local organisations. From April 2026, this partnership will operate in shadow form, allowing us to test and develop new ways of working together before full implementation. The partnership will concentrate on delivering better-connected services, minimising unwarranted clinical variation and making more effective collective use of workforce, estates and resources across the Leeds Place.

This work builds upon our already strong regional relationships through the West Yorkshire Association of Acute Trusts (WYAAT) and reflects our conviction that the most meaningful improvements in care and efficiency are best delivered through shared leadership and collective accountability, rather than through any single organisation acting independently.

Our collaboration with academic, city, health, social care and industry partners supports research and encourages innovative approaches to healthcare. Our efforts to establish an Innovation Village as part of a wider Innovation Arc will generate employment opportunities and drive economic growth for Leeds and the surrounding region. It is equally important that we continue to modernise our estate and embrace digital technologies to enhance care pathways and provide patients with more flexible ways to access services.

1.6 Managing risk

The Trust Board continually monitors the risks that could affect the delivery of our services. During the year we have faced challenges to the delivery of our services, including changes to the Hospital of the Future plan, continued industrial action and ongoing concerns related to capacity. Risks related to treating patients in line with constitutional standards remain challenging across a number of specialties.

The Trust has a well-embedded Risk Management Framework, which supports robust and efficient risk management and has an important role in supporting the Trust to:

- Protect our patients from harm and adverse outcomes
- Support staff to protect their health and wellbeing and ability to do their job
- Protect the Trust from unplanned financial outcomes
- Have greater resilience to operational risks
- Meet stakeholders' and regulators' expectations

During 2025/26 the Board reviewed the risk categories and risk appetite statements and refreshed the Trust risk appetite document. Risk appetite statements set the amount of risk the Trust is prepared to accept for each category of risk. The document provides a summary of our Risk Management Framework and sets out our risk appetite statements. Risks are identified from various sources, including proactive risk assessments, strategic planning, performance data, incident reporting and trends, clinical benchmarking and audit data, complaints, legal claims, patient and public feedback and internal and external assurance from stakeholders and regulators.

The Trust's most serious risks are set out in our Corporate Risk Register, which is reviewed each month at the Risk Management Committee chaired by the Chief Operating Officer, and at the Trust Board. The risks described in the Corporate Risk Register are regularly reviewed with Executive Directors and designated leads and aligned to the risk types and categories set out in the Trust risk appetite document.

The current corporate risks are aligned to the following risk types: workforce risks, operational risks, clinical risks, financial risks and external regulatory risks. Significant risks that have been reviewed will continue to be key risk areas for the year ahead:

- **Staffing**

  There is a national shortage of registered nurses, medical staff, allied health professionals and clinical support workers in some specialties, which has been exacerbated by staff retention challenges and changes to the Internal Medicine Training. The Trust has undertaken gap analysis, developed workforce plans to mitigate risks identified and expanded international recruitment. Following this mitigation, the risk level has been reduced. At a national level, industrial action has impacted on staffing across several disciplines. We will continue to respond and mitigate the risks to patient safety as a consequence of industrial action and support staff during these periods. Staff absence, health, safety and wellbeing is also reviewed and documented as a dedicated corporate risk. The Trust has recorded a corporate risk around potential breaches of regulations of the health and social care act (2008) in relation to Maternity staffing for both midwifery and medical staffing.

- **Finance**

  All NHS trusts were faced with a significant financial challenge in 2025/26, reflecting the national economic climate. This impacts on both revenue and capital allocation and the wider Trust estate and digital infrastructure. We will continue to review this risk with our clinicians and management teams to identify waste reduction programmes to achieve a balanced financial position.

- **Capacity planning**

  Demand for hospital treatment continues to grow in some specialties, which is greater than the capacity available to treat patients within the timeframes set out in the constitutional standards. This risk continues to be managed working in conjunction with system partners to manage demand, prioritise treatment based on clinical need, and maximise flow through the healthcare system.

- **Operational risks**

  Business continuity, infrastructure and threats to core services are considered as part of the monthly corporate risk register review, including consideration and horizon scanning of threats and risks outside of the Leeds Teaching Hospitals NHS Trust.

- **External regulatory risks**

  Following inspections of maternity services and under the "Well-led" domain, risks were recorded to monitor improvement works and compliance with regulatory standards of the health and social care act (2008) relating to safe care and treatment, premises and equipment, good governance, staffing and receiving and acting on complaints.

We will continue to focus on the most significant risks reported by CSUs and corporate functions at the Risk Management Committee. We will continue to review corporate risks in line with the annual programme, ensuring we have focused discussions about controls and mitigating actions for specific risks. We will review the Trust's Board Assurance Framework, which sets out the key strategic risks to achieving the Trust's objectives, linking this to our Risk Management Framework.

1.7 Research and Innovation

Leeds Teaching Hospitals NHS Trust is a world-leading centre for excellence for research and innovation, delivering cutting-edge medical breakthroughs and the latest medical advancements to transform health and care for all. Research and innovation enables the Trust to adopt the latest medical advancements to deliver the best-possible treatment and care for patients while tackling health inequalities and creating a healthier community.

Research delivery

Throughout March 2025 – April 2026, the Trust has continued to manage and deliver a complex and diverse research portfolio, recruiting over 14,500 participants into 1,365 active research studies.

The Trust is the UK-site for international research, one of the country's leading Trusts for recruitment to specialist cancer studies; the highest adult acute hospital for recruitment to medical device studies, the highest recruiter for complex interventional studies and the third highest for portfolio studies (second in the north of England) and commercial studies.

Leeds Teaching Hospitals hosts a £40m National Institute for Health and Care Research (NIHR) infrastructure, supporting the delivery of more than 1,153 research studies each year. This includes early-phase translational research delivered by the NIHR Leeds Biomedical Research Centre, spanning six key specialist themes, alongside a wide portfolio of first-in-human trials taking place at the NIHR Leeds Clinical Research Facility within the Trust.

The Trust continues to demonstrate national leadership in research delivery. During the reporting period, Leeds Teaching Hospitals was the first site in the UK to open four NIHR commercial studies and five non-commercial studies. In 2025/26, the Trust was also the first UK site to achieve First Patient First Visit (FPFV) in 45 studies, representing an achievement rate of 31% across participating UK sites.

These achievements reflect the strength of our research infrastructure, efficient study set-up processes, and the commitment of our clinical research teams to enabling earlier patient access to innovative treatments and life-changing research opportunities.

In addition, Leeds Teaching Hospitals continues to collaborate with industry partners and has run 387 commercially sponsored trials throughout 2025/2026, including studies into new medications, vaccines and treatments.

Research activity spans all of the Trust's CSUs, and our portfolio is highly diverse, ranging from research that helps to understand more about diseases through to trials of world-first surgical procedures, evaluations of new medical devices and diagnostics (including Artificial Intelligence (AI) algorithms in clinical imaging), and clinical trials of novel therapeutics.

The Trust's patient and public involvement and engagement (PPIE) activity supports the delivery of research by ensuring studies reflect the region's diverse, local populations. During 2025/26, PPIE activity has held more than 24 outreach events, reaching more than 700 people to engage and collaborate on research.

Setting a bold ambition

In August 2025, we published our new five-year strategy, a bold and ambitious roadmap that builds on our strong foundation and sets out a clear vision for the future. It outlines how we will develop a supportive, inclusive research culture, embed research and innovation into everyday clinical practice, harness the power of data, AI and diagnostics and strengthen industry partnerships to make Leeds a true testbed for new ideas and technologies.

The strategy puts the NHS 10-year plan into action, showing how research and innovation can deliver tomorrow's healthcare today. The Trust is helping to prevent illness, pioneer new therapies, and creating high-skilled jobs that will make Yorkshire a global leader in health innovation.

Embedding research across the Trust

Our strategy set out our vision to embed research across every department in the Trust to ensure every colleague has the opportunity to participate and benefit from research to positively impact patient care.

During the year 2025/26, 1,697 colleagues have participated in research and innovation training. Between April 2025 and the end of March 2026, we supported 104 applications (75 grants and 29 fellowships). Colleagues have represented a wide range of professional disciplines (doctors, nurses, allied health professions, healthcare scientists and pharmacists) demonstrating the breadth of research-active colleagues across the Trust.

To further embed research with our colleagues, the Trust held its fourth annual Research and Innovation Conference at the University of Leeds in July, its most ambitious event to date. Shaping Future Healthcare was attended by over 400 colleagues, partners, innovators and clinicians from across Leeds and beyond who heard from over 70 expert speakers across research, healthcare, academia and industry.

Pioneering treatment and care

The Trust is at the forefront of research into new treatments and care for patients, not only in Leeds but around the world. Some examples of this ground-breaking work during last year include:

- We became the first Trust outside London to use robotic technology for minimally invasive liver and kidney cancer treatment, using the Epione system. This new robotic guidance system is enabling precise, minimally invasive CT-guided ablation of tumours, allowing clinicians to accurately locate and destroy cancerous tissue without the need for traditional surgery.
- We have launched a pilot which could transform diagnostic testing for prostate cancer and save some men up to a month of waiting. The new 'one stop shop' pilot, funded by NHS England, will use artificial intelligence to interpret MRI scans for men with suspected prostate cancer, helping to spot lesions in a matter of minutes. The AI tool is being trialled at up to 15 NHS hospitals and supports a 'rapid diagnosis' pathway which offers all investigations within one day.

Dr Oliver Hulson, Consultant Radiologist, trial lead for prostate cancer diagnostic trial

- The results of a new UK-wide FLAIR trial, offered major hope for people with chronic lymphocytic leukaemia (CLL), showing that personalised treatment with two targeted drugs, provides significantly better outcomes than traditional chemotherapy. The groundbreaking study, led by the Trust and sponsored by the University of Leeds, demonstrates that using personalised blood tests to guide treatment can improve survival, reduce long-term side effects and offer many patients a future free from chemotherapy and paves the way for how the treatment will be delivered globally.
- We were announced as one of 15 NHS sites to fast-track patients into a head and neck cancer vaccines trial, as part of NHS England's expanding efforts to match eligible patients with clinical research. The news builds on the Trust's existing expertise into cancer vaccines and aims to increase access to a clinical trial investigating mRNA cancer vaccines for patients with advanced head and neck cancer.
- The Trust is taking part in a pioneering new research study launched to better understand and prevent childhood lead exposure in the UK. The Elevated Childhood Lead Interagency Prevalence Study (ECLIPS), co-led by Northumbria University, the UK Health Security Agency (UKHSA) and Leeds Teaching Hospitals, will trial an innovative home-testing model that could transform how lead exposure in children is monitored nationwide.

Supporting innovation

Throughout 2025/26, the Innovation Pop Up has continued to strengthen its role as a gateway for collaboration between the NHS, academia and industry, supporting innovation that improves patient care and delivers measurable impact across the Trust.

The team is now in its third year of involvement in the NHS InSites programme, supported by NHS England funding. This initiative enables companies to work directly with NHS organisations to test and evaluate innovative technologies in real-world clinical environments, accelerating adoption of solutions that improve patient outcomes and service efficiency.

The Innovation Pop Up also contributed to Leeds Digital Festival 2025, hosting a collaborative event with the NHS Innovation Accelerator (NIA). The event brought together 75 representatives from across healthcare, academia and industry to explore how digital innovation can be adopted more rapidly to improve patient care and operational performance.

Alongside these programmes, the team has continued to develop strategic partnerships that support the responsible use of real-world data to drive research and innovation. This includes new collaborations with Owkin and Arcturis, alongside continued partnership with Flatiron Health. The team has also supported the testing and evaluation of ambient voice technology within the Emergency Department. Initially supported through NHS England regional funding, the technology is now expanding to additional users and licences across the department, demonstrating its potential to improve productivity and clinician experience.

The Pop-Up also hosted the HealthTech Innovation in Partnership event, delivered in collaboration with the Association of British HealthTech Industries (ABHI). The event brought together more than 110 representatives from industry, universities, local government and regional innovation organisations to explore how collaboration can accelerate the development and adoption of new technologies that improve patient care.

Collectively, these activities have engaged more than 700 Trust colleagues and strengthened partnerships across the innovation ecosystem. This work supports the ambitions set out in the forthcoming NHS 10 Year Plan, helping to accelerate innovation, improve productivity and deliver better outcomes for patients.

Strategic partnerships

The Trust's partnership with the Leeds Academic Health Partnership continues to grow, supporting a range of high-profile initiatives that position Leeds as a national leader in health innovation.

This year also saw the launch of the Health Innovation Leeds Incubator, delivered in partnership with the University of Leeds (Nexus) and Leeds Beckett University, working closely with Leeds City Council. Supported through West Yorkshire Investment Zone funding, the programme provides targeted support to help companies across West Yorkshire grow and scale. The initiative has also enabled expansion of the innovation team, including recruitment of new roles to strengthen internal and external engagement, such as a Community Manager.

The Trust also plays a pivotal role as part of the NIHR at Leeds Forum, working collaboratively with partners across the NIHR infrastructure in the city. During 2025/26, the Trust, alongside city and regional leaders, welcomed HM Treasury representatives to Leeds to showcase how the city's £40m NIHR infrastructure and world-leading research capability are delivering real-world impact for patients, the NHS and the wider economy.

Together, these partnerships demonstrate Leeds' position as a leading UK centre for innovation, supporting the translation of research into practical solutions that benefit patients locally and globally.

Future innovation

The plans for the Leeds Innovation Village, a key neighbourhood within the city's £2 billion Leeds Innovation Arc, and one of the flagship projects of the £160 million West Yorkshire Investment Zone – have continued to progress.

In May, the Trust announced that West Yorkshire Combined Authority is supporting a market engagement exercise and masterplan to explore opportunities within the Leeds General Infirmary site. The masterplan is progressing.

The first phase of the Innovation Village is already underway which involves the redevelopment of the historic Old Medical School on the Leeds General Infirmary site into a cutting-edge HealthTech innovation hub by one of the UK's most active, privately owned, mixed-use developers, Scarborough Group International (SGI). Trust partners, Scarborough Group International formally completed the acquisition of the iconic Grade II* listed Old Medical School in March 2026, marking a major milestone in the transformation of one of the region's most significant medical and scientific buildings.

The acquisition also supports the Trust's long term estates strategy to release land and estate at Leeds General Infirmary for sympathetic development in the heart of the city. This move is possible following the relocation of the Trust's pathology services to the state-of-the-art Centre for Laboratory Medicine at St James's University Hospital.

1.8 Sustainability

Our vision: to become one of the greenest NHS Trusts in the UK

Our mission: to empower the delivery of sustainable healthcare services through continuous improvement

At Leeds Teaching Hospitals NHS Trust, we recognise the significant threat climate change poses to our environment and the health of our patients. As an anchor institution and one of the largest teaching hospital trusts in the UK, we have a vital role to play in mitigating our environmental impact and reducing carbon emissions across Leeds. We aspire to become one of the greenest NHS Trusts in the UK, improving sustainability throughout our organisation and the wider region.

In recognition that the need for healthcare organisations to act on climate change is now urgent the NHS has mandated that all trusts achieve net-zero carbon for their NHS Carbon Footprint (direct emissions) by 2040 and NHS Carbon Footprint Plus (indirect emissions) by 2045 (see figure 1).

Whilst these targets serve as the ultimate carbon reduction goals that trusts should be seeking to achieve, trusts are also obligated, as part of the UK Government's Climate Change Act 2008 (amended 2019), to meet the following interim targets, to help support them on their carbon reduction journeys:

1. Reduce NHS Carbon Footprint emissions by 80% by 2032 (from a 1990 baseline)
2. Reduce NHS Carbon Footprint PLUS emissions by 80% by 2039 (from a 1990 baseline)

Historically, Leeds Teaching Hospitals has utilised a baseline year of 2013/14 for its carbon footprint reporting, against which the carbon emissions from all subsequent years have been compared. This baseline year was originally selected because 2013/14 was the

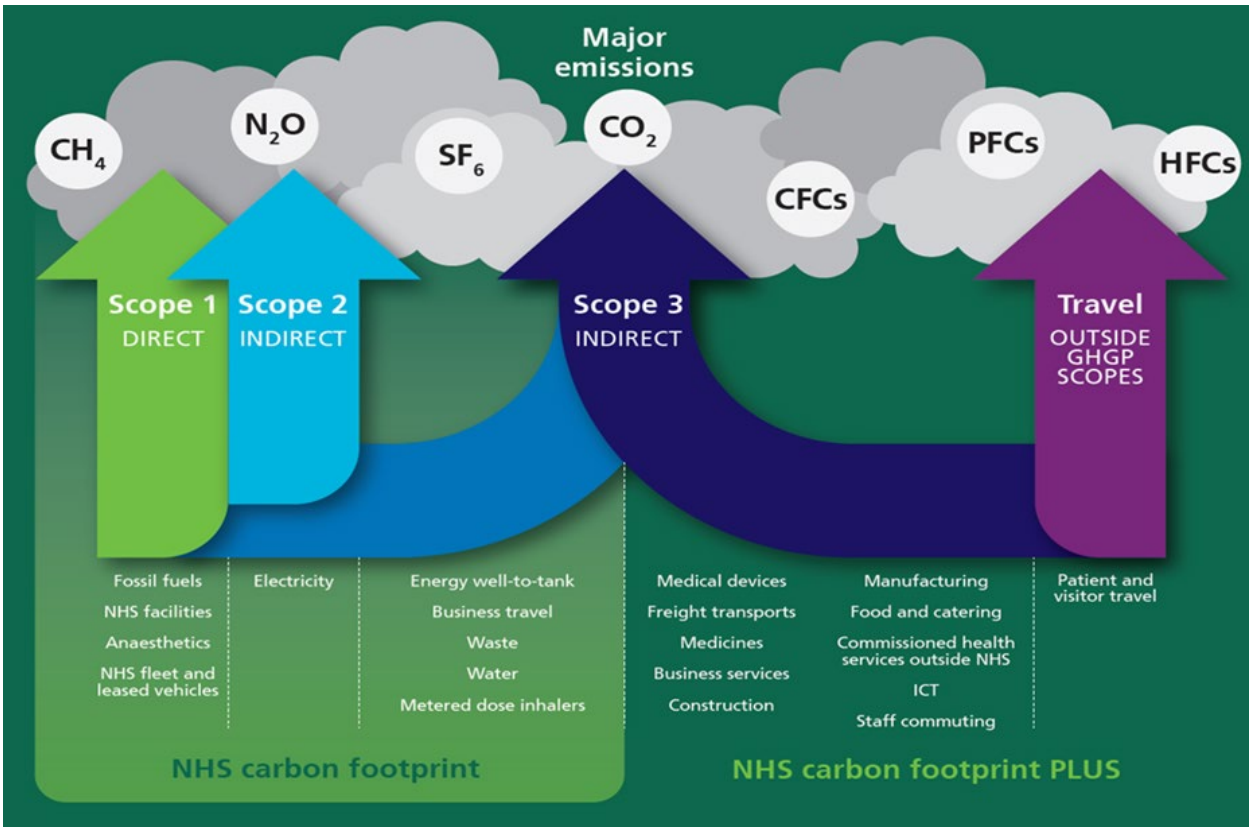


Figure 1: Scopes of NHS Carbon Footprint & NHS Carbon Footprint Plus

first year from which an accurate and reliable dataset pertaining to energy and resource consumption could be obtained by the Trust. Prior to 2013/14, data pertaining to the aspects within the Trust's carbon footprint was not readily available and, tracing further back into the early 2000s and 1990s, credible carbon conversion factors for these years were not (and have still not) been explored or published by UK Government and/or other organisations who are now involved in undertaking this work.

Consequently, it is not possible to understand with accuracy or in detail what an organisation's carbon footprint likely was in the year of 1990, and this has posed challenges for NHS trusts in being able to determine the progress they have been making against the mandatory 80% reduction targets above.

For example, Leeds Teaching Hospitals currently uses its historical 2013/14 baseline year to determine the progress it is making against its NHS Carbon Footprint target of an 80% reduction by 2032. However, an 80% reduction from the 2013/14 baseline year suggests the trust should be achieving an annual carbon footprint of 18,875 tCO2e by 2032. With a carbon footprint for 2025/26 which currently totals 55,717 tCO2e, this means the trust needs to reduce its carbon footprint by an additional 36,842 tCO2e in the next six years to meet the legislative milestone target.

In using a baseline year 2013/14, which is 23 years later than 1990 (the year against which the 80% reduction target applies), and in consideration of the carbon emission forecast modelling, this report argues that the Trust is currently aiming for a 2032 carbon reduction target which is neither feasible nor necessary.

To address the challenges faced by NHS trusts in monitoring against and meeting their respective 80% carbon reduction targets, NHS England has now undertaken work to determine a suitable baseline year for trusts, based upon the UK's nationally mandated 1990 baseline reporting year, which enables for a level of standardisation amongst healthcare providers. The NHS's Green Plan Support Tool, accessible on the NHS's Federated Data Platform, establishes the following carbon reduction targets, equivalent to a 1990 baseline:

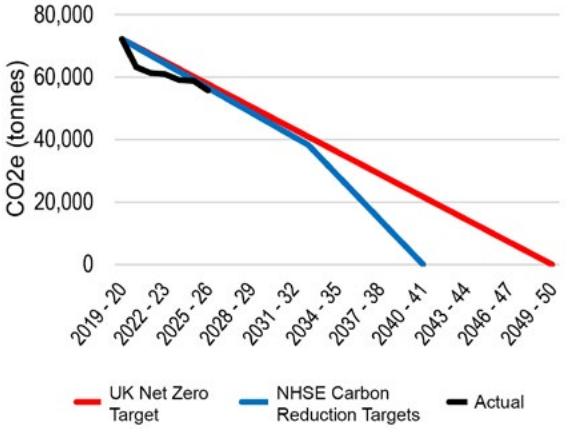
1. Reduce NHS Carbon Footprint emissions by 47% by 2032 (from a 2019/20 baseline).
2. Reduce NHS Carbon Footprint Plus emissions by 73% by 2038 (from a 2019/20 baseline)

Carbon Footprint (Scope 1 & 2 Emissions) – Progress against LTHT/ NHSE baseline years.

Year	Target Emissions Reductions (%)	Target Emissions Reductions (tonnes CO2e/annum)
2013/14 (LTHT baseline)	0%	94,375
2019/20 (NHSE revised baseline)	0%	72,168
2025/26	**41% (reduction vs LTHT baseline)**	**55,717 (current total)**
2025/26	**40% (reduction vs NHSE baseline)**	**55,717 (current total)**
2032/33	47% (reduction target for NHSE Carbon Footprint emissions from a 2019/20 baseline)	38,249 (on track to achieve target)
2040/41	100% (reduction target for NHSE Carbon Footprint emissions)	0% (off track – expected to achieve 16,211 with key interventions delivered)

The graph below has been developed, considering these newly established baseline years, to provide a fairer and more accurate assessment of the progress that Leeds Teaching Hospitals is making on its mandatory 80% carbon footprint reduction target. The graphs have taken the Trust's carbon footprint as reported by the Trust in 2019/20 and have re-adjusted the carbon reduction target trajectory in line with what the trust is reasonably expected to achieve by NHS England. With a carbon baseline of 72,168 tCO2e in 2019/20, the graphs show that not only is the Trust currently in line with the NHS carbon reduction targets, but that it is also expected to achieve an annual carbon footprint of 38,249 tCO2e by 2032 (a 47% reduction). With a 2025/26 carbon footprint totalling 55,717 tCO2e, a further reduction of 17,468 tCO2e is therefore expected over the next six years for the Trust to be able to meet the 2032 target. This is a significantly lower, more achievable and far more justified carbon reduction target for the trust to aim for and should be used to provide assurance to the relevant regulators and stakeholders should questions be raised on the trust's carbon reduction progress.

LTHT Carbon Emission Reduction Forecast against a Re-aligned Baseline year



Carbon Footprint PLUS - progress against targets

At this time, the Trust has not started to calculate or report on its NHS Carbon Footprint Plus emissions. The enabler would be for the Trust to undertake an assessment of its supply chain based carbon reduction progress against the 2038 target cited above, although this cannot be made with a great deal of accuracy. However, carbon foot printing work undertaken by the NHS national team has determined the Trust's 2019/20 Carbon Footprint Plus to total 320,436 tCO2e. This would mean that the Trust is expected to achieve an annual Carbon Footprint Plus of 86,518 tCO2e by 2038 (a 73% reduction). With a 2024/25 Carbon Footprint Plus totalling 317,275 tCO2e, a further reduction of 230,757 tCO2e is therefore expected over the next 12 years for the Trust to be able to meet the 2038 target. The scale of progress required on the Trust's Carbon Footprint Plus requires further detailed analysis, with a level of urgency to ensure the nationally mandated reduction targets are met. A good exercise for the Trust to undertake is to engage with its largest suppliers to present the carbon reduction targets needed to achieve and request the support of the supply chain in meeting these.

Year	Target Emissions Reductions (%)	Target Emissions Reductions (tonnes CO2e/ annum)
2019/20	0%	320,436 (NHSE revised baseline)
2025/26	**1% (reduction vs NHSE baseline)**	**317,275 (current total)**
2038/39	73% (reduction target for NHSE Carbon Footprint Plus emissions from a 2019/20 baseline)	86,518 (target)
2045/46	100% (reduction target for NHS Carbon Footprint Plus emissions)	0 (target)

To ensure assurance can be provided to stakeholders on progress being made against the NHS's interim reduction targets, an action has been taken for the re-alignment of the Trust's baseline year to 2019/20 (as equivalent to 1990).

The Green Plan 2025-28

The new revised version of the Green Plan (www.leedsth.nhs.uk/wp-content/uploads/2025/08/LTHT-Green-Plan-2025-28.pdf) outlines the Trust's goals and objectives to reduce our carbon emissions and contribution to climate change, alongside improving our overall sustainability performance. Significant progress has been made to date; the current version will guide our sustainability direction until 2028.

The Green Plan sets out the Trust's vision for carbon reduction and sustainable development, accompanied by a comprehensive action plan that is designed to prioritise and deliver our strategic sustainability objectives. The 2025 Green Plan focuses on nine key focus areas which are aligned to the Greener NHS Delivering a Net Zero Health Service guidance.

Content of the Green Plan

- The Green Plan outlines how the Trust will contribute to the NHS's overall net zero goals.
- Detail actions and timescales for reducing emissions, aligning with the national trajectories set out in the Delivering a Net Zero National Health Service report.
- Identifies specific clinical areas for focus and implement quality improvement projects to reduce emissions, with a focus on measurable outcomes and benefits to patient care.
- Addresses how the Trust will adapt to the impacts of climate change.

Nine Focus Areas

1. Workforce & System Leadership	Our approach to engaging, developing, and supporting our workforce and system leaders to learn, innovate and embed sustainability into everyday actions.
2. Net Zero Clinical Transformation & Medicines	Our approach to ensuring high-quality, preventative, low-carbon care is provided to patients at every stage, including reducing "point of use" emissions whilst improving patient care and reducing waste.
3. Digital Transformation	Our approach to prioritising sustainability in the procurement, design and management of digital services and harnessing technology and systems to streamline service delivery, optimise resources and reduce carbon.
4. Travel & Transport	Our approach to working to reduce carbon emissions from travel and transport through the provision and promotion of sustainable travel modes, while providing cost saving and health benefits.
5. Estates & Facilities	Our approach to reducing the carbon emissions arising from the organisation's buildings, infrastructure, and facilities, including sustainability considerations for capital projects, waste, and utilities.
6. Biodiversity & Greenspace	Our approach to improving the quality, quantity, and access to our greenspaces, and improving our monitoring of biodiversity across the estate.
7. Supply Chain & Procurement	Our approach to embedding circular solutions, such as using reusable, remanufactured or recycled solutions by engaging with our suppliers on our sustainability and net-zero commitments.
8. Food & Nutrition	Our approach to delivering high-quality, healthy, and sustainable food and minimising waste.
9. Adaptation	Our approach to collaborating with our partners to build resilience and adaptation into business continuity and longer-term planning to avoid climate-related service disruption.

The Green Plan is complemented by a Greener Care Plan. This was developed by our Clinical Sustainability leads, aimed at clinical teams, and creating/developing Greener Care Pathways (in support of the Trust strategic commitment to Sustainability for 2025/26).

The Strategic Sustainability Group (SSG) continues to oversee the implementation of the Green Plan. Over the past year, the group has supported colleagues to advance initiatives across the key focus areas.

The Sustainable Action Plan

The Green Plan is underpinned by the Sustainable Action Plan (SAP), a comprehensive list of actions for each of the nine focus areas. The original 245 actions have been rationalised into a SMART action plan, developed through extensive colleague engagement to increase accountability, understand the opportunities for improvement and identify best practices which can be scaled up across the Trust.

There has been significant progress, with some milestone achievements in our sustainability maturity as a Trust. There are a number of actions which need additional support, especially those related to biodiversity and adaptation, areas which are undergoing development. The Trust is actively working to increase engagement in biodiversity and will be issuing its first Climate Change Adaptation Plan in 2026, therefore, ensuring balanced progress across the SAP nine key focus areas.

Sustainability initiatives

Over the past 12 months, we have achieved numerous milestones through our actions to improve accountability and engagement across the Trust. The highlights include:

- Published our revised Green Plan (2025-28)
- The Trust is Bronze accredited by the Carbon Literacy Organisation
- The launch of our newly published clinically focused 'Greener Care Plan'
- We have developed an Introduction to Greener Care – 30-minute training session
- Greener Care Network was launched in April 2025 & holds meetings every month with featured topics and speakers
- The Environment team successfully presented at the Trust's Waste Reduction Planning Conference, focusing on financial sustainability (carbon & cost reduction benefits)
- National leaders in decommissioning piped nitrous oxide

Estates decarbonisation

The heat decarbonisation progress achieved to date has been enabled through external grant funded Government schemes, such as the Public Sector Decarbonisation Scheme (PSDS) and the Department for Energy Security and Net Zero (DESNZ).

The Trust has been successful in bidding to secure c. £30m over the past five financial years and has delivered complex infrastructure projects, receiving national recognition for their innovation and progress towards net zero.

As part of our estate's decarbonisation efforts, the current grants have been secured:

- Public Sector Decarbonisation Scheme 4 grant funding value of £6.5m secured for a 2-year project running from 2025-27, which will connect Bexley Wing and the Education Training & Development Centre to the St James low-carbon heat network, further progressing the decarbonisation of the estate.
- Department for Energy Security and Net Zero 2025 energy efficiency grant funding value £1.3m secured to install low energy LED lighting at St James's and Wharfedale Hospital. The upgrades include 3,444 light replacements across both sites, expected to make savings of £262,000 / 373 tCO2e each year.

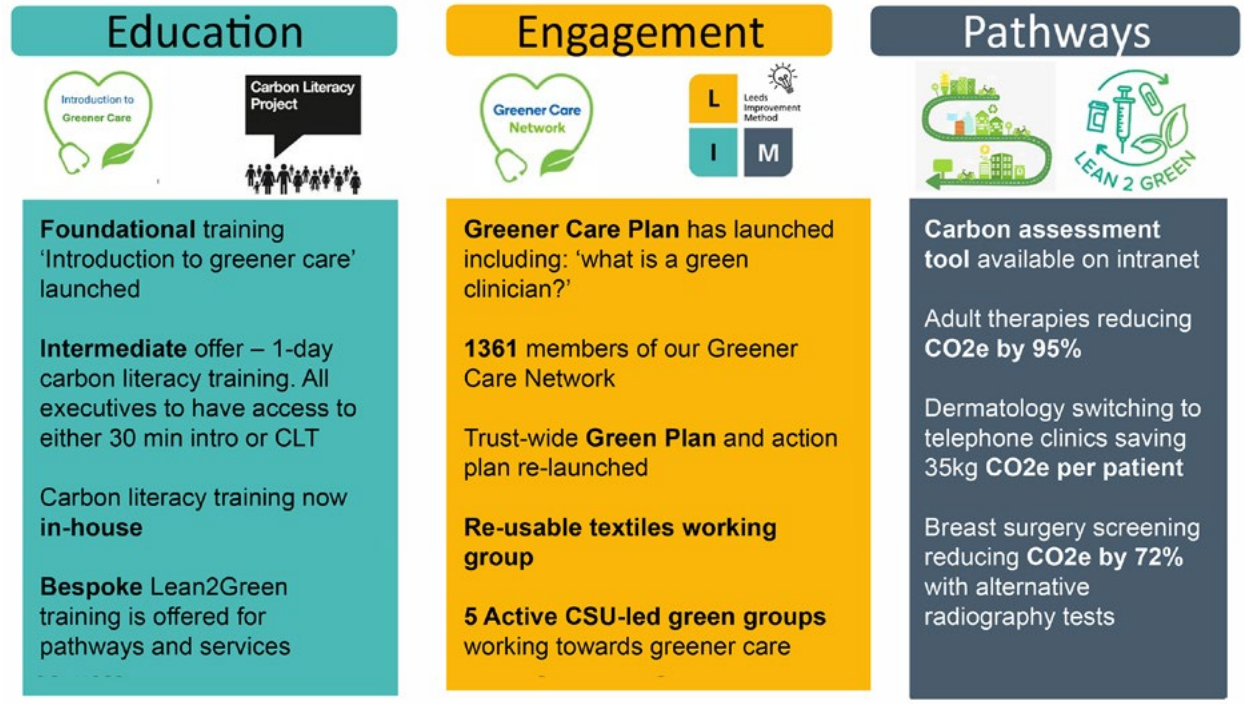
Sustainability and Lean 2 Green - Reducing our carbon footprint through greener patient pathways

Early in 2024 the first sustainability commitment was launched by the Trust with the Leeds Improvement Method (LIM) as a key driver for greener care. By aligning improvement activities with our organisational priorities, we have strengthened our commitment to reducing our carbon footprint through greener care. Using the LIM, our teams have delivered impactful, sustainable improvements. The Lean 2 Green (L2G) team is well established and remains at the core of this commitment delivery, through providing specialist support, facilitating training, and scaling sustainability solutions and improvement capability across the organisation. The L2G team breaks down traditional silo working and has multi-disciplinary collaboration at the heart of its ethos.

Key achievements to date:

- Development of a Greener Care Assessment Tool
- 1352 tonnes of CO2e & £555,323 saved in various projects (2024/25)
- 108 tonnes of CO2e saved in various projects (2025/26)
- Partnership with Leeds City Council to recycle mobility aids (received a national Keep Britain Tidy award)
- Ongoing collaboration with University of Leeds
- Clinical leadership & future leaders' clinical fellow

2025-26 Progress



2025-26 Metrics

Greener care Metrics	Baseline	Target	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	% Change
Pathway 1 - Dermatology	54.2Kg co2e per patient	<co2e/£	36.16kg	18.8kg	18.8kg	18.8kg	66%
Pathway 2 - Breast Surgery screening (radiology tests)	31.05kg per patient	<co2e/£	8.8kg	8.8kg	8.8kg	8.8kg	72%
Pathway 3 - Adult therapies - vascular amputees/home visits	31kg per patient	<co2e/£	1.5kg	1.5kg	1.5kg	1.5kg	95%
Pathway 4 - Diagnostics	Inpatient SJUH US groin = 1851 kg	<co2e/£	1851kg	1851kg	1240kg	1240kg	67%
Pathway 5 - Children's chemo home delivery	27.05 kg per patient	<co2e/£	27.05kg	0.88kg	1.06kg	1.06kg	96%
Increase the overall number of colleagues trained in carbon literacy	150 (24/25)	450 (25/26)	168	175	200	235	-
Trial new intro to greener care - 30 min session	0	100%	0	0	36%	100%	
Launch new network and increase the number of greener care network members	180	250	1330	1334	1368	1361	
Reduce trust paper use task and finish group	37 million sheets / Co2e	<10%	TBC	TBC	33 million sheets	33,831,000	6%
Carbon savings ** from greener projects known about across the trust in 2025	Running total of all known/measured projects					108.2 tonnes co2e (exc. training offset)	

** Estimated savings based on trust assessment tool

Aims and objectives for 2026/27

Implement the new SMART Sustainable Action Plan

To successfully implement our current Board approved Green Plan (2025-28) and associated Sustainable Action Plan (SAP), the Trust requires clear Executive accountability, operational ownership, and structured engagement across all nine key focus areas of the Green Plan. Leeds Teaching Hospitals has a well-established sustainability structure, operating several strategies under the Green Plan:

- Workforce
- Greener Care Plan
- Digital
- Travel Plan
- Estate Decarbonisation Strategy
- Climate Change Adaptation Plan

The Environment team Estates & Facilities will continue to work collaboratively with:

- Quality Improvement (QI) Specialist
- Clinical Sustainability Leads
- CSU leadership

All improvement activity is underpinned by the Leeds Improvement Method (LIM), ensuring measurable, waste-reducing, quality-improving interventions aligned to Trust strategic priorities.

To deliver net-zero by 2040, the Trust must move from strategy to structured implementation, with the agreed executive sponsorship and operational accountability. This will support the embedding of sustainability into the day-to-day business operations.

The key to success will be our workforce - through awareness and engagement we will support key stakeholders to understand the role they play individually and within their services.

Reaching net-zero by 2040 will require bold decisions and system-wide change, enabled through a whole-Trust transformation programme.

With clear Executive sponsorship, structured operational delegation, and Leeds Improvement Method-based performance tracking, the Trust can maintain itself as one of the greenest NHS trusts in the UK – delivering environmentally sustainable, financially responsible, high-quality care for the communities we serve.

Greener Care Pathways

A Greener Care Assessment Tool is now available to support frontline colleagues to understand the carbon footprint of their services and explore service improvements through the implementation of sustainable processes, supported by The Greener Care Network, a forum which enables grass-roots improvement, sharing of good environmental practices and innovation/research into sustainable healthcare.

Throughout 2025/26 we have strengthened our collaboration with health and care system provider partners, the NHS West Yorkshire Integrated Care Board (ICB) and Board level Net Zero leads by sharing our objectives, challenges and best practices, and identifying opportunities for scaling improvement initiatives beyond our organisation.

Through our Trust commitment to Sustainability, we aim to further embed a culture of continuous improvement, ensuring our staff have the tools, knowledge, and support to drive greener care and sustainable change across the organisation, actively supporting our Trust objectives to improve the health of the local population by delivering our agreed shared 'place-level' priorities and establishing a sustainable neighbourhood health service for our local communities.

New documents to be published in 2026/27

- Estates Decarbonisation Strategy (Phase 2 - 2026-29)
- Climate Change Adaptation Plan (2026-29)
- Travel Plan (2026-29)

Conclusion

In the 2025/26 financial year, the Trust recorded a total of 55,717 tCO2e emissions, representative of approximately a 40% reduction with a 2019/20 carbon baseline of 72,168 tCO2e. This provides assurance that not only is the Trust currently in line with the NHS carbon reduction targets, but that it is also expected to achieve an annual carbon footprint of 38,249 tCO2e by 2032 (a 47% reduction).

This indicates a high level of success in our recent emissions reduction efforts, highlighting the need for continued action in 2026-27 to remain on track with our net-zero targets. Progress has been supported by a combination of decarbonisation projects and the completion – either fully or partially – of carbon reduction measures outlined in the previous Green Plan. These initiatives continue to contribute positively toward our long-term net-zero targets.

One key area in which progress has been made when comparing 2025-26 to 2024-25 is in natural gas consumption (the largest proportion of our scope 1 emissions), which has recorded a reduction in emissions from this source over the past year of 1,547.02 tCO2e, highlighting the sustained effort in the delivery of complex infrastructure heat decarbonisation projects delivered by Estates and Facilities. Additionally, a key area of progress across the year, when compared to 2024-25 has been in anaesthetic gas use (scope 1 emissions). This is shown by a reduction of 667.93 tCO2e over the year from this source, highlighting successful work in decommissioning piped nitrous oxide, further decarbonising clinical care.

To ensure further progress is made during 2026-27 and the Trust returns to its trajectory for reaching net-zero by 2040, the Trust continues to require substantial funding and sustained investment and support, particularly

in areas such as Estates and Facilities, to enable a reversal in the rising emissions from sources including natural gas, non-clinical waste and electricity consumption. Moreover, to ensure assurance can be provided to stakeholders on progress being made against the NHS's interim reduction targets, this report advocates for the re-alignment of the Trust's baseline year to 2019/20 (as equivalent to 1990).

The Trust remains committed to its net-zero targets and will continue to embed sustainability across all areas of the organisation, seeking funding opportunities where possible. The Trust is confident that the existing and planned decarbonisation projects, once implemented, will be successful in ensuring the targets are met, and the 2026-27 carbon footprint more accurately represents the progress the Trust is continuously seeking to make. However, the delivery of these targets is contingent upon the drawdown of significant funding to implement the estates decarbonisation strategy. The future clinical strategy, and allocation of funding for decarbonisation projects, remains the biggest risk to the ability of the Trust to meet future net zero targets.

1.9 Task Force on Climate-Related Financial Disclosures (TCFD)

The Task Force on Climate-related Financial Disclosures (TFCD) is a framework for reporting climate related financial risks and opportunities and is being implemented in a three-phase process for all NHS trusts. 2025/26 is the final year of the three-year implementation period of the TCFD, and within a publication by NHS England, the TCFD report is now an annual report requirement. This requirement asks that NHS trusts describe how operations, strategy and financial planning are being affected by climate change.

Four thematic areas of the TCFD

In line with these annual reporting requirements, the Trust has produced its Phase 3 report, outlining its exposure to climate-related risks, opportunities and implementation of the TCFD's four pillars.

Governance

The Trust complied with the TCFD recommendations and disclosure requirements of the governance pillar for 2023/24 and 2024/25, and now set out its compliance with the 2025/26 requirements. A statement of the Trust's alignment with TCFD has been included within the 2023-24 Annual Report, further updated and expanded for the 2024-25 Annual Report and includes detailed disclosures regarding the Trust's governance of climate issues. The Trust has a clearly defined governance structure in place for climate-related issues, ensuring accountability for managing climate-related issues and successful implementation of the Green Plan 2025-28. The Green Plan is overseen at an executive level by the Trust's Executive Director of Estates & Facilities, who is a member of the Board.

The Trust operates a Strategic Sustainability Group (SSG) which meets bi-monthly. The SSG is formed of leads from across the Trust and reports progress on decarbonisation and net-zero into the Infrastructure Management Committee, which in turn provides an annual update and an annual sustainability report to the Trust Board, measuring progress against strategic milestones. Key actions relating to sustainability, climate change mitigation and adaptation are identified, considered, and managed via the Trust's Sustainable Action Plan (SAP). This details the thematic aims, objectives, and tactical interventions the Trust is taking as part of the Green Plan 2025-28, and members of the SSG have been assigned

as accountable leads for the different actions contained within this SAP. This year, the Trust's SAP has been redeveloped to include a SMART measurement system, so that tangible progress against specific interventions contained within the plan can be reviewed and tracked with greater accuracy. The Trust regularly reports progress against this action plan and towards our net-zero carbon targets to the Board.

Actions, along with their respective goals and targets, are embedded within the Green Plan 2025-28 and SAP which is regularly reviewed, and progress recorded at least bi-monthly. The Green Plan is reviewed and updated with approval from the Board once every three years in line with the timescales of NHS England, and in line with the relevant Green Plan guidance, in which updated governance arrangements for sustainability are included. We also provide the board with a year-end carbon performance report, which is independently validated by a third-party sustainability consultancy against NHS England's Carbon Footprint methodology.

Management plays an active role in assessing and managing climate-related issues. All internal managers are responsible for ensuring environmental and sustainability policies are accessible to their teams and actively incorporated within operations. Additionally, all accountable sustainability leads are represented at the SSG. All Leeds Teaching Hospitals employees are responsible for working to reduce the impact their individual actions have on the environment and carbon emissions associated with the Trust. The 'Lean to Green' team, formed of sustainability colleagues, quality improvement specialists, and clinical sustainability leads, has been operating for several years and work to convene the Trust's Greener Care Network (GCN), a wide pool of engaged staff who work to deliver various sustainability projects related to the carbon reduction of the Trust's clinical services. Monthly Estates & Facilities Finance and Performance reports are presented to the Executive Director of Estates & Facilities, providing a strategic overview of the SAP, performance against carbon targets, and colleague participation with the Trust's colleague engagement programme. Annual reports on sustainability progress are also developed and submitted to the Trust Board and Infrastructure Management Committee.

In acknowledgement to the escalating threats posed by climate change, as illustrated by climate scenarios and projections of global scientific bodies including the Intergovernmental Panel on Climate Change (IPCC), the Trust has produced a Climate Change Adaptation Plan (CCAP). The CCAP, to be published in 2026, will be overseen by senior-level sponsor and Chief Operating Officer, and will list a range of measures the Trust can take to enhance its long-term resilience to climate change. A Climate Change Preparedness Group (CCPG) has been established to proactively implement this plan, addressing and adapting to the challenges posed by climate change as they relate to business continuity and emergency planning, and facilitating the reporting of progress on adaptation up to the Board. The CCPG meets on an interim basis when capacity allows, and plans are underway to re-mobilise with a fixed schedule this calendar year. The CCPG reports to the Emergency Preparedness Coordinating Group (EPCG), which, in turn, reports to the Risk Management Committee. This group is co-chaired by the Clinical Director for the Operations Centre and the Director of Operations. The group includes representatives from key departments, ensuring a holistic approach to addressing climate change challenges.

The Trust also has an Adverse Weather Plan which is updated annually and provides a framework for how the Trust will respond to various adverse weather events, with different rankings. When an adverse weather event occurs, warnings are sent to the Trust to be reviewed by the Emergency Preparedness, Resilience & Response (EPRR) team. Actions taken on these risks are reported and discussed at the Trust's Corporate Operations group which meet once a fortnight and is chaired by the Trust's Chief Operating Officer. The risks posed by more immediate climate-driven extreme weather events are identified, monitored and managed by the Trust's EPRR team.

The Trust's governance structure ensures continual progress is made against the Trust's sustainability objectives and enables necessary steps to be taken towards net-zero targets. The Trust continues to provide transparent and validated reporting on our impacts, with a standing sustainability section included in the Trust's annual report.

Strategy

Leeds Teaching Hospitals has aligned with the TCFD recommendations and disclosure requirements of the strategy pillar for 2025-26. We have identified the climate-related risks and opportunities for the Trust over the short, medium and long-term, including actual and potential impacts of a range of climate-related risks and opportunities.

The Trust currently considers climate-related risks in the short-term up to 2040, medium-term up to 2060, and long-term up to 2080. We also look at current risk based on a 0-3 year period. In acknowledgement that projections of long-term climate change often extend beyond 2080 and up to 2100 in the worst-case scenario, we will work to expand our perception of risk across this period, where possible, to ensure preparedness on climate risks and opportunities into the future.

Aligning with the timescales above, the Trust has analysed the local climate adaptation tool to identify climate risks and opportunities relating to each weather variable (heat, rainfall, etc). The tool is used for local authority areas and is categorised by local authority boundary. The table below shows the modelled changes in temperature, rain, wind and cloudiness under the RCP 6.0 scenario (equivalent global warming of 2.0-3.7°C) expected under existing global policies for Leeds. All values given are subtracted from the scenario year from 1980, for example, a '+0.02' value is an increase of 0.02 from 1980 to 2050, not an increase from 2040 to 2050.

Changes in weather variables from 1980 baseline to defined time-periods under RCP 6.0 scenario (yearly)

	Short term (2040)	Medium term (20260)	Long term (2070)
Temperature °C	2.01	2.39	2.99
Rain (mm/day)	0.01	0.02	-0.14
Wind (m/s)	-0.05	-0.19	-0.1
Cloudiness (W/m^2)	15.15	18.12	20.67

Note: this tool only provides data up to 2070, therefore this has been included for the long-term.

This table shows that temperature is consistently rising and this will pose a multitude of risks to Trust operations and sites through heatwaves, droughts and higher summer temperatures. Weather variables such as rain and wind are more difficult to predict given they are influenced by atmospheric dynamics; however the Trust has considered the risks of increased frequency of severe storms and flooding. These weather events and their impact on Trust assets have been investigated in detail within the Trust's Climate Change Risk Assessment (CCRA) and within Trust risk registers.

According to the Climate Central Coastal Risk screening tool's projections of sea level rise and annual coastal flood risk, in the short, medium and long-term, risk to the Leeds area is not expected. This extends to 2100 in which risk of coastal flooding is not shown. Risks relating to coastal flooding and erosion (perturbed by climate change) have been included within the Trust's CCRA.

We have also explored past extreme-weather events, reviewing logged hazard events back to 2015. These showed cases relating to cold weather, downpours and flooding, heatwaves and high temperatures and droughts. As a result, the most likely climate-related risks to potentially arise in the area in the short, medium and long-term are those relating to heatwaves and high temperatures, cold weather, downpours and flooding, and severe weather.

The Trust has produced a bespoke Climate Change Risk Assessment Tool (CCRA) to help identify climate-related risks to our sites, operations, and impact on healthcare delivery and has highlighted opportunities to implement adaptation measures to ensure continuity of our services during extreme weather periods and events. Collaboration was required on the tool and required input from estates, digital and sustainability teams. The tool is based on the NHS (CCRA) tool.

Within the CCRA, the Trust has analysed a variety of resources to help determine which risks and opportunities could have a material impact. We analysed the different resources referenced within the CCRA tool, including

the Met Office climate change visualisation tool; UK climate risk indicator tool; Met Office integrated data archive system; UK climate risk, evidence for the third UK climate change risk assessment document; local climate adaptation tool; gov.uk's long-term flood risk for areas in England document; and climate central's coastal risk screening tool, and reviewed past climate-related hazard events which have impacted the Trust.

In alignment with the climate-related risks addressed in table A1.1 of the HM Treasury application guidance, the Trust acknowledges the following risks relevant to the entity:

- Policy and legal risks, including increased pricing of greenhouse gas emissions and enhanced emissions reporting obligations, leading to increased operating costs.
- Technology risks, including substitution of existing products with lower emission alternatives and costs of transitioning to lower emission technology, leading to reduced demand for products and services and capital investment costs.
- Market risks, including increased costs of raw materials, leading to increased costs of utilities.
- Increased severity of extreme weather events, including flooding and heatwaves, leading to negative impacts on workforce.
- Changes in precipitation patterns, rising mean temperatures, and rising sea levels, leading to increased operating costs.

In alignment with the climate-related opportunities addressed in table A1.2 of the HM Treasury application guidance, the Trust acknowledges the following opportunities relevant to the entity:

- Resource efficiency including that of modes of transport, buildings, utilities and resources, leading to reduced operating costs. This could be through promoting active transport, reducing water consumption and retrofitting buildings.
- Energy source utilisation, including use of low-emission energy sources, leading to reduced operational costs, reduced exposure to imported fossil fuel price increases and reduced exposure to GHG emissions. This could be by implementing new technologies (such as solar, wind) and using lower-emission sources of energy (biogas).
- Resilience through participation in renewable energy programmes, leading to increased reliability of supply chain. This may be through participating in renewable energy programmes, adoption of energy-efficiency measures and resource diversification.

The Trust has identified climate-related opportunities within table A1.2 of the TCFD disclosure framework and has undertaken works to investigate utilising energy sources and resources. The Trust has made several energy efficiency and sustainability improvements, including:

- The development of a pathology building at St. James's University Hospital which is fully electrified and powered by the CHP unit.
- The development of a low-carbon heat network, with a connection to the Leeds PIPES district heat network and heat generated from renewable and low-carbon sources.
- The development of on-site low-carbon technologies, installation of double-glazing, roof replacements and air source heat pumps.

The key climate-related issues impacting the Trust have been identified as heatwaves and high temperatures, downpours and flooding, severe weather and cold weather. In response to tackling climate-related issues, the Trust intends to bring up to date and publish its Climate Change Adaptation Plan (CCAP) in which our CCRA has been used to identify specific actions which can be taken to address the risks identified. The CCAP will support the Trust's Green Plan and focus on building resilience against climate impacts from extreme weather events, such as floods, heatwaves and cold weather.

The Trust has considered the potential impact of climate-related risks and opportunities on its operations, strategy and financial planning across the short, medium and long term under a global warming pathway of 2°C or lower, in line with HM Treasury TCFD application guidance. These considerations have been informed by outputs from the CCRA tool, the Trust's risk management processes, and regional climate projections.

Outputs from the CCRA indicate that the most relevant climate hazards affecting the Trust's operating environment include heatwaves and high temperatures, periods of prolonged cold weather, and heavy rainfall and flooding. In addition, this CCRA tool has considered drought, wildfires, storm and wind events, mass movement, air pollution, indoor environmental quality and health, outdoor airborne allergenic pollen and fungal spores, infectious diseases, new vector borne diseases and disruption to food supply. These hazards may affect several organisational elements that support the delivery of healthcare services, including service demand, estates and infrastructure, supply chains and procurement, workforce wellbeing, and financial planning.

The CCRA categorises impacts into broad categories of patients, staff, visitors, buildings and equipment, essential supplies and utilities, demand for healthcare services, transport and site access, and essential services and emergency systems. The CCRA tool has a comprehensive list of detailed impacts which apply to each impact category, with a description on how the impact applies to different assets of the Trust.

The CCRA found the following impacts for each category produced by climate events in the short, medium and long-term scenarios of a 2°C warming (please note, this list is not exhaustive):

Colleagues:

- Heatwaves and high temperatures shall impact colleagues due to increased ward temperatures creating difficult working conditions and increased strain due to volume of patients.
- Colder temperatures increase strain on colleagues due to increased demand for services resulting from cold weather-related illness and covering of staff unable to get to work.
- Storm and wind events could make it difficult for colleagues to get to work, creating risks to health and safety when commuting to work. This would then increase pressure and workload of remaining members of colleagues.
- Indoor environmental quality and health implications will increase patient volumes Trust-wide.
- Outdoor airborne allergenic pollen and fungal spores will increase in patients suffering negative health impacts from outdoor airborne allergic pollen.
- Colleagues are equally vulnerable to health problems as the public (physical and mental), so rising cases of infectious diseases will increase staff absence and leads to increased workload for other colleagues, affecting staff wellbeing.
- Colleagues will require training on new infectious diseases, increasing workload. This may lead to more staff absence and an inability to maintain workforce due to less desirable working conditions.

Patients:

- Heatwaves and high temperatures will impact vulnerable patients at high risk of high temperatures. This could lead to increased patient mortality and create reputational risks.
- Cold weather will reduce access to patients off-site leading to appointment cancellations and delays.
- Storm and wind events could delay emergency services from reaching patients leading to disruption to emergency care.
- Air pollution aggravates existing respiratory conditions of patients.

Demand for healthcare services:

- Heatwaves could cause damage to larger IT services such as computer servers, cascading impacts to communication methods or patient records.
- Increased cases of cold weather will increase attendances of those groups whose health is affected by cold weather and increases likelihood of injury arising from slips, trips and falls.
- Long-term health issues are exacerbated by lack of water. This will lead to increased demand for healthcare services and increased workload for colleagues.

- The health effects of flooding including injury, infection and mental health impacts will increase patient numbers, particularly through increased mental health impacts which persist for months or years after the event.
- Wildfires create a risk of injury and smoke inhalation. This will increase patient admissions and increase volumes.
- Storms and wind events increase risk of injuries, increasing demand for emergency care.
- Mass movement will drive increases in health inequalities between populations.

Essential supplies and utilities:

- High temperatures and heatwaves can damage larger IT services, creating a potential cascade to communication methods and patient records.
- Extreme cold creates delays in delivery of supplies due to snow/ice.
- Drought creates food insecurity due to decreases in water availability.
- Flooding also creates supply chain disruptions through impacting food production and reducing transport access.

Essential services or emergency systems:

- Heat stress makes working conditions challenging in ambulances, causing service disruptions.
- Extreme cold and ice make it difficult for ambulances to operate and provide emergency care.

Transportation and site access:

- Snow and ice make it difficult for vehicles to access Trust sites.
- Extreme precipitation causes surface water flooding, also reducing ability for vehicles to reach Trust sites.

Buildings and equipment:

- High ambient temperatures impact equipment and building infrastructure.
- Old guttering and drainage systems become overwhelmed during heavy snow fall.
- Old guttering and drainage systems can't cope in extreme rainfall, creating localised flooding.

Climate-related risks and opportunities may also influence the Trust's financial planning and investment priorities. Investment may be required to strengthen estate resilience, improve energy infrastructure and support decarbonisation initiatives. These actions also present opportunities to reduce operational costs over time through improved energy efficiency, reduced energy consumption and more sustainable procurement practices.

The Trust's approach to managing climate-related risks and opportunities will take place over the identified time horizons. In the short-term, the Trust's focus is on strengthening operational resilience to extreme weather events and delivering actions set out within the Green Plan 2025-28. Over the medium-term, greater emphasis will be placed on estate decarbonisation, infrastructure resilience and sustainable procurement practices, including consideration of supply chain resilience during extreme weather events. In the long term, strategic planning will focus on ensuring that the Trust's infrastructure and services remain resilient to evolving climate conditions while contributing to net-zero targets.

Due to the Trust's inland location, risks associated with coastal flooding and erosion are considered low. However, wider climate impacts across the UK may influence population distribution and demand for healthcare services over the longer term.

Climate-related risks to the Trust are categorised into:

- Physical risks - resulting from increased exposure to climate hazards.
- Transition risks - arising from the transition away from greenhouse gas-emitting activities.

The CCRA has largely considered physical risks to the Trust's assets, colleagues, patients, operations and supply chain, as detailed above.

Outputs from our CCRA indicate that the most significant physical risks for the Trust are associated with heatwaves and high temperatures, extreme rainfall events and severe weather. These risks were identified through the CCRA as the most relevant climate hazards affecting the Trust's estates

and operations under a 2°C warming scenario and are expected to have increasing impacts on estate infrastructure, patient safety and service continuity.

In the short term, physical risks are primarily associated with acute weather-related disruptions, including heatwaves, cold weather events and heavy rainfall, which may affect service delivery, access to care and operational resilience. The CCRA assessment indicates that these risks are already present and are likely to occur with increasing frequency.

In the medium term, the frequency and severity of these events are expected to increase, resulting in greater pressure on estate performance, infrastructure resilience and service demand. The CCRA outputs highlight that risks associated with extreme temperatures and heavy rainfall are likely to become more significant over this period, particularly in relation to building performance, supply chain reliability and impacts on vulnerable populations.

In the long-term, physical risks are expected to become more systemic, with sustained changes in climate conditions affecting the long-term resilience of infrastructure, increased cooling and energy demands, and ongoing pressures on healthcare services. These risks may require significant adaptation measures to ensure the continued delivery of safe and effective care.

Transition risks are primarily associated with national policy and regulatory requirements relating to decarbonisation and environmental sustainability. The Trust is required to reduce direct emissions to net-zero by 2040, and indirect emissions, including those associated with the supply chain, by 2045, in line with NHS net-zero targets.

In contrast to physical risks, transition risks are expected to materialise more significantly in the short to medium term, driven by policy, regulatory and market changes. In the short term, this includes requirements to develop and implement decarbonisation plans and meet interim emissions reduction targets. In the medium term, transition risks may increasingly affect procurement and supply chains, as suppliers are required to meet emissions standards and adapt to new regulatory requirements. In the long term, these risks are expected to stabilise as decarbonisation becomes embedded across the healthcare system.

The Trust has used the CCRA tool to evaluate potential climate risks across its estates, operations and supply chains under a 2°C warming scenario. This assessment identified extreme temperatures and heavy rainfall events as the most likely and impactful physical climate hazards affecting the Trust's operational environment, with risk levels increasing over time. These findings support the Trust's assessment that physical risks will become more significant over the medium and long term, while transition risks will be most prominent in the short to medium term.

Risk management

Leeds Teaching Hospitals has aligned with the TCFD recommendations and disclosure requirements of the risk management pillar for 2025-26. The Trust systematically identify, assess and manage climate-related risks and integrate them within the Trust's overall risk management framework. The Trust operates several risk registers on which high-level risks pertinent to the organisation have been identified and are tracked.

The Trust's Estates and Facilities risk register contains a risk specifically related to the (non) delivery of net-zero, which currently reads as follows:

- There is a risk of Leeds Teaching Hospitals being unable to achieve 80% reduction in scope 1/2 direct carbon emissions by 2032 and 100% (net-zero) by the year 2040 as is mandated by NHS England Health and Social Care Act.
- Due to the fact that the Trust does not have full visibility of its pathway/financial investment and control in the delivery of interventions.
- Resulting in possible contractual penalties being applied by NHS England (or the applicable governance body), increased financial costs, and detrimental impacts on the Trust reputation.

The risk (ID 10518) currently scores as a 12 out of 25, which reflects medium severity and likelihood of occurrence. This risk score increased from 9 to 12 when the Trust received confirmation of inclusion in the Phase 2 New Hospitals Programme in January 2025. Mitigating actions are in place to strengthen the Trust's controls over the risk. These include:

1. Regularly reviewing the Trust's Green Plan on a three yearly basis to identify market-ready innovation and emerging best practices which can be adopted into future versions of the green plan, thereby ensuring additional opportunities are factored into the Trust's potential to meet the 2040 target.
2. Regularly reporting progress on (a) the delivery of Green Plan, and (b) progress towards carbon targets to the Trust's senior leadership team.
3. Providing Board level direction and support to enable all action holders in the Sustainable Action Plan to fully implement decarbonisation interventions.
4. Implementing a Board-approved Estates Decarbonisation Strategy which provides a detailed site by site roadmap of staged costed interventions to achieve Net Zero Carbon.

Additional mitigation measures which the Trust has put in place to tackle the net-zero (non)delivery risk include:

1. Securing significant financial investment from the Public Sector Decarbonisation Scheme (PSDS) totalling £29 million over the last five years which has allowed the Trust to implement several decarbonisation schemes. These include but are not limited to the roll out of solar PV and connecting 11 buildings at St James's University Hospital to the low-carbon heat network, which has several low-carbon heat sources, including a connection to the Leeds PIPES district heat network.
2. Integrating sustainability into all business cases submitted by the Trust. All business cases should demonstrate how the proposed project or change is aligned to the Trust's Green Plan. Capital projects, depending on the value of the proposal, must demonstrate further alignment in the form of reviews by the Trust's Environment Team, to formal carbon assessments being undertaken.
3. Contracting an external sustainability consultancy, Walker Resource Management Limited (WRM) to independently assess and validate the carbon emissions of the Trust and several clinical projects.

The implementation of these risk mitigation measures over time will support the Trust with its ambition to be one of the greenest Trusts in the UK and identify the barriers/opportunities to deliver net-zero.

The Trust's EPRR risk register also contains a risk specifically related to the (non)delivery of climate change adaptation, which currently reads as follows:

> *"There is a risk of disruption caused by the effects of climate change including increases in adverse weather events (heat, cold and flooding), new diseases to the UK, supply chain disruption and water shortages resulting in suboptimal patient care, increased or additional costs and poor working conditions for staff."*

The risk currently scores as a 12 out of 25, which reflects major severity and possible likelihood of occurrence. Mitigating actions are limited by the current Trust infrastructure.

The Trust's Adverse Weather Plan was updated in May 2025 to address the planning and response requirements for Trust services for hot weather (heatwaves and high temperatures), cold weather low temperatures and snow), flooding coastal flooding, fluvial flooding and surface water flooding), severe weather warnings rain, fog, wind, thunderstorms, snow, ice and extreme heat), and drought. However, air quality and wildfires were excluded from this plan but will be considered in future iterations.

The Trust's Corporate Risk Register (ID number 386) references 'climate change which includes extreme weather events' as a risk.

The Trust's Finance Risk Register identifies the risk of Supply Chain resilience failure meaning goods and services are not available to the Trust. This specific risk highlights the risk

associated with ongoing global disruption causing rising energy, transport and shipping costs. However, this should also be applied to the global climate shocks and the impact on supply chain.

The Trust's Business Continuity Plans need to include greater detail on how priority services will be delivered during adverse weather. Our efforts have focused on putting in place several mechanisms to attempt to strengthen the Trust's controls over the risk. These include:

1. Continuing to improve our Adverse Weather Plan in line with NHS guidance.
2. Developing a new business continuity management system to support improvements and re-establish a regular validation (exercising) programme. This is reviewed on a quarterly basis by the Trust's Emergency Preparedness Coordinating Group, with an internal audit of business continuity every two years.
3. Producing a Climate Change Risk Assessment (CCRA) and Adaptation Plan (CCAP) used to focus on most likely weather events. The Trust previously commissioned external sustainability consultancy, WRM, to undertake this work. It included:
    a) A CCRA which identified a total of 60 current and potential climate change impacts and the risks these pose to the delivery of the Trust's healthcare services. The risks draw upon the UK's CCRA framework and span fourteen core categories, including heat stress, extreme cold, extreme precipitation, drought, flooding, wildfires, storm and wind events, mass movement, air pollution, indoor environmental quality and health, outdoor airborne allergic pollen, infectious diseases, new vector borne diseases, and disruption to food supply. The risks have been scored in line with the Trust's Risk Management Framework and currently score between 1/25 and 12/25. Risks have been scored more highly for the impacts which are expected to become worse over our defined short-, medium- and long-term time periods. The risks within the framework employed are also applicable on a site-by-site basis where relevant to the Trust's estate.
    b) A CCAP in which over 100 mitigation interventions have been scoped to enhance the Trust's resilience to climate change and address the risks identified. The interventions were then allocated accountable leads who are responsible for overseeing the implementation of these. Further work needs to be done to allocate higher priority actions to the CCAP's delivery timeframe.
4. Undertaking a Climate Risk Adaptation, and Resilience Assessment to identify physical vulnerabilities, plan mitigation strategies, and understand how to future-proof the Trust's estates and facilities against escalating climate risks. The Trust commissioned external engineering firm, Equans, to undertake this work. It included an audit of eight buildings across two estates; Leeds General Infirmary (LGI) and St James's University Hospital (SJUH), advanced climate modelling to predict climate scenarios, building engineering analysis, and recommended measures to adapt buildings and infrastructure. The recommendations made were aligned to industry standards, such as CIBSE thermal comfort guidelines.

The implementation of these risk mitigation measures over time will support the Trust with its ability to cope with the impacts of climate change and strengthen its business continuity/ resilience planning.

The CCPG serves as the vehicle through which progress on the implementation of the interventions detailed within the CCAP (and subsequent tackling of the risks identified within the CCRA) can be facilitated, assessed and managed. In assessing and prioritising the risks identified, an assumption has been made that the CCPG will review the risks regularly to ensure risk scoring remains accurate and reflective of the climate scenarios and projections reported by the relevant bodies. The CCRA is not a traditional risk assessment in the sense that the risk scores remain static until reduced by mitigating actions but includes informed perceptions of climate risk over short, medium, and long-term time periods to ensure risks can be proactively managed.

The organisational risks related to the delivery of both net-zero and the impacts from climate change, are assessed through the Trust risk appetite governance framework and monitored annually. The assurance regarding proactive risk management and control, reflects the seriousness with which the Trust is treating the issue of climate change.

Metrics and targets

The Trust has aligned with the TCFD recommendations and disclosure requirements of the metrics and targets pillar for 2025-26. We have disclosed and described the metrics and targets that the Trust uses to assess and manage climate-related risks and opportunities, below.

At the highest level, the Trust has committed to align with NHS England's mandatory net-zero targets:

1. To achieve net-zero for our NHS Carbon Footprint (emissions which we can directly control) by 2040, with an 80% reduction compared to 1990 figures and a 50% reduction compared to 2019 figures by 2032 at the latest.
2. To achieve net-zero for our NHS Carbon Footprint Plus (emissions which we can influence) by 2045, with an 80% reduction compared to 1990 figures and a 76% reduction by 2019 figures by 2039 at the latest.

Progress against these targets is measured using our carbon footprint, and the most recently published update of this can be found in our Green Plan 2025-28. Since the publication of the plan, we have continued to update the carbon footprint quarterly and will publish annual updates to compare against our baseline year and forecast our performance towards our net-zero targets.

The Trust does not employ internal carbon pricing, however carbon assessments and validation exercises are regularly undertaken by external consultancy WRM. Assessments undertaken by our consultants, which in turn support the appraisal and evaluation of capital projects, clinical projects and procurements, using the same metrics and methodologies employed for our organisational carbon footprint assessment as detailed within our Green Plan.

The Trust has also established multiple metrics and measures to manage and realise the climate-related opportunities detailed within the Green Plan 2025-28 and corresponding Sustainable Action Plan, and the L2G programme's work. The Trust's Green Plan is the organisation's strategy for achieving carbon reduction progress and is implemented over a three-year period. The Trust's CCAP is also based on an implementation framework. It is therefore the intention of our Green Plan and CCAP (once published) to achieve all interventions listed within these strategies within the set timeframes.

The Trust includes qualitative progress measures, indicative costs and expected emissions reductions in the Green Plan 2025-28, along with specific, measurable, achievable, relevant and time-bound actions with applicable key performance indicators (KPIs), to ensure progress can be measured against all target actions. These metrics align with the aims of the NHS's 10-year plan and therefore act as a hook-in for senior leaders and partners. Metrics are wide ranging and, by way of example, include the likes of the following for the area of workforce and leadership:

Metrics and Targets used in the trust's Green Plan

Ref	Green Plan category	10-year plan link	SMART target	Metric/Measure
1	Workforce & System Leadership	Sickness to Prevention	Deliver Carbon Literacy training to all Board members and senior leaders by April 2027	Number of leaders trained
2	Workforce & System Leadership	Sickness to Prevention	Deliver Introduction to Greener Care to 2% of 10 largest CSUs by April 2027	% of CSUs reached
3	Workforce & System Leadership	Sickness to Prevention	Expand Greener Care Network participation from 25 to 50 active attendees in the GCN meetings by April 2027	Number of active GCN attendees
4	Workforce & System Leadership	Sickness to Prevention	Increase Viva Engage channel participants from 178 to 300 by April 2027	Number of active channel members
5	Workforce & System Leadership	Sickness to Prevention	Implement Green Accreditation programme for bronze, silver and green CSUs by Summer 2026	Number of CSUs achieving each accreditation level

All targets which have been established will be reviewed and uplifted by 5-10% annually from 2027/28 onwards (once the implementation timeframe for the Green Plan has concluded).

Aligned with our targets to achieve net-zero for our carbon footprint, the Trust also has a series of milestone targets for the decarbonisation of our operational energy consumption and estate, which fall in line with our decarbonisation progress and mandated net-zero targets. These include:

1) To achieve an 80% reduction in carbon emissions by 2032 from our baseline reporting year.
2) To achieve net zero by 2040 from our baseline reporting year.

Full details of our KPIs can be made available upon request.

The Trust confirms there are no intentional differences between the targets we have set and any public announcements or reports which establish other climate-related commitments, pledges or goals, and that those actively pursued by the Trust are aligned with those visible in our organisational plans.

Signed: 

Date: 25 June 2026

Brendan Brown, Chief Executive

Section 2

Accountability

Section 2 - Accountability

2.1 Members of the Trust Board 2025/26

During the financial year 2025/26, the Board continued to hold bi-monthly formal meetings in public, held in locations across our sites. This is alongside timeout meetings throughout the year, which have been used for education, training and development sessions.

The Board delegates duties to its assurance committees, that in turn report assurance directly back to Board. Following the CQC Well-led inspection in June 2025 and publication of the report in September 2025, the Board has reviewed its assurance committees. In November 2025, following the review, the Board formally closed the Infrastructure; Research & Innovation; and Digital Informatics Committees. From January 2026, the Board established a new Committee of the Board, the Perinatal Improvement Assurance Committee, alongside existing Committees: Audit, Finance & Performance, People & Culture, Quality Assurance and Remuneration. The terms of reference for the assurance committees are cited within standing orders, with amendments to these approved at public Board meetings.

Changes in membership of the Trust Board

Dame Linda Pollard's term of office expired on 31 July 2025 having served at the Trust since 1 February 2013. The appointment of the Chair is made by NHS England (NHSE), with a new Chair, Antony Kildare, commencing in role on 1 August 2025.

As a Teaching Hospital, the University of Leeds holds a nominated Non-Executive Director position, which changed during the year, with Jane Nixon standing down as from 31 July 2025 and Professor Angela Graves commencing in role from 1 September 2025. Angela brings a wealth of skills as she is Professor in Maternal Health & Professional Education, and Head of the School of Healthcare at the University.

Andrew Greenwood was appointed by NHS England during the summer to the Non-Executive Director vacancy and commenced in role on 1 October 2025.

Two Non-Executive Directors' terms of office expired during the year; Chris Schofield, on 31 July 2025 and Phil Corrigan on 31 March 2026. Simon Le Clerc joined the Board on 22 November 2025. As part of the succession plan for the Board, Ricky Singh was appointed as an Associate Non-Executive Director from 1 January 2026 and will become the Chair of the Audit Committee in January 2027, when Gillian Taylor's terms of office expire.

Mike Baker commenced his role as Senior Independent Director from 13 June 2025 taking over from Chris Schofield as part of our succession plan.

Professor Phil Wood announced his retirement in July 2025 and stood down as the Accountable Officer on 14 September 2025. Brendan Brown took over this role from 15 September 2025, as Chief Executive facilitated by NHS England Regional Director.

Clare Smith, Deputy Chief Executive and Chief Operating Officer, announced at the start of August 2025 her successful appointment to become the Chief Executive of York & Scarborough Teaching Hospitals NHS Foundation Trust. Tim Hiles took over as Interim Chief Operating Officer for a six-month period from 10 November 2025 and was confirmed in post on 8 April 2026.

Jenny Lewis, Director of Human Resources & Organisational Development, left the Trust on 28 September 2025 to relocate and commence her new role as Group Chief People and Culture Officer at the Bristol NHS Group. Kate Simms commenced as the Interim Chief People Officer from 29 September 2025 until 19 December 2025 and was on secondment from West Yorkshire ICB. Suzanne Dunkley commenced as the substantive Chief People Officer from 5 January 2026. The two-week period from 20 December 2025 to 4 January 2026 was covered by Craige Richardson, Director of Estates & Facilities (with no financial reward).

Rabina Tindale, Chief Nurse commenced a period of leave from 9 September 2025 until 9 November 2025 with duties initially covered by Lorna Johnson (with no financial reward) until Beverley Geary joined the Trust on 29 September 2025. This was initially as the temporary Chief Nurse, becoming the Interim Chief Nurse from 10 November 2025. Beverley was on secondment from West Yorkshire ICB and was confirmed in post on 8 April 2026.

Appointment of Non-Executive Directors

Non-Executive Directors of the Board have been appointed through NHS England's appointments processes which define the term of office for each appointment. Re-appointments can be made, but Non-Executive Directors will not normally serve more than six years to ensure independence and to comply with the good practice defined by Code/s of Governance, and any exception requires approval from NHS England.

Our Associate Non-Executive Directors are the appointment of Leeds Teaching Hospitals NHS Trust; however the recruitment processes are jointly facilitated by NHS England appointment processes and used to support the Board's succession plan, which will assist the Trust in the future recruitment of Non-Executive Directors.

Termination of the term of office of the Chair would be carried out by the Chair of NHS England.

All Board directors comply with the CQC's requirements 'fit and proper person test' that was introduced from November 2014, along with the strengthening of these requirements issued in August 2023, as a result of the Kark Review and recommendations. The extended criteria and compliance checks are carried out annually for the Board and reported to the March public meeting and submitted to the NHS England Regional Director as required by June each year.

Measuring the performance of Board members

The Senior Independent Director (Chris Schofield) facilitated the Chair's appraisal with a summary report received at the July 2025 public Board meeting, and a formal submission as required to NHS England. The Trust Chair carried out the appraisal of the Chief Executive (Professor Phil Wood) which was reported to the Remuneration Committee during Quarter 1 of 2025. The Chair (Dame Linda Pollard) in turn carried out appraisals for the Associate/Non-Executive Directors, as did the Chief Executive for his direct reports, between April-July 2025.

The appraisal process was a review of the assessment of the performance and independence of the Associate/ Non-Executive Directors, reflecting on their contribution to the Trust during the year, with 360° feedback, each prepared their appraisal preparation based the NHS Leadership Competency Framework for Board Members.

The Trust Board requires all Associate/Non-Executive Directors to be independent in their judgement (with the Audit Committee reviewing the register of their interests each March). The structure of the Trust Board and its assurance committees ensures, along with the integrity of individual directors, that no one individual or group dominates the decision-making processes.

Should the Chair have any concerns about the performance of Associate/ Non-Executive Directors, this would be discussed with the individual and their term of office would be terminated, with communication to NHS England. Associate Non-Executives are the appointment of the Trust and action would be taken.

The Board can delegate duties for its assurance committees to carry out as defined in the Terms of Reference of each committee. Each committee has an annual workplan and provides assurance of the work carried out as set out within an annual report which reported to the May Audit Committee meeting with an evaluation of their performance during the year. This also sets out the work plan for the year ahead. These are received at the May public Board meeting. In reviewing and resetting the governance of the

Board and assurance committees, the Board approved new work plans at the November 2025 meeting which were implemented from January 2026.

From September 2025 the Board has reset its development programme, with a formal review and report presented at the March public Board meeting.

Remuneration of Board members

The remuneration of Executive Directors is determined by the Remuneration Committee which takes into account relevant guidance from NHS England, the Department of Health and Social Care and, where required, by defined thresholds approval by HM Treasury. The remuneration of the Chair and Non-Executive Directors is set by NHS England. The Trust applies the same local remuneration for the Associate Non-Executive roles.

Register of interests

The register of interests for Trust Board members is available on the Trust website: www.leedsth.nhs.uk/about/board/register-interests

Code of Governance for Provider Boards

The Board is required to report against the NHS England Code of Governance by comply or explain. The Board reviewed the Code at the March public Board meeting and confirmed the following;

- Statement B, 2.5. The chair should be independent on appointment when assessed against the criteria set out in Section B, provision 2.6. The roles of chair and chief executive must not be exercised by the same individual. A chief executive should not become chair of the same trust. The board should identify a deputy or vice chair who could be the senior independent director. The chair should not sit on the Audit Committee. The chair of the Audit Committee, ideally, should not be the deputy or vice chair or senior independent director.

Comply and explain – However as from September 2024 the deputy Chair is Chair of the Audit Committee.

- Statement Section B, 2.12. Non-Executive directors have a prime role in appointing and removing executive directors. They should scrutinise and hold to account the performance of management and individual executive directors against agreed performance objectives. The chair should hold meetings with the non-executive directors without the executive directors present.

Comply and explain – The Chief Executive reports directly to the Chair, with Executive Directors reporting to the Chief Executive. Appointment of Executive Directors will include relevant Non-Executive Director on the interview panel and inclusion of others with the assessment centre process.

Annually the Chief Executive reports formally to the Remuneration Committee on his appraisal meetings and objective setting with each Executive. The Remuneration Committee approve the remuneration of executive directors' appointments. Any concerns relating to the performance of any executive would be discussed with the Chair and in the consideration of poor performance and consideration of removal would be discussed within the Remuneration Committee (which is a meeting without the Executive Team present).

By exception as required, the Chair would hold meetings with Non-Executive Directors.

- Statement C, 2.1. The nominations committee or committees of foundation trusts, with external advice as appropriate, are responsible for the identification and nomination of Executive and Non-Executive Directors. The nominations committee should give full consideration to succession planning, taking into account the future challenges, risks and opportunities facing the trust and the skills and expertise required within the board of directors to meet them. Best practice is that the selection panel for a post should include at least one external assessor from NHS England and/or a representative from the Integrated Care Board, and the foundation trust should engage with NHS England to agree the approach.

Comply – External assessors are routinely used within interview panels for Executive Directors. As an NHS trust it is a requirement for the NHS England regional team to be part of the recruitment process for the Chair and non-executive directors.

The appointment of an Associate Non-Executive Director 1 January 2026 is succession planning to become the Chair of the Audit Committee in 12 months' time.

Explain – The Trust does not currently hold a succession plan for the full Board, in light of the changes to the Executive Team during the year. Stability is required through the recruitment of substantive positions, to then develop a succession plan.

- Statement C, 4.3. The chair should not remain in post beyond nine years from the date of their first appointment to the board of directors and any decision to extend a term beyond six years should be subject to rigorous review. To facilitate effective succession planning and the development of a diverse board, this period of nine years can be extended for a limited time, particularly where on appointment the chair was an existing non-executive director. The need for extension should be clearly explained and should have been agreed with NHS England.

Explain – Not compliant during the year, as the Chair's terms of office were extended by NHS England (having served over 12 years) and expired in July 2025.

Comply – As from 1 August 2025 with the incoming Chair, appointed by NHS.

- Statement C, 4.11. The board of directors should ensure it retains the necessary skills across its directors and works with the council of governors to ensure there is appropriate succession planning.

Partially Comply – The appointment of an Associate Non-Executive Director 1 January 2026 is succession planning to become the Chair of the Audit Committee in 12 months' time.

Explain – The Trust does not currently hold a succession plan for the full Board, in light of the changes to the Executive Team during the year. Stability is required through the recruitment of substantive positions, to then develop a succession plan.

- The long statement E-2.1 relates to performance related elements of Executive Remuneration e.g. a bonus scheme.

Explain – Non-compliant, as no scheme exists.

Provider Licence

The Trust is required to comply with the requirements of NHS England Provider Licence. On the 7 October 2025, NHS England took regulatory action and issued the Trust with an Enforcement Notice which stated; 'The Licensee (the Trust) submitted to NHS England as part of a recovery plan setting out the steps it will take to achieve quality standards overseen by the CQC and to ensure good standards of corporate governance'.

The Trust is in breach of G6 of the Provider Licence: Registration with the Care Quality Commission.

The Care Quality Commission (CQC) conducted unannounced inspections of Maternity Services on 9 to 11 December 2024 and of Neonatal Services 14 to 16 January 2025.

The Trust received a Warning Notice under Section 29A of the Health and Social Care Act 2008 (maternity staffing), on 14 February 2025. The Trust responded setting out the actions that will be taken, advising the CQC and the NHS England Quality Improvement Group that Birthrate Plus will be achieved in December 2025.

Following the publication of the final inspection report on 20 June 2025 the Trust received notification of breaches in the following regulations: Regulation 12 Safe care and Treatment, Regulation 15 Premises and Equipment, Regulation 17 Good Governance and Regulation 18 Staffing.

The CQC Well-led inspection was carried out at the Trust during 17-19 June 2025 with the report published on 24 September 2025, where the Trust was downgraded to 'requires improvement'. As a result, the Trust was required to develop a report on improvement actions it will take to meet the Health and Social Care Act 2008, its associated regulations in relation to the Well-led CQC inspection report.

NHS England as the regulator, facilitates monthly Integrated Quality Improvement Group (IQIG) meetings with the Trust, with attendance of the CQC and other key stakeholders. The purpose of these meetings is to hold the Trust to account for delivery of improvement of the action plans to respond to recommendations and breaches in keeping with overall oversight and accountability.

Non-Executive Directors of the Board during 2024/25

Antony Kildare
Chair

From 1 August 2025

A highly respected and accomplished senior leader, Antony Kildare brings extensive experience from non-executive, trustee and chair roles across healthcare and the NHS, as well as over 25 years in leadership positions, with experience spanning commerce, innovation, economic development and regeneration.

Antony was appointed Chair by NHS England in June 2025 with a start date of 1 August 2025 and joined the Trust in July 2025 for induction and handover.

He brings substantial board-level leadership experience across the NHS, public services, and the voluntary sector. Antony is a former Independent Chair of Medway Community Healthcare and former Non-Executive Director and Independent Chair of Brighton and Sussex University Hospitals NHS Trust. He has also served as a Board Director of the International Health Alliance and as Chair of The Health and Europe Centre.

Alongside his NHS roles, Antony was Chair of national advocacy provider POhWER for over five years until August 2025. He has held Chief Executive roles in leading national charities and was Board Advisor and inaugural Chief Executive Officer of a children's services company.

Antony has more than two decades of experience in commercial and strategic leadership, specialising in partnership development, organisational change, and large-scale transformation across health, education, children's services, and community programmes in the UK and Europe.

Dame Linda Pollard DBE DL Hon LLD
Chair

From February 2013 – 31 July 2025

Linda was a member of the Finance & Performance Assurance Committee. She was also a Trustee of Leeds Hospitals Charity, the charity for Leeds Teaching Hospitals, during her tenure of office.

Linda also co-chaired the Health & Wellbeing Board for the city and Chairs the Leeds Innovation District Partnership, a partnership between Leeds Teaching Hospitals, the University of Leeds and Leeds City Council, Leeds Trinity University, Leeds Beckett University, Leeds City College, West Yorkshire Combined Authority, and private sector. Linda led the ambition to create a world-class hub for research, innovation and entrepreneurialism for the city. An exciting part of this will be the development of the new state-of-the-art hospital build for Leeds, and the Old Medical School as a Health Tech Innovation Hub.

Alongside Sir Chris Wormald, Linda worked closely on the new Leeds Health and Social Care Hub which was launched to help improve Health and Social Care Policy Makers, alongside the Civil Service. She contributed to the Thirlwall Inquiry, NHS Leadership, Performance and Patient Select Committee and the Health and Social Care Select Committee.

By rotation, Linda Chaired the Committee in Common for West Yorkshire Association of Acute Trusts (WYAAT), the collaboration of acute providers across the region. She also facilitated the Chair's network of the Yorkshire and the Humber Regional Chairs Forum of NHS trusts for the NHS England Regional Office.

Alongside General Sir Gordon Messenger, Linda led the Leadership and Management Review in the NHS, and the seven recommendations have been accepted by the Government.

Linda was part of the Department of Health and Social Care 10 Year Plan People Workstream.

Linda advocated partnership working, bringing together leaders from across the region and beyond to facilitate closer working between health and social care, building economic investment in Leeds and the wider City region.

Linda was passionate about the diversity on Boards and gender balance, and was elected Vice Chair and Senior Independent Director (SID) and Chair of the Remuneration Committee of the NHS Provider Board, representing acute trusts which ended when her term of office expired.

In 2020 Linda was made a Dame Commander for her services to healthcare, which spans almost 30 years, and in recognition of her unbroken contribution to the community. This honour also recognised her tireless commitment to address the under representation of women in senior roles across corporate Britain and in public services.

Linda served as a Deputy Lord Lieutenant for West Yorkshire and was awarded a CBE in 2013 for her work in the business community in Yorkshire, an OBE in 2003 for her work in Bradford, along with an Honorary Doctorate by the University of Leeds. She also won the Institute of Directors Dr Neville Bain Memorial Award for Excellence in Director and Board Practice in 2019, which was the first time this was awarded to the public sector. Linda was also awarded a Sunday Times 2025 Non-Executive Director Award in the category of Not-For-Profit/Public Service.

Gillian Taylor

Non-Executive Director and Deputy Chair

From December 2018

A qualified accountant, and business transformation expert, Gillian is applying her professional skills gained as an executive in a Non-Executive capacity in the health and environmental engineering sectors. She has operated at Board level in the utility, social housing and social business sectors, including British Gas and Centrica.

Since 2021, Gillian has been a Non-Executive Director at JBA Group; an environmental, engineering and risk management group. Since 2024, she has been a Trustee Director for JBA's Employee Ownership Trust – this was established when JBA became an employee-owned organisation.

Gillian was a Board member at Beyond Housing from 2019-2025 and in 2022 was appointed the Senior Independent Director; she was also a member of the Audit and Risk Committee.

During 2023/24, Gillian chaired a Regulatory Task Group which has successfully achieved the highest-level Governance and Viability ratings for Beyond Housing. She has also been a member of a Task Group to refinance the business with a £250m sustainability bond. The bond is enabling investment in existing customers' homes, providing more energy efficient homes, helping move to a carbon zero organisation, and supporting the delivery of an ambitious housing development plan.

Gillian is the Deputy Chair of the Trust and along with chairing the Audit Committee, she is a member of the Finance & Performance Committee and the Perinatal Improvement Assurance Committee. She is the Non-Executive Director Champion for Freedom to Speak up.

Chris Schofield

Non-Executive Director, Deputy Trust Chair and Senior Independent Director

From April 2018 – 31 July 2025

A Non-Executive Director, Chris became Deputy Trust Chair and Senior Independent Director at the beginning of November 2022.

A practising solicitor who specialises in corporate law, Chris is the Founding Partner of Schofield Sweeney LLP Solicitors, a Trustee of Leeds Hospitals Charity and a number of other local charities.

Chris is the Chair of Governors at the One in a Million Free School and is Non-Executive Director of JBA Group and Constant Systems Holdings. Chris has previously served as the Under-Sheriff of West Yorkshire.

Other senior previous roles include Non-Executive Director for the NHS Leeds West Clinical Commissioning Group, and roles within the Trust during his tenure were Senior Independent Director, Chair of the Research and Innovation Committee, a member of Infrastructure Committee, and the named Non-Executive Director for Medical Staff in Difficulty.

Mark Burton

Associate Non-Executive Director

From 11 April 2022

Non-Executive Director

From 1 November 2024

Mark is currently a Senior Executive in Lloyds Banking Group and as part of his role is Head of UK Regions for their Corporate Bank as well as acting as the Lloyds Banking Group Ambassador for the Yorkshire & Humber Region.

A 28-year career in finance has seen Mark take leadership roles for several prominent banks, working with clients from around the UK and across multiple sectors.

Mark has mentored and coached individuals and businesses, including advising social enterprises. In his current role he works closely with the Leeds City Region, supporting businesses and working to make the region a great place to live and work in.

A father of three, Mark mainly spends his leisure time with his family. He's a keen sportsman, enjoying cycling and skiing. He's also been a junior sports coach and is an advocate of physical activity, wellbeing and mental health.

Mark is the Chair of Finance & Performance Committee and is a member of the People & Culture Committee.

Mike Baker CBE

Associate Non-Executive Director

From April 2022

Non-Executive Director

From 1 November 2022

Mike has held some of the most senior leadership roles in the three largest UK Departments of State.

Most recently he was Chief Operating Officer at the Ministry of Defence, an organisation of 230,000 military and civilian colleagues with an annual spend of £60 billion. Joining the Ministry of Defence in 2019 as Director for Transformation, Mike established a defence-wide transformation programme designed to achieve efficiencies of up to £12 billion.

In the Department for Work & Pensions he led as many as 25,000 colleagues designing and delivering welfare delivery and reform. And in Her Majesty's Revenue and Customs he was Director for Personal Tax Operations, leading c20,000 colleagues to deliver services to over 50 million customers whilst harnessing leading edge technology to radically change delivery channels.

Having been chairman of a charity, and a Non-Executive Board member in each of the four UK Military Services, in April 2022 he joined the Trust. Mike is also a Senior Advisor to Oliver Wyman, supporting and growing their government and public institutions practice. In 2024 Mike was made Professor of Practice at the University of York.

Mike has deep knowledge and experience of leading operational delivery, transformation and cultural change in large, complex businesses and environments.

Mike is the Senior Independent Director of the Board.

Mike is a member of the Finance & Performance Committee and the People & Culture Committee.

Professor Angela Graves

Non-Executive Director

From 1 September 2025

Professor Angela Graves, PhD, Senior Fellow Higher Education Academy, PgCert Clinical Education, Masters in Midwifery, BSc (Hons), Registered Midwife.

Angela is Professor in Maternal Health & Professional Education and Head of the School of Healthcare at the University of Leeds. Research and education interests include health professional education with a focus on obstetric emergencies and enhanced maternal care.

Angela is passionate about quality and safety in care delivery, achieved through excellence in education and research, and represents the Council of Deans of Health on the National Midwifery Council Midwifery Strategic Advisory Group. A visiting Professor at UNISA Yogyakarta, Indonesia (since 2019) she has consulted on curriculum development and led the development of the BSc (Hons) Midwifery blended degree programme with successful funding from NHS England.

Angela has been Deputy Principal Investigator for the My First 1000 days project – a landmark early years research project aimed at improving health and social outcomes for families and children in the crucial first two years of life in the Leeds area. This focus continues as a member of CHORAL (Child Health Outcomes Research at Leeds) fundraising project team, working towards improving lives and life chances for children growing up in the UK.

Angela is a member of the Quality Assurance Committee and Perinatal Improvement Assurance Committee. Angela is the second Maternity Board Safety Champion.

Andrew Greenwood

Non-Executive Director

From 1 October 2025

Andrew is a senior executive with over 20 years' board-level experience in complex, regulated organisations. He has a proven track record of leading transformational change, combining strategic insight with deep legal and risk expertise.

As Deputy Chief Executive of Leeds Building Society, he oversees all colleagues across customer operations and property and business services, delivering £10m in efficiency savings and leading a major head office transformation to support hybrid working and sustainability. Previously, as Executive Director and Chief Risk Officer, he pioneered the Society's "Inclusion By Design" strategy and successfully led high-level regulatory engagement.

Alongside his executive career, Andrew contributes to industry and education through roles with the Shared Ownership Code Limited and Leeds Beckett University. He is recognised as a collaborative, pragmatic leader who builds inclusive, high-performing cultures founded on trust and integrity.

Andrew is a member of the Finance & Performance Committee, Audit Committee and Champion for Security Management (Fraud).

Dr Simon Le Clerc MStJ CF

Non-Executive Director

From 22 November 2025

Dr Simon Le Clerc is a dual-accredited consultant in Emergency Medicine and Pre-Hospital Emergency Medicine, with over 25 years' leadership experience across the NHS, Armed Forces, charitable and private healthcare sectors, and with strong regional ties to Yorkshire and the North East.

Simon now works as a portfolio Independent Non-Executive Director and Board Advisor, supporting organisations operating in high-risk, high-pressure environments with governance, risk, quality and duty of care oversight.

Alongside his Non-Executive roles, he holds fractional senior clinical governance positions within global healthcare organisations, providing strategic oversight to complex international operations.

He previously held senior executive and clinical leadership roles, including Medical Director positions within air ambulance and remote medical services, and served as an NHS Consultant in Emergency and Pre-Hospital Emergency Medicine. He is a retired Lieutenant Colonel in the Defence Medical Services, where he helped establish and led the Medical Emergency Response Team (MERT) in Afghanistan.

Simon is a former Honorary Lecturer at the Royal Centre for Defence Medicine and Teesside University, and a recipient of a Churchill Fellowship. He brings extensive experience in clinical assurance, patient safety, emergency preparedness, workforce wellbeing and organisational resilience, and holds portfolio trustee and advisory appointments within the air ambulance and emergency care sector.

At the Trust, Simon is a member of the Quality Assurance Committee and from April he became Chair of the Perinatal Improvement Assurance Committee and is the Non-Executive Director Champion for Health & Wellbeing Guardian.

Philomena (Phil) Corrigan

Non-Executive Director

From 1 November 2022 – 31 March 2026

Phil began her career as a qualified nurse in the 1980s. By 1990 she was a Clinical Nurse Specialist at Leeds General Infirmary and throughout the 1990s she gained a great deal of experience in both nursing and senior management in several hospitals in West and South Yorkshire.

Since then, Phil has held a number of senior leadership roles, including at Leeds and Bradford Primary Care Trust and moved to be Chief Executive of NHS Leeds West Clinical Commissioning Group from 2012-2017.

She became the first Chief Executive of the newly formed NHS Leeds CCG in 2017, retiring in 2019.

During the year she became the Chair of Thank You Healthcare Staff, a national Charity which is just being formalised by the Charity Commission.

Phil was Chair of the Perinatal Improvement Assurance Committee and a member of the Quality Assurance Committee until the end of March.

She supported the Lay Representative process for the Advisory Appointments Committee.

Professor Jane Nixon

Non-Executive Director

From 1 June 2024 - 31 July 2025

Prof. Jane Nixon is the Institute Director at the University of Leeds Institute of Health Sciences School of Medicine. As a teaching hospitals Board member, Jane is the nominated Non-Executive from the University of Leeds.

In 2016, Prof. Nixon was appointed as a National Institute for Health and Care Research Senior Investigator, an appointment which was renewed in 2020, and she was awarded an MBE in 2017 for services to health research. Prof. Nixon's current research focuses on the design and evaluation of complex interventions to improve the delivery of health services and assess their impact on health.

During her successful career, Prof. Nixon has led the development of an internationally renowned portfolio of skin and wounds research, supported the development of clinical trials capacity and played a major national role in NHS research capacity development to support wounds research. During that time, she received around £42m in major grants, research and infrastructure awards and her research work has influenced guidelines internationally.

She was a member of the Workforce, Research and Innovation, and DIT committees of the Board.

Amanda Stainton

Associate Non-Executive Director

From 1 November 2022

Amanda has over 30 years of HR experience across various sectors, focusing on putting people at the heart of business to drive success.

Most recently she was HR Director for Portakabin Ltd, part of the privately-owned Shepherd Building Group, where during her 14 years she worked with her colleagues to deliver significant business growth.

She served on the Employment & Skills Committee of the Leeds City Region LEP for five years.

She now provides consultancy and coaching support to a variety of businesses on a part-time basis.

She is currently Chair of Governors at a local infant school and is a Board Trustee for Ilkley Community Enterprises – a thriving and innovative social enterprise which delivers high-quality services and activities to positively change the lives of its members and clients.

Amanda is Chair of the People & Culture Committee and a member of the Quality Assurance Committee. She is the Non-Executive Director Champion for Doctors in Difficulty.

Joanne (Jo) Koroma

Associate Non-Executive Director

From 1 April 2023

Joanne (Jo) Koroma is Director National Infrastructure for Openreach (BT plc) and is a highly accomplished, senior executive with experience operating at board level in challenging regulated roles in a complex organisation. She has also led businesses through critical transformational change programmes.

Jo has had a highly successful career to date starting at Openreach (BT) on their graduate scheme in 2003 and she has taken on several roles within the organisation leading to the role of Director National Infrastructure.

Some of Jo's key achievements during her career include leading the establishment of a scale product that underpins the roll out of fibre for the UK. She also led the delivery of fibre broadband to the west of the UK.

Jo is a member of the Audit Committee and People & Culture Committee.

Professor Laura Stroud

Associate Non-Executive Director

From December 2020 - end September 2023 (was the University of Leeds Nominated Non-Executive Director). Returned 22 February 2024 as an Associate Non-Executive Director

Laura Stroud is Pro-Vice Chancellor and Dean of the Faculty of Health Sciences and Wellbeing at the University of Sunderland, where she is a Professor of Public Health and Education Innovation. Her professional interest is in population health and well-being, from community activism in the voluntary sector through to education and research, policy and strategy. She is committed to supporting the development of individuals and teams, bringing expertise in education, leadership, and innovation in health management.

Laura was previously the nominated Non-Executive Director from the University of Leeds, re-joining the Board in March 2024 as an Associate Non-Executive Director after a short break following her appointment at Sunderland in October 2023.

She is Chair of the Quality Assurance Committee and retains her role as Maternity Board Safety Champion.

Ricky Singh

Associate Non-Executive Director

From 1 January 2026

Ricky is an experienced senior leader with a strong background in strategic financial management, governance and business transformation. He has held multiple Chief Finance Officer roles in the commercial and construction sectors, where he built a reputation for shaping strategy, driving performance improvement, and leading organisational change.

With a proven track record in end-to-end financial leadership from strategy formulation through to execution, Ricky combines commercial insight with a global mindset and a deep commitment to diversity and inclusion. His career highlights include delivering significant cost savings, leading complex mergers and acquisitions, and implementing major operational transformations.

Ricky is recognised as a collaborative, forward-thinking leader who champions innovation and high-performing teams.

Ricky is a member of the Audit Committee and will become the Chair of this committee from January 2027.

Executive Directors of the Board during 2025/2026

Brendan Brown

Chief Executive

From 15 September 2025

Brendan joined the Trust in September 2025 from Calderdale and Huddersfield NHS Foundation Trust.

Brendan was Chief Executive at Calderdale and Huddersfield from 2022 until 2025, following almost four years as Chief Executive at Airedale NHS Foundation Trust alongside his role of System Partnership Lead for the Airedale, Wharfedale & Craven Partnership.

He has previously held the position of Executive Director of Nursing/Deputy Chief Executive at both Calderdale & Huddersfield and Burton Hospitals NHS foundation trusts. Brendan has a clinical and therapeutic background, and

holds a Masters with Distinction from the University of Nottingham.

He has a proven track record for health and care leadership, and consistent improvements in the delivery of healthcare across hospital and community settings.

Professor Phil Wood

Chief Executive

1 February 2023 - 14 September 2025

Phil joined the Trust in 2002 as a Consultant Immunologist and during his career has worked in many operational and strategic roles including Clinical Director for services such as pathology and oncology, Medical Director for Strategy and Planning and latterly Chief Medical Officer. He was a champion and advocate of a continuous improvement approach to healthcare, working with the Virginia Mason Institute over the past decade to help develop the Trust's improvement system, the Leeds Improvement Method, and was one of the two chief executives from North East and Yorkshire leading work on the national Learning & Improvement Network.

Phil held several regional roles including as Senior Responsible Officer for the initial COVID-19 vaccination programme in West Yorkshire. He was committed to partnership working across health and care systems, and currently co-chairs the West Yorkshire Cancer Alliance. A continued passionate advocate for the role of research and innovation in improving outcomes and reducing inequalities in healthcare, he was Chair of the North East & Yorkshire Genomic Medicine Service Board, a member of the NHS England National Genomics Board and a director and board member at the Northern Health Science Alliance.

An Honorary Professorship in Healthcare Leadership from the University of Leeds was awarded in November 2022, recognising Phil's leadership contribution across education and training, research, innovation and improvement. He was the Chair of the Leeds Academic Health Partnership and a member of the NHS IMPACT National Improvement Board.

Tim Hiles

Chief Operating Officer

Interim Chief Operating Officer from 10 November 2025, confirmed in post on 8 April 2026.

Tim brings a wealth of experience, a strong patient-centred perspective, and a proven track record in leading complex services to his role as Chief Operating Officer at the Trust.

Tim began his career in the NHS as a Complaints Officer in one of the large London trusts. He went on to manage the complaints service and played a key role in establishing one of the country's first Patient Advice and Liaison Service (PALS) teams, piloting this new approach to patient support. These early roles gave him valuable insight into the concerns and priorities of patients when accessing NHS services, shaping his commitment to improving care and experience.

With nearly 25 years of operational management experience, Tim has worked across therapy services, theatres, and renal services. In 2013, he returned to Yorkshire and joined the Trust as General Manager for Urgent Care. He later managed Abdominal Medicine and Surgery and took on the role of Director of Operations for the Leeds Vaccination Centre, leading delivery of the COVID-19 vaccination programme. Most recently, Tim has served as Deputy Chief Operating Officer, supporting the Trust's operational leadership and service delivery.

Clare Smith

Chief Operating Officer

From December 2018, becoming Deputy Chief Executive from 15 May 2023 – 24 November 2025

Clare worked at the Trust from January 2014 and was Deputy Chief Executive from May 2023 and Chief Operating Officer (COO) from December 2018. Prior to joining the Trust, she worked as an acute trust Divisional General Manager in Scotland.

Clare was responsible for leadership and delivery of the Trust's operational services, ensuring high-quality care and delivery of performance standards are achieved through our clinical service units. She was also the Accountable Emergency Officer for the Trust.

Clare was also the chair of the West Yorkshire Association of Acute Trusts' Chief Operating Officer group and the Senior Responsible Officer for Urgent and Emergency Care for the West Yorkshire Integrated Care System.

Magnus Harrison

Chief Medical Officer

From 18 September 2023

Magnus joined the Trust in September 2023 and has held Executive Medical Director and Deputy Chief Executive roles at both Burton Hospitals NHS Trust and the University Hospitals of Derby and Burton NHS Foundation Trust.

In 2022 he became Interim Chief Executive Officer of University Hospitals of Derby and Burton before becoming Chief Medical Officer of an independent healthcare provider, Newson Health.

Prior to his executive roles, Magnus was a Consultant and Clinical Director in Emergency Medicine for 10 years.

Magnus is the Director of Infection Prevention Control and the Caldicott Guardian for the Trust. Magnus chairs the North East and Yorkshire Neurosurgical Network.

Beverley Geary

Chief Nurse

Temporary Chief Nurse from 29 September 2025, becoming Interim Chief Nurse from 10 November 2025, confirmed in post from 8 April 2026

Beverley joined the Trust in September on a temporary basis as the Trust's Chief Nurse from her role as Director of Nursing at the NHS West Yorkshire Integrated Care Board (ICB).

Before joining West Yorkshire Health and Care Partnership, Beverley was the Executive Chief Nurse at Hull University Teaching Hospitals NHS Trust, where she worked since March 2019. She has been a Registered Nurse for over 30 years and is dual trained in general and mental health nursing. Beverley has worked in several acute providers across the region and was previously Chief Nurse at York and Scarborough Teaching Hospitals NHS Foundation Trust.

Beverley was Humber Coast and Vale Health and Care Partnership regional nursing workforce lead, Chair for the Local Maternity System, and lead provider senior responsible officer for the COVID-19 vaccination programme for this partnership.

Rabina Tindale

Chief Nurse

From 2 January 2024 – 9 November 2025

Rabina was formerly Executive Chief Nurse and Director of Infection Prevention and Control for Wrightington, Wigan and Leigh NHS Foundation Trust with responsibility for strategic leadership of the nursing, midwifery and allied health professional workforce. She had Executive Director responsibility for quality and safety, adult and child safeguarding and Infection Prevention and Control. Prior to this, Rabina held senior nursing roles in London and Essex.

Rabina has served on the Royal College of Nursing's (RCN) Emergency Care Association Forum steering committee as both a member and subsequent Chair.

Rabina undertook her nursing training locally at Harrogate School of Nursing, and she began her career in emergency nursing in Leeds at St James's University Hospital.

Jenny Ehrhardt

Director of Finance

From 5 August 2024

Jenny re-joined the Trust in August 2024, having previously been Group Chief Finance Officer at Manchester University NHS Foundation Trust. Prior to this she worked as the Director of Finance here at the Trust for five years up to 2019.

As an experienced NHS finance leader, Jenny is a Fellow of the Chartered Institute of Public Finance and Accountancy, having trained through the NHS Graduate Management Scheme. She has worked across many different NHS organisations including the ambulance service and commissioning, but mainly in acute trusts.

Jenny is a member of the NHS Finance Leadership Council and Chair of the National Finance Innovation Forum, which seeks to successfully share finance innovations developed and implemented within the NHS, for the benefit of patients. She is also an Honorary Founding Fellow and former Treasurer of the Faculty of Medical Leadership and Management.

Suzanne Dunkley

Chief People Officer

From 5 January 2026

Suzanne joins the Trust with experience across both the private and public sector in strategic HR roles. Beginning her career at Pinderfields Hospital, Suzanne spent eight years leading a dotcom before moving into local authority and transport sectors prior to joining the NHS.

She believes that the role of HR is to spot talent and help it grow, that a great colleague experience leads to a great patient experience, and that organisations that work together can achieve the impossible.

Kate Simms

Interim Chief People Officer

From 29 September 2025 – 19 December 2025

Kate joined the Trust on an interim basis as the Trust's Chief People Officer from her role as Director of People at the NHS West Yorkshire Integrated Care Board (ICB).

Previous roles include People Director for West Yorkshire Police where she worked from 2017 to 2022. During this time, she brought about substantial and tangible change in the way that West Yorkshire Police delivers for its people. This has included action on diversity and a focus on transforming the experiences of the public and the police.

Before joining the police, Kate worked in senior people roles in several NHS organisations, including NHS Digital, Yorkshire Ambulance Service NHS Trust, Chesterfield Royal Hospital NHS Foundation Trust and Wirral University Teaching Hospital NHS Foundation Trust.

Jenny Lewis

Director of Human Resources and Organisational Development

From August 2018 – 28 September 2025

Jenny is an experienced People and Culture Executive who is passionate about advancing personal and organisational growth using the skills the Human Resources (HR) and Organisational Development profession brings. She has mentored talent across all health and care and is an alumni mentor for the University of Gloucestershire.

She was previously the first HR director for the unique public services partnership in Hampshire across a large county council, police and fire services and 500 schools, comprising 55,000 staff.

Since joining Leeds in 2018 Jenny had been the joint Executive Sponsor for the Leeds Health and Care Academy with Leeds City Council. She used her previous experience to enable and champion the work of the Academy to develop a 'one workforce' approach across Leeds to improve health outcomes and close inequality gaps. The Academy is now well established across all health and care sectors in Leeds and recognised nationally for its work.

Craige Richardson

Director of Estates and Facilities

From August 2019

Craige is an accomplished healthcare estate and facilities leader with three decades of experience at the Trust.

Throughout his career, he has held a variety of estates and facilities roles, progressing to the executive position of Director of Estate and Facilities, where he plays a pivotal role in shaping the future of one of the largest and most complex acute estate portfolios in the NHS.

Craige has been instrumental in leading local, regional and national, projects aimed at transforming the Trust's estate, ensuring it meets the evolving needs of patients, staff, and the wider community.

He is responsible for overseeing estate management and strategic development, the effective delivery of operational estate and facilities services, sustainability initiatives, and violence reduction and prevention.

His leadership extends across a workforce of more than 2,400 Estates and Facilities professionals who deliver critical support services across the city.

Committed to excellence in patient care, Craige ensures that Estate and Facilities operations are aligned with the Trust's overarching healthcare objectives.

He is a Fellow of the Chartered Management Institution (CMI) and actively contributes to a range of strategic forums. He is a key member of the West Yorkshire Net Zero Board Leads Network, the City's Strategic Estate Board, and the Integrated Care Board Capital and Infrastructure Board. Additionally, he chairs the West Yorkshire collaborative for directors of Estates and Facilities, fostering regional collaboration to drive innovation and efficiency across NHS estates and facilities management.

Craige's leadership continues to shape the sustainable, safe, and efficient development of healthcare estate, ensuring it remains fit for the future while supporting the delivery of exceptional patient care.

Dr Paul Jones

Chief Digital Information Officer

From November 2019

Paul joined the Trust in November 2019. He has held senior roles across the public and private sector including as Chief Technology Officer for the NHS in England and Group CIO of Serco. Paul's background is rooted in technology with a BSc and PhD in Computer Science. He is a Fellow of the British Computer Society and a Chartered IT Professional.

Paul leads a team of more than 400 digital, IT and information specialists, delivering vital services across the Trust to support exceptional patient care. This includes development of the Trust's electronic patient record, applications to support specialist functions, reporting and information insight, data quality and coding and records management. The team is also responsible for information governance and core IT services covering devices, cyber, networks, data centres, service desk and service management.

Paul is also Chief Information Officer (CIO) for the West Yorkshire Health and Care Partnership Digital Programme, supporting the enablement of digital technologies at a regional level.

In 2023, Paul was elected Chair of the CIO Advisory Panel, which includes 12 CIOs from various NHS trusts and regional organisations, elected by peers from across the country. The panel is responsible for setting direction for the CIO Network, providing an independent, nationally-elected voice for local NHS digital leaders.

2.2 Attendance tables

Trust Board

Members	29/05/2025		31/07/2025		25/09/2025		27/11/2025		17/12/2025	29/01/2026		11/02/2026	26/03/2026	
	Public	W/S	Public	W/S	WS	Public	WS	Public	ExO W/s	WS	Public	ExO	WS	Public
Antony Kildare			Obs	Obs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Angela Graves					✓	✓	✓	✓	Apols	✓	✓	Apols	✓	✓
Andrew Greenwood							✓	✓	✓	Apols	Apols	✓	✓	✓
Amanda Stainton	Apols	Apols	✓	✓	✓	✓	✓	✓	✓	✓	✓	Apols	✓	✓
Beverley Geary							✓	✓	✓	Apols	Apols	Apols	✓	✓
Brendan Brown					✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Chris Schofield	Apols	✓	✓	✓										
Clare Smith	✓	✓	✓	✓	✓	✓								
Craige Richardson	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Gillian Taylor	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Jane Nixon	✓	✓	✓	✓										
Jenny Ehrhardt	✓	✓	Apols	Apols	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Jenny Lewis	✓	✓	Apols	Apols	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Jo Bray	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Jo Koroma	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Apols	Apols
Kate Sims							✓	✓	✓					
Laura Stroud	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Linda Pollard	✓	✓	✓	✓										
Magnus Harrison	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Apols	Apols
Mark Burton	✓	✓	✓	✓	✓	✓	✓	✓	✓	Apols	Apols	✓	✓	✓
Mike Baker	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Paul Jones	✓	✓	Apols	Apols	✓	✓	✓	Unwell	✓	✓	✓	✓	✓	✓
Phil Corrigan	✓	Apols	✓	✓	✓	✓	✓	✓	Apols	✓	✓	✓	✓	✓
Phil Wood	✓	✓	✓	✓										
Rabina Tindale	✓	✓	✓	✓										
Ricky Singh										✓	✓	✓	✓	✓
Simon Le Clerc							✓	✓	✓	✓	✓	✓	✓	✓
Suzanne Dunkley										✓	✓	Apols	✓	✓
Tim Hiles							✓	✓	✓	✓	✓	✓	✓	✓

Board Time Outs

Members	26/06/2025	23/10/2025	24/10/2025	19/03/2026
Antony Kildare		✓	✓	✓
Angela Graves	✓	✓	✓	✓
Andrew Greenwood		Apols	✓	✓
Amanda Stainton	Apols	✓	✓	✓
Beverley Geary		✓	Apols	✓
Brendan Brown		✓	✓	✓
Chris Schofield	✓			
Clare Smith	✓			
Craige Richardson	✓	✓	✓	✓
Gillian Taylor	✓	Apols	Apols	✓
Jane Nixon	Apols			
Jenny Ehrhardt	✓	✓	✓	✓
Jenny Lewis	✓			
Jo Bray	✓	✓	✓	✓
Jo Koroma	✓	✓	✓	✓
Kate Sims		✓	✓	
Laura Stroud	Apols	✓	✓	Apols
Linda Pollard	✓			
Magnus Harrison	✓	✓	✓	✓
Mark Burton	✓	✓	✓	✓
Mike Baker	✓	✓	✓	✓
Paul Jones	✓	✓	✓	✓
Phil Corrigan	✓	Apols	✓	✓
Phil Wood	✓			
Rabina Tindale	✓			
Ricky Singh				✓
Simon Le Clerc				Apols
Suzanne Dunkley				✓
Tim Hiles		✓	✓	✓

Audit Committee (changes in NED membership from Nov)

Members	01/05/2025	06/05/2025 (Ex-O)	25/06/2025	04/09/2025	08/01/2026	05/03/2026
Gillian Taylor (Chair)	✓	✓	✓	✓	✓	✓
Jo Koroma	✓	✓	✓	Apols	✓	✓
Phil Corrigan	✓	Apols	Apol	✓		
Jenny Ehrhardt	✓	✓	✓	✓	✓	✓
Jo Bray	✓	✓	✓	✓	✓	✓
Ricky Singh					✓	✓
Andrew Greenwood					✓	✓

Finance & Performance (F&P) Committee

(changes in Committee ToR from Nov - hence changes to membership)

Members	30/04/2025	28/05/2025	25/06/2025	30/07/2025	27/08/2025	24/09/2025	29/10/2025	26/11/2025	17/12 2025	09/01/2026 (Ex-O)	28/02/2026	25/03/2026
Mark Burton (Chair)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Apols	✓
Jenny Ehrhardt	✓	✓	✓	Apols	✓	✓	✓	✓	✓	✓	✓	Apols
Clare Smith	✓	✓	✓	✓	✓	✓	✓					
Craige Richardson	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Gillian Taylor	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Jenny Lewis	✓	✓	✓	Apols	✓	Apols						
Jo Bray	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Linda Pollard	✓	✓	✓	✓								
Phil Wood	✓	✓	✓	✓	✓							
Rabina Tindale (alternate attendance)	✓	✓	Apols	✓	✓	Alter-nating						
Tim Hiles								✓	✓	✓	✓	✓
Magnus Harrison (alternate attendance)	Apols	✓	Alter-nating	Alter-nating	Alter-nating	✓	Alter-nating	Alter-nating				
Paul Jones	Apols	✓	✓	Apols	✓	✓	Apols	✓				
Andrew Greenwood							✓	Apols	✓	Apols	✓	✓
Beverley Geary (alternate attendance)							✓					
Kate Sims							✓					
Mike Baker									✓	✓	✓	✓

Quality Assurance Committee

(changes in Committee ToR from Nov - hence changes to membership)

Members	17/04/2025	19/06/2025	21/08/2025	16/10/2025	04/12/2025	19/02/2026
Laura Stroud (Chair)	✓	✓	✓	✓	✓	✓
Amanda Stainton	✓	✓	✓	✓	✓	✓
Jo Bray	✓	Apols	Apols	✓	✓	✓
Phil Corrigan	✓	✓	✓	Apols	✓	✓
Rabina Tindale	✓	Apols	✓			
Magnus Harrison	Apols	✓	✓	✓	✓	✓
Tim Hiles						✓
Beverley Geary				✓	✓	✓
Angela Graves				Apols	Apols	Apols
Simon Le Clerc					Apols	✓

Perinatal Improvement Assurance Committee

Members	15/01/2026	12/03/2026
Phil Corrigan (Chair)	✓	✓
Simon Le Clerc	✓	✓
Angela Graves	✓	✓
Gillian Taylor	✓	✓
Beverley Geary	✓	✓
Magnus Harrison	Apols	✓
Jo Bray	✓	✓

Workforce Committee

Members	15/05/2025	17/07/2025	10/09/25	12/11/25
Amanda Stainton (Chair)	✓	✓	✓	✓
Jenny Lewis	✓	✓	Apols	
Phil Wood	✓	Apols	Apols	
Craige Richardson	✓	Apols	✓	✓
Jo Bray	✓	✓	✓	✓
Mark Burton	✓	Apols	Apols	✓
Jane Nixon	✓	Apols		
Magnus Harrison	Apols	Apols	Apols	Apols
Rabina Tindale	Apols	✓	Apols	
Kate Sims				✓
Beverley Geary				Apols
Angela Graves				Apols
Paul Jones (nominated attendance via Mark Richardson)	✓	✓	✓	✓

People and Culture Committee (revised from January 2026)

Members	14/01/2026	11/03/2026 (Ex-O)
Amanda Stainton (Chair)	✓	✓
Mark Burton	✓	Apols
Mike Baker	✓	✓
Jo Koroma	✓	✓
Suzanne Dunkley	✓	✓
Craige Richardson	✓	Apols
Jo Bray	✓	✓
Paul Jones	✓	Apols

Infrastructure Committee

Members	10/04/2025	12/06/2025	14/08/2026	09/10/2025
Mike Baker (Chair)	✓	✓	✓	✓
Chris Schofield	✓	Apols		
Phil Wood	✓	✓	✓	
Craige Richardson	✓	✓	✓	✓
Jenny Ehrhardt		✓	✓	
Jo Bray	✓	✓	Apols	✓
Andrew Greenwood				✓

Research and Innovation Committee

Members	08/04/2025
Chris Schofield (Chair)	✓
Jane Nixon	✓
Jo Bray	✓
Magnus Harrison	✓
Rabina Tindale	Apols

Digital, Information And Technology Committee

Members	06/06/2025	08/072025 (Ex-O)	05/092025
Jo Koroma (Chair)	✓	✓	Apols
Mike Baker	✓	✓	✓
Jo Bray	✓	✓	✓
Jenny Lewis	✓	Apols	Apols
Paul Jones	✓	✓	✓
Magnus Harrison	Apols	Apols	Apols
Rabina Tindale			Apols

Annual Governance Statement (2025/26)

1. Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Trust Accountable Officer Memorandum.

2. The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Leeds Teaching Hospitals NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Leeds Teaching Hospitals NHS Trust for the year ended 31 March 2026 and up to the date of approval of the annual report and accounts.

3. Capacity to handle risk

The Board of Directors provides leadership and governance of the Trust. The Board is supported by a range of Committees that scrutinise and review assurances on internal control. Following the CQC Well-led review and publication of recommendations in September 2025, the Board reviewed its governance structure and formally closed the Digital & IT, Research & innovation and Infrastructure Committees. From January 2026 the Assurance Committees are Audit, Quality Assurance, Finance & Performance, People & Culture (formally Workforce) and established the Perinatal Improvement Assurance Committee as a new Committee of the Board.

The Risk Management Committee is an operational management Committee, and as part of the governance review, the Chair of the Audit Committee no longer observes this meeting. Assurance, Advise or Alert from these meetings are reported to the Board within the Chief Executives report to Board as from January 2026.

The current Assurance Committees of the Board have all provided an annual report to the 7 May 2026 Audit Committee meeting, which were also received at the 28 May 2026 Board meeting.

The Board has a number of overarching principles and procedures related to governance defined within our risk appetite, underpinned by policies and procedures, with means of monitoring and assurance. Our approach to risk identification, assessment and control, and the management and investigation of incidents is aligned to the values and behaviours set out in the Leeds Way, and a culture of accountability and transparency.

3.1 The Risk Management Committee focuses on the most significant risk exposures and oversees risk treatment to ensure: (a) the correct strategy is adopted for identifying and managing risk; (b) appropriate controls are present and operating effectively: and

(c) action plans are robust to mitigate risks to remain within tolerance. The Risk Management Committee is chaired by The Chief Operating Officer and comprises all Executive Directors. Senior Managers, Specialist Advisors are in attendance, and the Audit Committee Chair routinely attends each meeting as an observer. The Trust has kept under review and updated risk management policies during the year. Whilst the Risk Management Committee reports directly to the Board through my Chief Executive report, it also works closely with front line Clinical Service Units (CSUs) and all Committees of the Board to identify, triangulate and prioritise risk, working together to continuously enhance risk treatment. Chairs of Board Committees escalate, as appropriate, issues to the Risk Management Committee.

3.2 The Board commissioned a Task and Finish Group in October 2020 to further develop the Risk Management Framework, focusing specifically on the Trust's approach to setting and embedding its risk appetite and risk categories, supported by a Non-Executive Director and working in collaboration with commercial partners at Yorkshire Building Society. The work of the Task and Finish Group was presented to Trust Board in March 2021, including the revised risk categories and risk appetite statements, which were approved by the Board. A document was published; Risk Appetite 2021/22, to be used as a resource for staff working in the Trust to support them in adopting the risk appetite categories and risk appetite statements, to implement this in practice. This was updated the following year, and a second edition published.

The Risk Management Framework has continued to be developed, including agreeing the Trust's risk appetite statements and level 1 and level 2 risk categories, to help guide Executive Directors, senior managers and clinicians in the assessment and prioritisation of risk within the organisation. The risk categories have also been subject to a programme of reviews at Audit Committee, for assurance. The Accountable Executive for each risk category provides an overview of the assurance regarding each level 2 risk category to the Audit Committee on an annual basis.

The risk categories and the risk appetite statements have been cross referenced and incorporated into the Trust's Corporate Risk Register (CRR), to establish a fully integrated Risk Management Framework based on the work that has been undertaken to date. Executive Directors have supported CSUs and corporate leads to implement the Risk Management Framework, providing oversight through the monthly Risk Management Committee. The risk categories and risk appetite statements were reviewed again at Board in March 2026. These will be further reviewed by Committee chairs to agree whether any changes are needed. A revised framework will be published in Q1 2026/27, to support the further development (fourth edition).

3.3 Training and support are provided to relevant staff on incident reporting, assessment of risks related to patient safety incidents and incident investigation to meet the requirements for staff training to control key risks. A training needs analysis informs the Trust's mandatory training requirements and has been kept under review; this sets out the training requirements for all members of staff and includes the frequency of training in each case.

3.4 Incidents, complaints and patient feedback are routinely analysed to identify learning opportunities and improve control. Shared learning is disseminated to colleagues using a variety of methods, including Quality and Safety briefings, Learning Cascades and personal feedback where required. The Trust is leading a network with West Yorkshire Association of Acute Trusts (WYAAT) partners to share learning from patient safety incidents, including Never Events and it was an early adopter of the Patient Safety Incident Response Framework (PSIRF). The Quality Assurance Committee provides oversight on this process, with a complaints annual report presented to the Board of Directors each July and a six month in-year report.

3.5 I have ensured that all significant risks of which I have become aware, are reported to the Board of Directors and Risk Management Committee. All new significant risks are escalated to me as Chief Executive and validated by the Executive Team and Risk Management Committee. The residual risk score determines the escalation of risk.

3.6 The Board of Directors regularly scan the horizon for emergent opportunities or threats and considers the nature and timing of the response required in order to ensure risk is appropriately managed at all times. Collectively the Board reviews the Board Assurance Framework (BAF) and our risk appetite statements each year.

4. The Risk and Control Framework

4.1 (i) Determine priorities

The Board of Directors determines corporate objectives annually and these establish the priorities for Executive Directors and clinical services.

(ii) Risk Identification

Risk is identified in many ways. We identify risk proactively by assessing corporate objectives, work related activities, analysing adverse event trends and outcomes, and anticipating external possibilities or scenarios that may require mitigation by the Trust.

(iii) Risk Assessment

Risk Assessment involves the analysis of individual risks, including analysis of potential risk aggregation, where relevant. The assessment evaluates the severity and likelihood of each risk and determines the priority based on the overall level of risk exposure.

(iv) Risk Response (Risk Treatment)

For each risk, controls are ascertained (or where necessary developed), understood and documented. Controls are implemented to avoid risk; seek risk (take opportunity); modify risk; transfer risk or accept risk. Gaps in control are subject to mitigating actions that are implemented to reduce residual risk. The Board of Directors has considered its appetite for taking risk and reviewed its risk appetite to guide the management of risk throughout the Trust.

(v) Risk Reporting

Significant risks are reported at each formal meeting of the Board of Directors and Risk Management Committee. In addition, in the event of a significant risk arising, arrangements are in place to escalate a risk to the Chief Executive and Executive Team. The level at which risk must be escalated is clearly set out in the Risk Management Policy, which is reviewed every two years and was last updated and approved in June 2024. Risk reporting to the Board of Directors also details what actions are being taken, and by whom, to mitigate the risk and monitor delivery. The Audit Committee and Board of Directors have reviewed assurance on the effective operation of controls to manage the significant risks set out in the Corporate Risk Register and supporting report and undertake regular reviews of the Board Assurance Framework.

(vi) Risk Review

a. Those responsible for managing risk regularly review the output from the risk register to ensure it remains valid, reflects changes and supports decision making. In addition, risk profiles for all CSUs remain subject to detailed scrutiny as part of a rolling programme by the Risk Management Committee. The purpose of the Trust's risk review is to track how the risk profile is changing over time; evaluate the progress of actions to mitigate or reduce material risk; ensure controls are aligned to the risk; risk is managed in accordance with the Board's appetite; resources are reprioritised where necessary; and risk is escalated appropriately.

b. Incident reporting and investigation is openly encouraged as a key component of risk and its management to help us learn and take action in response to patient safety incidents. An electronic incident reporting system is operational throughout the organisation and is

accessible to all staff. Incident reporting is promoted through induction and training, regular communications, leadership walk rounds or other visits that take place. Board Leadership visits have continued in 2025/26. A programme to support staff who have been involved in an incident is in place, and a process for sharing lessons across the organisation is established, overseen by the Patient Safety Learning Hub that was established in 2024/25 to share learning across the Trust, replacing the Lessons Learned Group. In addition, arrangements are in place for staff to raise any concerns at work confidentially and anonymously through the Freedom to Speak Up process.

4.2 As at 31 March 2026, Leeds Teaching Hospitals NHS Trust has identified a range of significant risks, which are currently being mitigated, whose impact could have a direct bearing on requirements within the NHS Single Oversight Framework, CQC registration or the achievement of Trust policies, aims and objectives should the mitigation plans not be effective. The Corporate Risk Register is a live and therefore a dynamic record, which is reported to each public Board meeting (noting exclusions of some sensitive information for example cyber). An example of the movement in year is the cash risk that existed during part of the year. Currently, the significant risks documented on the Corporate Risk Register on 31 March 2026 relate to the following areas:

Workforce risk

- Insufficient staff to provide treatment, care and services to patients.

Operational risk

- Power failure (electrical infrastructure) leading to disruption of clinical services
- Brotherton Wing infrastructure
- Staff absence, health, safety and wellbeing
- Cyber-attack leading to potential loss of IT systems and/or data
- Insufficient DIT resources to maintain Trust IT estate
- Delivery of the LGI site Development Project (Building the Leeds Way)

Clinical risk

- Exposure to health care associated infection
- Achieving the emergency care standard
- 18-Week Referral to Treatment target
- Cancer waiting times standards
- Cancelled operations not rebooked within 28 days
- Patients waiting longer than six weeks following referral for diagnostic tests

Capacity planning risk

- Patient flow and capacity for emergency admissions (health economy)
- Airedale Hospital infrastructure: potential risk (patient transfers)

Financial risk

- Failure to deliver financial plan 2025/26
- Reduction in operational capital allocation

External (Regulatory) Risk

- CQC Registration: breaches of Regulation(s) Maternity and Neonatal Services
- CQC Registration: breaches of Regulation(s) Well-led

4.3 Detailed risk registers are proactively used throughout the organisation. These set out arrangements for risk treatment, risk appetite thresholds and further mitigating actions planned. We have established arrangements to allow a review of significant risk exposures by the full Board at each formal meeting; the process for this is examined by the Audit Committee to underpin this Statement.

4.4 The NHS England Code of Governance defines best practice for corporate governance and within the supporting appendices and statements which the Trust has reviewed and reported against the requirement to 'comply' or 'explain'. This report was received at the March 2026 public Board meeting and below are the relevant statements.

- Statement B, 2.5. The Chair should be independent on appointment when assessed against the criteria set out in Section B, provision 2.6. The roles of Chair and Chief Executive must not

be exercised by the same individual. A Chief Executive should not become Chair of the same trust. The Board should identify a deputy or vice Chair who could be the Senior Independent Director. The Chair should not sit on the Audit Committee. The Chair of the Audit Committee, ideally, should not be the deputy or vice Chair or Senior Independent Director.

Comply and explain - from September 2024 the deputy Chair is Chair of the Audit Committee.

- Statement Section B, 2.12. Non-Executive Directors have a prime role in appointing and removing Executive Directors. They should scrutinise and hold to account the performance of management and individual executive directors against agreed performance objectives. The Chair should hold meetings with the Non-Executive directors without the Executive Directors present.

Comply and explain - The Chief Executive reports directly to the Chair, with Executive Directors reporting to the Chief Executive. Appointment of Executive Directors has and will include relevant Non-Executive Director on the interview panel and inclusion of others in any assessment centre process.

Annually the Chief Executive reports formally to the Remuneration Committee on his appraisal meetings and objective setting with each Executive. Remuneration Committee approve the remuneration of Executive Directors appointments.

Any concerns relating to the performance of any Executive would be discussed with the Chair and in the consideration of poor performance and consideration of removal would be discussed within the Remuneration Committee (which is a meeting without the Executive Team present).

By exception as required, the Chair would hold meetings with Non-Executive Directors.

- Statement C, 2.1. The Nominations Committee or Committees of foundation trusts, with external advice as appropriate, are responsible for the identification and nomination of Executive and Non-Executive Directors. The Nominations Committee should give full consideration to succession planning, taking into account the future challenges, risks and opportunities facing the trust and the skills and expertise required within the Board of Directors to meet them. Best practice is that the selection panel for a post should include at least one external assessor from NHS England and/or a representative from the ICB, and the foundation trust should engage with NHS England to agree the approach.

Comply – External assessors are routinely used within interview panels for Executive Directors. As an NHS Trust it is a requirement for NHSE regional team to be part of the recruitment process for the Chair and Non-Executive Directors.

The appointment of an Associate Non-Executive Director 1 January 2026 is succession planning to become the Chair of the Audit Committee in 12 months' time. Explain – The Trust does not currently hold a succession plan for the full Board, in light of the changes to the Executive Team during the year, stability is required through the recruitment of substantive positions, to then develop a succession plan.

- Statement C, 4.3. The Chair should not remain in post beyond nine years from the date of their first appointment to the board of directors and any decision to extend a term beyond six years should be subject to rigorous review. To facilitate effective succession planning and the development of a diverse Board, this period of nine years can be extended for a limited time, particularly where on appointment the chair was an existing non-executive director. The need for extension should be clearly explained and should have been agreed with NHS England.

Explain - not compliant during the year, as the previous Chair's terms of office were extended by NHS England (having

served over 12 years) and expired at the end of July 2025.

Comply - as from 1 August 2025 with the incoming Chair, appointed by NHS England.

- Statement C, 4.11. The Board of Directors should ensure it retains the necessary skills across its directors and works with the council of governors to ensure there is appropriate succession planning.

Partially Comply - The appointment of an Associate Non-Executive Director 1 January 2026 is succession planning to become the Chair of the Audit Cttee in 12 months' time.

Explain – The Trust does not currently hold a succession plan for the full Board, in light of the changes to the Executive Team during the year, stability is required through the recruitment of substantive positions, to then develop a succession plan.

- The long statement E-2.1 relates to performance related elements of Executive Remuneration e.g. a bonus scheme.

Explain - non-compliant, as no scheme exists.

4.5 Equality impact assessments are integrated into core Trust business. All reports to Trust Board follow a standard reporting template, which includes an 'Improve Health Equality' section where authors of the report are required to set out any areas of impact on equalities or health inequalities using the Health Equity Impact Assessment Tool to support the structured review of the impact of their proposal on groups most at risk of poor health outcomes. All Trust policies and procedures require an equality impact assessment to be completed before Executive Team approval. In organisational change projects, the Operational Team within the People Function or Line Managers in undertaking their duty to prepare equality impact assessments on the proposed change and to then take this into consideration in implementing that change. The Trust is at present reviewing the impact assessment process.

4.6 The Trust has a Medical and Dental Optimisation Group (MDOP) and a Workforce Availability Group (WAG) membership includes the Trust's Professional Workforce Leads. These Groups lead and report on activities with a focus on workforce planning, alignment of workforce with finance, performance and quality metrics, initiating and overseeing projects that support workforce planning and workforce availability for the short, medium and longer term, such as initiatives to address high temporary spend in both the Agenda for Change and Medical and Dental workforce.

4.7 During Q4, the People Function have developed a Performance Improvement Framework (PIF) which provides a 'heat map' of Clinical Service Units and Corporate Teams against key people metrics. This information is reviewed monthly by the People Function in the Performance Improvement Focus Meeting (PIFM) to identify appropriate support and corrective action for CSUs who are red against these metrics. Some of this supportive work will take place through MDOP and WAG.

4.8 PIFM reports into the Performance Assurance Group (PAG) on a monthly basis, which in turn provides assurance to the People & Culture Committee, which meets bimonthly reporting to Board. This Committee seeks assurance on the People Function Priorities; supports and reports on activities related to resource management with a focus to develop workforce resource plans; align the developed workforce resource plans with finance, performance and quality metrics and seek assurance on projects that are in place to address specific workforce hotspots and issues and challenges.

4.9 The Trust has embedded a corporate workforce planning framework with each Clinical Service Unit and Corporate Teams producing their own operational workforce action plan. The plans identify and reduce high-cost bank and agency spend, promote new roles to support skill mix reviews; effectively deploy staff and focus on learning and the sharing of best

practice. All workforce plans are signed off by the Deputy Director of Human Resources (HR) and relevant Clinical Service Units, Director of Operations and Executive Director for Corporate Teams. Our Senior HR Business Partners work with the Clinical Service Units and Corporate Teams to co-produce effective workforce solutions supporting their short, medium and longer-term workforce planning.

5. Care Quality Commission (CQC) Registration

5.1 Compliance with the provisions of the Health & Social Care Act 2008 (Registration Regulations) 2010 is co-ordinated by the Director of Quality. The Director of Quality oversees compliance by:

- Reporting and keeping under review, matters highlighted within the Care Quality Commission's inspections and regular engagement
- Self-assessment against the Quality Standards defined within the criteria of the Well-led review, and preparing the Trust for an external review
- Liaising with the Care Quality Commission and Clinical Service Units to address specific concerns
- Engaging with the Care Quality Commission on the inspection process, co-ordinating the Trust's response to inspections and recommendations/ actions arising from this
- Analysing trends from incident reporting, complaints, and patient and staff surveys to detect potential non-compliance or concerns in Clinical Service Units
- Reviewing assurances on the effective operation of controls
- Receiving details of assurances provided by Internal Audit and being notified of any Clinical Audit conclusions which provide only limited assurance on the operation of controls
- Challenging assurances or gaps in assurance by attending meetings of the Risk Management, Quality Assurance and Audit Committees.

5.2 The Trust Chair holds and maintains the 'Fit and Proper Persons Test Register' for the Board. Checks are carried out annually to ensure all those listed are fit and proper against the requirements defined by the Care Quality Commission.

5.3 The Care Quality Commission issued a section 29A warning notice in relation to staffing following the inspection of maternity services in December 2024. The service was rated 'inadequate' for safety and Well-led.

5.4 CQC's inspection of Maternity and Neonatal services at St James's University Hospital and Leeds General Infirmary identified the Trust was in breach of regulations relating to learning following incidents, risk management, safe environment, infection prevention and control, medicines management and some governance processes. A Perinatal Improvement Plan was developed and is being delivered with oversight of NHS England.

5.5 In June 2025 the CQC completed an inspection against the Well-led quality statements. The CQC rated the Trust as 'requires improvement' and identified the Trust were in breach of regulations relating to Complaints, Good Governance and Staffing. A Trust Improvement Plan was developed and is being delivered with oversight of NHS England.

5.6 Following the publication of the Trust Well-led report and entry into the Maternity Support Programme, NHS England put in place enforcement undertakings (as per section 106 of the Health and Social Care Act 2012) to underpin and guide the actions required in response to breaches, or suspected breaches, of the NHS Provider Licence principles, systems and standards of good corporate governance.

5.7 During 2025/26 the Trust has worked constructively with NHS England and key stakeholders to respond to the findings, providing regular oversight of delivery of the Perinatal and Well-led Improvement Plans and measures of performance, finance and quality to the Integrated Quality Improvement Group.

A formal Committee of the Board has been established, Perinatal Improvement Assurance Committee for internal assurance.

5.8 In October 2025 the Secretary of State announced that there would be an Independent Inquiry Review into the Maternity and Neonatal services at the Trust. The Trust is engaging with NHS England in this and in due course will incorporate the findings into the Perinatal and Well-led improvement plans that have been established.

6. Register of interests, including gifts and hospitality

The Trust publishes on its website a live register of interests, including gifts and hospitality, for decision-making staff (as defined by the Trust with reference to the guidance) within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS' guidance. The register for the Board can be found at https://leedsth.mydeclarations.co.uk/reports/GroupReport and the full staff report at: https://leedsth.mydeclarations.co.uk/

7. Pensions

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

8. Sustainability

The Trust has undertaken risk assessments on the effects of climate change and severe weather and has developed a Green Plan following the guidance of the Greener NHS programme. The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

9. Review of economy, efficiency and effectiveness of the use of resources

9.1 As Accountable Officer, I am responsible for ensuring that the Trust has arrangements in place for securing value for money in the use of its resources. To do this I have maintained systems to:

- Set, review and implement strategic and operational objectives
- Engage actively with patients, staff, members and other stakeholders to ensure key messages about services are received and acted upon
- Monitor and improve organisational performance
- Establish plans to deliver waste reduction programmes. The waste reduction programme has been strengthened with a monthly Finance Improvement Board and during Q4 became the weekly Turnaround Executive, chaired by myself, Chief Executive

9.2 The five-year integrated plan is refreshed each year and used to develop the annual operational plan for the Trust. The Trust actively engages Commissioners, regulators (NHS England), system functions (West Yorkshire Integrated Care System (WYICS) which is now the WYICB and West Yorkshire Association of Acute Trusts (WYAAT), staff and others as necessary to develop and agree detailed financial and operational plans. Planning takes account of the national priorities and operational planning guidance published annually by NHSE

and system initiatives and their impact to ensure that planning within the broader ICS is aligned. These detailed operational plans and budgets are approved by the Board.

9.3 The Board approved the five-year Integrated Delivery Plan in February 2026 which was submitted to the NHS England Regional Team. At the start of April, the Trust received feedback on trajectories for year two and three and will work with NHSE to clarify further.

9.4 Updates to the plans include revisions to our operational, financial, workforce and strategic plans. These submissions contain a variety of technical documents prepared by members within the Trust and an overall narrative which describes these submissions and their associated risks. This informs the detailed operational plans and budgets which are also approved by the Board.

9.5 The Trust is a key member of WYAAT provider collaborative, which in the year has continued to make good progress with the Committee in Common (CiC) meeting four times during 2025/26 for the governance and accountability of work streams to support transformation across West Yorkshire, reporting and accountable to each sovereign Board. The CiC has membership from each provider organisation with both Executive and Non-Executive membership from each, usually by the Chief Executive and Chair.

9.6 The Trust continues to operate its Financial Management Framework to ensure that the Trust is meeting its strategic target of financial sustainability. Each quarter a fundamental review takes place of the financial position, and this is reviewed by the Board and relevant action plans developed. Each month reports are prepared for the Finance & Performance Committee on the financial position, alongside monthly finance reports issued to CSUs that show performance against budget. These reports contain both financial and non-financial information.

9.7 The Trust has a Programme Management Office (PMO) Team in place to support CSUs and Corporate Functions in achieving their Waste Reduction Programme targets, and through the Leeds Improvement Method increase performance and overarching quality. This is supported by other initiatives within the Trust such as Getting It Right First Time (GIRFT) and benchmarking against the model hospital. During 2025/26, the Trust commissioned PwC to undertake a grip and control review. This report has been discussed and resulting actions are overseen at the weekly Turnaround Executive meeting.

9.8 Assurances on the operation of controls are commissioned and reviewed by the Audit Committee and, where appropriate, other Committees of the Board of Directors as part of their annual cycle of business.

9.9 The Trust has outsourced its internal audit function to PwC. External auditors, Mazars, were appointed in 2015 by the Audit Commission for a period of two years. They were subsequently reappointed by the Trust in 2017 and with the closure of the 2020/21 accounts completed six years. NHSE guidance states that Trusts should put the external audit contract out to tender every five years, noting that the same auditors can be reappointed up to a maximum of 20 years.

Mazars were re-appointed as external auditors following a competitive tender exercise, from April 2021. During 2023/24 the Trust extended the external Auditors for one year under the contract in place. During 2024/25 a full tender process was carried out resulting in the re-appointment under their new legal entity, Forvis Mazars until 31 March 2028 with scope for extension for up to two further years.

The Audit Committee annually reviews the independence and performance of internal and external audit, with a report presented at the January 2026 Audit Committee. The implementation of recommendations made by Internal and External Audit is overseen by the Audit Committee.

10. Information governance

Information Governance incidents within the Trust are managed through rigorous and standardised processes with an appointed Caldicott Guardian and Deputy, a qualified Senior Information Risk Owner and the Data Protection Officer for the Trust. During 2025/26, there were seven SIRI or near-miss incidents that required reporting, of which two was reported to the Information Commissioners Office (ICO). The Trust Information Governance (IG) Team has investigated all of the cases and worked with all concerned parties to ensure that the appropriate governance and information security procedures have been implemented. The IG Team has also provided advice and guidance on the way in which staff should handle information, in particular the personal, sensitive and corporate data processed by the Trust. This ensures that information is dealt with legally, securely, efficiently and effectively, to deliver the best possible care.

11. Data quality and governance

11.1 The Data Security & Protection Toolkit (DSPT) is an annual self-assessment produced by NHS England. In September 2024 the DSPT changed to adopt the National Cyber Security Centre's Cyber Assessment Framework (CAF) as its basis for cyber security and IG assurance.

The DSPT is now split into several contributing outcomes, each of which are supported by indicators of good practice grouped into levels of achievement:

- 'Not Achieved'
- 'Partially Achieved'
- 'Achieved'

Of the 47 contributing outcomes, 39 contribute from the CAF with a further eight contributing outcomes in a custom section on 'using and sharing information appropriately', to ensure that data protection, confidentiality, and other information governance disciplines such as clinical coding are covered

There are six contributing outcomes noted as requiring a 'not achieved' standard, these where formally known as 'non-mandatory' assertions in the previous DSPTs prior to the CAF alignment. However, following previous submissions, the Trust has completed all contributing outcomes to a partially achieved or achieved standard, including those detailed as a 'not achieved' standard

The Trust supplied a total of 389 pieces of evidence to the Toolkit.

The Trust was able to successfully submit its DSPTv7 Submission for 2024/25 on 24 June 2025 with all contributing outcomes successfully completed.

11.2 The Trust reports on elective waiting times throughout the year, in nationally mandated submissions and in regular updates to the Finance & Performance Committee and Trust Board. Data validation is required of CSU teams to confirm the waiting time data recorded for patients waiting for treatment. Training is provided to teams by the PAS Team and additional support and training is provided by the performance and development team where concerns are identified, or requests are made for additional support. A number of reports are available to identify potential data quality concerns and identify areas for improvement. The Trust also uses a well-established clinical harm process to assess the extent of any harm associated with long waits and the risks of extended waits are recorded on the Trust's risk register. The Trust also contributes data to the LUNA (which is a data quality health platform) run by Northeast Commissioning Support Unit (NECS) which assesses performance for all Trusts in relation to confidence in data and potential pathway issues to strengthen the accuracy of key data quality performance indicators.

12. Review of Effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of

internal control is informed by the work of the internal auditors, clinical audit and the Executive Directors, my direct reports, Clinical Directors of the CSUs, and Committee Chairs within the NHS Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee, our assurance and management Committees reporting to Board and a plan to address weaknesses and ensure continuous improvement of the system is in place.

12.1 The Board of Directors

The Board has set out the governance arrangements including the Committee structure within the Standing Orders. These Assurance Committees, Chaired by Non-Executive Directors. Chairs of the Board's Committees report to the Board at the first available Board meeting after each Committee meeting and urgent matters are escalated by the Committee Chair to the Board as deemed appropriate.

Following the CQC Well-led review and publication of recommendations in September 2025, the Board reviewed its governance structure and formally closed the Digital & IT, Research & innovation and Infrastructure Committees. From January 2026 the Assurance Committees are Audit, Quality Assurance, Finance & Performance, People & Culture (formally Workforce) and established the Perinatal Improvement Assurance Committee as a new Committee of the Board.

Within the Well-led Improvement Plan there are a number of recommendations to strengthen governance processes of the Board, many of which have been implemented. The Trust has commissioned a phased approach to an external review of the CQC Well-led criteria, to objectively assess the progress made to date, which will take place during Q1 of 2026/27.

12.2 Internal Audit

As at 17 June 2026, 16 internal audit reviews have been completed, the draft report has been issued for two reviews and the draft report is in progress for one review. To date this has resulted in the identification of 13 high, 19 medium and 18 low risk related findings reported to the Trust.

The Audit Committee has considered the outputs of this work when endorsing the 2025/26 Annual Governance Statement.

The Head of Internal Audit Opinion states; 'We are satisfied that sufficient internal audit work has been undertaken to allow an opinion to be given as to the adequacy and effectiveness of governance, risk management and control. In giving this opinion, it should be noted that assurances can never be absolute. The most that the internal audit service can provide is reasonable assurance that there are no major weaknesses in the systems of internal control'.

12.3 External Audit

External audit provides independent scrutiny on the accounts (including Value for Money), annual report, and the Annual Governance Statement reporting by exception if the Trust fails to comply with the guidance and as defined by NHSE. There was no requirement for assurance on the Annual Quality Report.

12.4 Clinical Audit

Quality Assurance Committee received and were assured by the Clinical Audit Annual Report for 2025/26. This summarised clinical audit activity across the Trust, adhering to the national requirement reflected in the Trust Clinical Audit Procedure, which reflects national best practice. Quality Assurance Committee received and approved the clinical audit programme for 2026/27 at the meeting on 16 April 2026.

12.5 Health & Safety

The Health and Safety Team continues to deliver the Trust's core health and safety functions, working collaboratively with Clinical Service Units, Human Resources,

Infection Prevention and Control, Estates and Facilities, Occupational Health, and staff-side union representatives.

Health and Safety within the Trust is overseen by the Risk Management Committee, alongside supporting assurance groups. Colleague involvement and consultation is welcomed and encouraged, and information from the regular planned meetings of the Health and Safety Consultation Committee is posted on the Trust's Health and Safety intranet pages.

Risk-specific minimum performance standards (Active Monitoring) are in place across all departments. Compliance is assessed annually through the Health and Safety Controls Assurance process, with results published in the annual Health and Safety Report. To support continuous improvement, the Health and Safety Team has embedded the Leeds Improvement Methodology into the Controls Assurance process and other internal systems, using structured quality improvement tools to increase engagement, improve consistency, and strengthen local ownership.

In the latest cycle, we were pleased to see participation from approximately 700 wards and departments, consistent with previous years. To further support compliance and continuous improvement, the Health and Safety Team also undertakes 'Gemba'-style site visits, promoting lean working principles and practical support at the point of activity.

The Trust maintains robust systems for responding to national safety alerts issued via the Central Alerting System, ensuring appropriate actions are taken.

The Health & Safety Team continue to report notifiable incidents to the Health and Safety Executive. For an incident to be reportable there must be clear and reasonable evidence to confirm the link between the harm sustained and the work-related activity.

The Trust is one of a small number of NHS Trusts to receive recognition through the Royal Society for the Prevention of Accidents (RoSPA) Health and Safety Achievement Awards. In 2025, the Trust was awarded the RoSPA President's Award, recognising ten consecutive Gold Awards for health and safety performance. This internationally recognised award provides independent external validation of the strength, consistency and maturity of the Trust's Health and Safety Management arrangements.

As Chief Executive, I have received reports from the Trust Fire Safety Manager, that were reviewed and scrutinised for assurance at the Risk Management Committee, that set out our compliance against the Trust's statutory responsibilities under the Regulatory Reform (Fire Safety) Order. Assurance reports are reported twice yearly to the Risk Management Committee. During the year the Committee received a number of assurance reports that have included a strategic fire safety management plan, three-year fire safety plan, an Annual Certificate of Fire Safety Compliance and various assurance documents. The new Infrastructure Management Committee within Estates & Facilities has also reviewed reports and assurance for fire regulations and the requirements imposed by the new Building Safety regulations under the new act. The Trust continues to receive updates and learning reflecting national fire safety issues that are relevant to healthcare and there is a programme of implementation of any changes.

12.6 Promoting Safety

We continued to be compliant with NHS England guidance and national safer staffing policy requirements. Developing Workforce Safeguards (NHS England 2018) describes the governance and overarching principles that must be in place at a Trust level to provide assurance in relation to safer staffing regulations and requirements. The Board have been assured in relation to safer nurse staffing requirements, including the nursing workforce response to the opening of additional surge capacity and assessment of quality indicators against any wards that have reported below their planned

staffing levels. This is provided through the Nursing & Midwifery Quality and Safe Staffing report. Nursing and Midwifery workforce quality indicators, progress and assurance is well embedded and will continue to be monitored and reported through the appropriate governance and assurance groups from ward to Board.

The Trust's Maternity Services were subject to an unannounced CQC inspection in December 2024, with Neonatal services inspected in January 2025. One year on, the inspection process has concluded, and the Trust has received and reviewed the final reports. Over the past year, services have worked closely with NHS England and the Maternity Safety and Support Programme in response to concerns raised by families. This collaborative approach has supported a clear focus on learning, improvement and strengthening safety culture. A range of actions have been implemented and embedded to address identified themes, with ongoing oversight to ensure improvements are sustained and continue to enhance the quality and safety of care (see section 5).

Over the last year, the Trust's Nursing and Midwifery vacancy and turnover rates for registered staff have consistently reduced, reflecting the collaborative and sustained recruitment and retention efforts across the organisation. Registered Nursing and Midwifery vacancies have reduced to 5.8%, with turnover at 4.03%, demonstrating strong retention, better than typical national benchmarks for large acute trusts.

We have also sustained a significantly reduced Clinical Support Worker (CSW) vacancy gap and achieved an improved CSW turnover rate of 6.9%, which is notably below the wider NHS average for unregistered roles. This has been supported through an expanded offer of flexible and part-time opportunities to attract new entrants, alongside targeted investment in the existing CSW workforce through development programmes, forums and events that strengthen engagement and raise the profile of the CSW role. Continued focus remains on further reducing CSW vacancies while sustaining positive retention trends.

In addition to the focus on increasing the workforce through new and alternative entry routes, including a strengthened focus on supporting newly qualified nurses and those entering the profession through apprenticeship pathways, we also continued to review how we gain assurance in relation to the quality of care delivered. This included:

- Bi-annual quality reviews with CSUs
- Bi-annual establishment reviews to ensure we have the right workforce, with the right skills, at the right time
- Review of the Health Check metric audit questions for inpatient and Emergency Department areas (undertaken once a month) to ensure essential data is collected, including any recent changes to practice requirements, providing oversight and accountability
- A structured monthly escalation process is in place to monitor ward performance against key nursing performance indicators and the Health Check metrics. Wards that fall below the expected performance thresholds are placed in escalation and closely monitored for a period of three months. After this period, a ward will be deescalated if improvements are seen or further escalated for additional support
- Weekly assurance of the wards in escalation, are reported to the Weekly Quality Meeting
- Continuation of the monthly Ward Assurance Review Meeting where wards in escalation in the Ward Health Check programme are discussed and collaborative support to areas of concern are planned

The Clinical Support Team conducted a total of 46 ward assurance visits in response to wards in escalation, wards with red metrics or by exception at the request of either the Chief Nurse or Deputy Chief Nurse. The Clinical Support Team additionally conducted six follow-

up visits to ensure continuity of standards following local action plans and/or Clinical Support Team direct input.

In 2025/26, we have continued to strengthen the governance, quality and sustainability of our professional development offer, with a clear focus on workforce wellbeing, leadership capability, equity, and safe transitions into practice.

The Professional Advocate offer has continued to mature and expand, supporting the resilience, wellbeing and professional development of our Nursing, Midwifery and Allied Health Professional workforce. Our in-house Professional Advocate training programme, delivered in partnership with De Montfort University, has now been fully embedded and expanded to include external delegates alongside Trust colleagues, enabling us to grow our own workforce while also generating income to support sustainability.

We now have 127 trained and active Professional Nurse Advocates, representing a significant increase in capacity and reach. During the year, we also delivered our first multiprofessional Professional Advocate course, formally including Allied Health Professionals. This development has been well received, with increased interest from partner organisations and external enquiries, supporting the Trust's ambition to be recognised as a centre of excellence for professional advocacy and restorative clinical supervision. Every Clinical Service Unit continues to have access to Professional Advocate support, ensuring consistent availability of high-quality restorative supervision, career conversations and support for staff-led quality improvement.

In 2025/26, the full £2.1 million Continuing Professional Development (CPD) allocation was invested to support our Nursing, Midwifery and Allied Heal Professional Workforce. This investment supported a wide range of activity, including top-up and degree-level qualifications, embedding race equity masterclasses, targeted support for staff performance and capability, and continued investment in human factors, patient safety and complaints management. This approach has ensured CPD funding is aligned to both organisational priorities and workforce needs, supporting safe, inclusive and high-quality care delivery.

To further strengthen leadership at the point of care, 58 Band 7 ward and departmental leaders successfully completed the inaugural Excellence in Leadership programme. Building on this successful first year, the programme has now been established as a core element of our leadership development pipeline, with three cohorts planned for 2025/26, one of which is already well underway.

In addition, we introduced Excellence in Leadership for Matrons, incorporating the nationally recognised NHS Leadership Academy Rosalind Franklin Programme. The Trust became the first NHS organisation to hold a Rosalind Franklin licence, representing a significant milestone in leadership capability development and assurance. This programme supports matrons to develop as confident, values-driven system leaders, and strengthens leadership governance across clinical services.

We have continued to reinforce governance and assurance of the Preceptorship Programme, recognising its critical role in supporting newly registered staff. Following the successful attainment of the national interim Preceptorship Quality Marker, we are now preparing for the full national quality marker.

During the year, the preceptorship journey has been fully digitised, providing improved oversight, clearer accountability and enhanced ability to monitor compliance at scale. This has strengthened assurance that newly qualified staff across Nursing, Midwifery and Allied Health Professions are receiving a consistent, high-quality start to their careers, supporting early confidence, competence and retention within the Trust.

12.7 Freedom to Speak Up

The Trust is committed to maintaining a culture of openness, transparency, and learning, where colleagues feel safe and supported to raise concerns about patient care, safety, or wider organisational issues.

The Board is assured that effective Freedom to Speak Up (FTSU) arrangements are in place, led by an independent Guardian who provides objective insight into themes and trends arising from speaking up. The Chief Executive meets regularly with the FTSU Guardian, and a review group operates to assess, monitor and triangulate emerging themes, enabling early identification of risk, organisational learning, and appropriate escalation. The Trust is clear that colleagues who raise concerns are listened to, treated fairly and supported, and should not be disadvantaged for speaking up.

The Board receives the Guardian's formal annual report, alongside a mid-year update, and gains additional assurance through an annual report to the Audit Committee on the effectiveness of the Trust's speaking up processes, controls, and governance arrangements, including how learning from concerns is embedded within patient safety and clinical risk management systems. The Guardian's annual report and mid-year update are also received by the People & Culture Committee, alongside an annual Executive assurance report, providing focused assurance on workforce culture and supporting triangulation with wider Board and Audit Committee oversight.

Considering the serious failures highlighted through the Lucy Letby case and the ongoing Thirlwall Inquiry, the Board has reflected on the importance of further strengthening organisational responsiveness to concerns raised by colleagues. As part of this, the Trust has enhanced Executive-level oversight of Freedom to Speak Up matters, ensuring appropriate scrutiny, escalation and assurance, and reinforcing a clear line of accountability from operational response through to Board oversight.

These arrangements provide the Board with assurance that concerns raised are appropriately considered, acted upon, and used to drive continuous improvement in both patient safety and organisational culture. As Accountable Officer, I am satisfied that Freedom to Speak Up forms an integral part of the Trust's wider system of internal control and supports the effective identification and management of risks to patients, colleagues, and the organisation.

12.8 Guardians of Safe Working

The Chief Medical Officer works with the two Guardians of Safe Working (GoSW) to monitor resident doctors' working hours in line with national terms and conditions. The Board of Directors is sighted on this work through reports through the Learning, Education & Training Committee, a mandatory annual report is received at the May public Board, presented by the Guardians and information included as a statutory requirement within the Quality Account. Where there are increased reports in specific departments, the GoSW escalate this to the Medical Director (Medical Education) who works with them and the two Chief Registrars to get a detailed trainee narrative regarding events, then works with the department to explore how we make improvements. Reporting is in most cases related to high workloads as regional units have diverted acute work into the Trust or care of specific groups of patients where senior cover of trainees continues to be a challenge. In February 2026, new national rules came into effect concerning exception reporting, with a new process for managing fines. The Guardians worked closely with the People Function and Medical Directorate teams to implement a range of new processes that ensure compliance.

12.9 **Staff Safety**

The Trust has put in numerous measures to continue to support our staff. These include but are not limited to:

- Regular review of absence management data in place with Clinical Service Units (CSUs) Triumvirates team / Human Resource Business Partners/ Operational Human Resources/CSUs with actions agreed to support staff back to work
- Management of risks to staff health and wellbeing through the corporate risk CRR04, with robust management of any gaps in mitigations
- Stress risk assessment process in progress/Health & wellbeing conversations to ensure work related burnout and stress is managed effectively
- Review of the Supporting Absence Policy underway to ensure rapid support for staff and compassionate management
- Advice and support available for managers to support them to manage sickness absence available from Operational People Function Team and Occupational Health
- Occupational Health referrals prioritised to where OH can add most value. Significant work undertaken to provide written information as early as possible in interactions with OH, to enable managers to take local action. Flexible working and remote working policies have been developed to ensure the needs of the individual, team and service are met, alongside maximising staff availability
- Mental Health First Aid training in place
- Money Buddies one to one financial advice service available
- Launch of the Leading the Leeds Way Managers Toolkit is complete. There will be a further focus on the new Leadership and Management Framework released April 2026
- Range of support services available to support staff to return to work and stay well at work including Occupational Health, Staff Clinical Psychology, Staff Physiotherapy, Individual Risk Assessments and Vaccinations
- Occupational Therapist employed within Occupational Health to provide input to staff most in need of support
- Industrial Action steering group in place with staff from Emergency Preparedness, Human Resources, Corporate Nursing, Corporate Medical Team, Corporate Operations and CSUsTriumvirates representation
- Incident Command Centre in place in the event of any industrial action, with positive partnership working with Staff Side embedded. Standard work, including understanding what areas are derogated, established for how to manage the impact. Standard work processes are in place for deployment and staff mitigations and utilising agency workers to support essential services during industrial action
- Robust data analysis to ensure understanding of staffing absence in place, with long-term workforce plans supporting planning in each CSU
- We continue to work closely with recognised professional bodies and Trade Unions and have ensured mechanisms are in place for Health & Safety representatives to raise any concerns

13. Significant In-Year Matters

Activity

13.1 All Trusts are required by law to deliver the constitutional standards. The impact of COVID-19 has resulted in a backlog of patients, with NHS England setting out annual targets for providers to support recovery and achieve within year, and to make progress against this backlog.

The Board and its Committee structures receive reports on the performance of the organisation against its duties set out in the Provider Licence. Reporting information is supplied to provide insight to the actual performance position against constitutional standards, full year to date position displayed by Statistical

Process Charts and where appropriate agreed trajectories, to enable actual comparisons to be made year on year.

The Trust reports on elective waiting times throughout the year, in nationally mandated submissions and in regular updates to the Finance & Performance Committee and Trust Board. Data validation is required of CSU teams to confirm the waiting time data recorded for patients waiting for treatment. Training is provided to teams by the Patient Administration System Team and additional support and training is provided by the Performance and Development Team where concerns are identified, or requests are made for additional support.

A number of reports are available to identify potential data quality concerns and identify areas for improvement. The Trust also uses a well-established clinical harm process to assess the extent of any harm associated with long waits and the risks of extended waits are recorded on the Trust's risk register.

The Trust also contributes data to the LUNA health system run by NECS which assesses performance for all trusts in relation to confidence in data and potential pathway issues to strengthen the accuracy of key data quality performance indicators.

Through 2025/2026, the National planning guidance priority aimed to:

- Improve the percentage of patients waiting no longer than 18 weeks for treatment to 65% nationally by March 2026, with every trust expected to deliver a minimum 5%-point improvement: LTHT delivered Referral to Treatment Time at 67.2% in March 2025
- Improve the percentage of patients waiting no longer than 18 weeks for a first appointment to 72% nationally by March 2026, with every trust expected to deliver a minimum 5% point improvement
- Reduce the proportion of people waiting over 52 weeks for treatment to less than 1% of the total waiting list by March 2026
- Improve performance against the headline 62-day cancer standard to 75% by March 2026
- Improve performance against the 28-day cancer Faster Diagnosis Standard to 80% by March 2026
- Improve A&E waiting times, with a minimum of 78% of patients admitted, discharged and transferred from the Emergency Department within four hours in March 2026
- A higher proportion of patients admitted, discharged and transferred from Emergency Department within 12 hours across 2025/26 compared to 2024/25

In 2025/2026 monitoring of the service delivery contract was reported through the Finance & Performance Committee on a monthly basis, using the monthly Constitutional Standard Report, accompanied by a Constitutional Standards Assurance Report to ensure each standard was presented to F&P twice a year, and the Integrated Quality and Performance Report presented on a bi-monthly basis.

The Trust has continued to prioritise the most urgent patients for elective care and treatment, and this prioritisation has been undertaken in line with guidance developed by the Federation of Specialty Surgical Associations which categorised procedures as requiring treatment within specified time bands.

A key ambition during the year was to eliminate the longest waits for treatment except where patients were choosing to wait longer in specific specialties. Nationally, the priority was to reduce the proportion of people waiting over 52 weeks for treatment to less than 1% of the total waiting list by March 2026. The Trust was placed in Tier 1 escalation by NHS England for elective activity in July 2025 until November 2025 when this was removed.

Improvements across our operational priorities has been challenging in 2025/2026 with delivery continuing within an environment of GP collective action, Resident Doctor industrial action and periods of increased referral rates from GPs that were above the predicted demographic referral growth for the Trust at the start and end of the year. In addition, the delivery of CSU activity and performance has been balanced with the absorption of patients who have arrived via the collapse of some services is other trusts in the region, increasing the demand placed on our services. Regardless of this, all our patients who needed more urgent care were prioritised for treatment by our CSUs. Clinical services have worked resolutely across the year to improve waiting times for our patients. The planning guidance for 2025/2026 recognised this with a change in the approach being focussed on fewer than 1% of patient waiting over 52 weeks for care rather than eliminating waits over 52 weeks.

In April 2025, the total number of patients waiting over 52 weeks at the Trust was 2,355, and by the end of March 2026, the Trust delivered a reduced position of 1,302 patients waiting over 52 weeks, finishing March with 52 weeks as 1.5% of the total waiting list. Within this end of March position, 103 patients had waited longer than 65 weeks and these remain within our most challenged CSUs.

Nationally, for treatments within 18 weeks of referral to our services, the Trust ranked 36th out of 118 trusts and we delivered RTT at 67.2% in March 2025.

The Trust participated in the NHSE Total Waiting List (TWL) Validation sprint which ran from Q1 – Q4 of 2025/2026 which was a national housekeeping exercise aimed at reducing the TWL.

The 2025/2026 Priorities and Operational Planning Guidance required Emergency Care Standard (ECS) to be delivered at 78% by March 2026. ECS delivery for March 2026 was 78.6% at the Trust. For the same time last year ECS delivery was at 79.3%. The Trust delivered above the England national average for March 2026 which was 74.9% and ranked 36th for ECS delivery out of 118 Trusts, which was a change from March 2025 when LTHT ranked 21st out of 118 Trusts.

Our March 2026 position demonstrates that out of the 10 peer trusts, the Trust placed third for ECS delivery, with the second highest volume of attendances. This demonstrates the hard work and commitment of Trust teams to ensure that our patients received urgent and emergency care within the four-hour target and demonstrates embedded improvement from 2024/2025 when the Trust delivered on the same positions amongst peers, whilst improving our national position in 2025/2026.

The 2026/2027 Priorities and Operational Planning Guidance requires Trusts to improve A&E waiting times, so that 85% of patients wait no more than four hours, as well as reducing the number who wait over 12 hours, and in addition to support the Ambulance service to improve Ambulance Category 2 performance to an average of 18 minutes.

Attendance levels to the EDs remained high in 2025/2026 with a total of 364,084 attendances for the year across all our departments representing an increase of 1.5% compared to the year prior. Average attendances for 2025/2026 were 30,340, up from 29,903 in 2024/2025.

Q1 of 2025/2026 was particularly challenging for 62-day cancer delivery and a deteriorating position meant that the Trust was placed into Tier 1 for cancer (along with electives) in July 2025. This triggered a fundamental change in approach to cancer delivery which has been outlined in previous papers to the Finance & Performance Committee and the assurance that this provided led to the Trust being moved down into Tier 2 for cancer from November 2025.

As part of the tiering process a revised trajectory was agreed with NHSE from November 2025. The Trust has over delivered against this trajectory for five

consecutive months November 2025 to March 2026 and also achieved a 15% improvement in delivery from June 2025.

The number of patients who have waited over 62 days from GP referral to treatment reduced to 153 at the end of March 2026 with 36 patients waiting over 104 days demonstrating a continued focus on the longest waiting patients. Consistent delivery of the 31-day decision to treatment standard in radiotherapy and Systemic Anti-Cancer Therapy and improvements in the time to surgery has supported the improvement in delivery against the 62-day standard.

For 62 days, we delivered 71.2%, with a national ranking of 66th out of 118 trusts for Cancer 62-day performance.

High volume pathways have a significant impact on Trust-level delivery. Lower GI delivery dipped in May 2025 to 53.7% and has recovered to 84.5% in March 2026. Skin delivery dropped to 61.8% in November 2025 but has recovered to 84% in March 2026 as a result of focused work. Improved oversight of the 28-day backlog is now in place to anticipate and proactively respond to risks at pathway level going forward.

Continued work to reduce pathology turn-around times has been a significant contributor to the improved delivery against the 28-day standard and this work will continue into 2026/2027.

In March 2026 the Trust ranked 27th out of 118 Trusts for Cancer 28-day performance.

The Trust has implemented a number of initiatives to improve efficiency and support pathway changes including:

- Planned care (Admitted)
- Unplanned care
- Cancer
- Diagnostic services
- Outpatient services

Elective Surgical Hub: during 2025/2026, Wharfedale Hospital achieved GIRFT accreditation as an Elective Surgical Hub, with utilisation improved by more than 5%, and investment has been secured for two new theatres at Chapel Allerton Hospital for 2027/2028. Looking ahead to 2026/2027, the key opportunity remains reducing avoidable cancellations and lost case-time, supported by GIRFT guidance. Achieving utilisation and throughput levels comparable with peers will increase capacity, reduce waiting times, and continue to strengthen outcomes and patient experience.

Diagnostics: during 2025/2026, we made considerable progress in improving the way diagnostic tests are used and delivered across Leeds. Our Diagnostics Demand Optimisation (DDO) Programme has focused on ensuring patients receive the right test, at the right time, in the right place. By reducing the number of tests that offer limited clinical value, we have been able to free up capacity, reduce waiting times and improve the overall patient experience.

Engagement from staff across the city has been incredibly positive, with more than 140 improvement ideas submitted. Early results have already shown a reduction of up to 50% in the use of some tests, alongside marked improvements in radiology efficiency and quicker access for patients who need diagnostic investigations.

There are now three operational Community Diagnostic Centres (CDCs) for Leeds. Our three CDCs at Seacroft, Beeston and Armley offer of a range of cardio-respiratory tests, radiology tests and blood tests. The three sites have collectively delivered 115,586 tests between April 2025 to March 2026 which is an increase of 8,646 tests on the 2024/2025 position. Funding has been secured to expand the CDC at Seacroft and deliver increased activity which will be delivered mid-year 2027.

Unplanned care: our Emergency Departments have improved performance and are better than most in the country in delivering the four-hour Emergency Care Standard and average ambulance handover time.

A pilot for 'call before you convey' category 3 and 4 ambulance patients from care homes was agreed across Yorkshire Ambulance Service and the Trust with the purpose of not conveying some patients to A&E if they could safely be better cared for via a virtual ward or community geriatrician support. This aims to reduce disruption to frailer people and their family/friends whilst releasing ambulance time on the road. This initiative is now live.

Cancer: 2025/2026 has seen a number of improvements delivered across the cancer transformation programme:

Pathway review meetings: CSUs and services have taken a different approach to transformation programmes by adopting a model that focuses on pathway working. Bi-monthly sessions have brought together key individuals from all aspects of pathway delivery to identify and explore critical challenges in order to understand how all elements of the pathway need to work in unison to deliver the cancer performance standards. Pathways that have been initially chosen to undergo this approach for 2026/2027 are Lower GI, Skin, Gynae, Head & Neck and Lung.

Multi-Disciplinary Team (MDT) stream-lining: Review of the MDT process has taken place with opportunities provided to teams to identify Standards of Care (SoC) and efficiencies within their pathways. Two SoC's have been developed and established within MDTs to reduce waiting times for patients on a protocolised pathway with others in the pipeline. Other MDT's have reviewed the types of discussions taking place in the meeting and removed administrative tasks from the MDT.

Digital transformation: Digital developments continue to move MDTs and tracking from PPMv1 to PPM+ (patient record systems) providing clinical teams with the opportunity to review and make decisions outside of MDTs (based on SoCs in place) delivering discussions of the right patients at the right time. The transition to PPM+ will also enable the MDT team to 'track by exception', allocating valuable resource to be focused on progressing patients through pathways rather than tracking all patients unnecessarily.

Outpatients: One of our goals for 2025/26 was to make our services easier to use and provide a better patient experience. We wanted to reduce waiting times, make it simpler for people to attend their appointments, and ensure that those who need to be seen most urgently are prioritised.

We listened to patient feedback and redesigned our appointment letters to make them clearer and easier to understand. All letters now have a standard layout and are available in digital format, large print, and on paper. With the help of our expert patient volunteers, we created "easy read" versions of letters, simplified the wording and added clearer directions to help patients and visitors find their way around our busy hospital sites.

We have reduced the proportion of patients waiting over 18 weeks for their first appointment by 1.3% and provided over 9,000 additional new appointments.

A new booking tool has reduced the time needed to make appointments by 60% and expanded the choice available to patients. We have also introduced a new report to help services prioritise clinically urgent follow up patients and trialled new ways of contacting patients on waiting lists, which we plan to expand across more services in 2026/2027.

These actions have contributed to a 6% reduction (around 4,500 people) in the number of patients waiting for definitive treatment in Outpatients. We have also focused on reducing concerns and complaints related to contacting departments and appointment waiting times, leading to a 7% reduction in those enquiries to our Patient Advice and Liaison Service.

In 2026/2027, we will continue to focus on making things easier for patients to access healthcare at our hospitals. Our priorities will include modernising our outpatient services using technology to

improve the quality of interactions with our clinicians, improving the process for cancelling or changing appointments, and providing extra support for people living in the most deprived areas of the city, so that everyone can access the healthcare they need.

Safety

13.2 The Trust has embedded the NHS Patient Safety Incident Response Framework (PSIRF) and has developed a second Patient Safety Incident Response Plan for 2024/26. Due to ongoing regulatory activity, the two-year plan 2024/26 has been extended until 2027. In 2025/26 there were 12 patient safety events that met the criteria for reporting under the 2024/26 LTHT Patient Safety Incident Response Plan, a total of 26 for the whole 2024/26 period. Each case has been thoroughly investigated and reported to local commissioners and our Quality Assurance Committee. Detailed action plans have been developed and implemented in response to each specific case.

There were four incidents which qualified for reporting as a Never Event in 2025/26; Three retained items following invasive procedures and an overdose of insulin due to incorrect device used. Two of these incidents have been subject to a Patient Safety Incident investigation; the findings and actions have been shared with staff across the organisation. Two of the retained item events were reviewed through the after-action review process which engages those involved in the incident to understand how the incident occurred and action to be taken to prevent reoccurrence All never events were reported to the Quality Assurance Committee.

There was one formal Prevention of Future Death Report (known as Regulation 28 Report) issued by the coroner. The Trust has addressed the concerns raised by the coroner in this case.

There were 54 (46 of those relating to staff) events that met the criteria for reporting to the Health & Safety Executive under the provisions of the Reporting of Injuries, Diseases or Dangerous Occurrences (RIDDOR) Regulations for the period 2025/26. The RIDDOR reportable incidents submitted by the Trust primarily relate to moving and handling activities, slips, trips and falls, and physical assaults.

For slips, trips, and falls, incidents continue to reflect a range of contributory factors rather than a single dominant cause. These include liquid spillages or residue following cleaning, obstructions or items left in circulation areas, and behavioural factors such as rushing. Analysis has not identified any new or emerging trends. The Health and Safety Team continues to support the Falls Prevention Steering Group in its review of patient falls, ensuring shared learning and risk reduction across both staff and patient incidents.

Injuries related to moving and handling and physical assaults continue to occur during higher-risk activities, such as assisting patients to mobilise, or in situations involving unpredictable patient behaviour; for example, in post-anaesthetic recovery or where underlying medical conditions contribute to confusion, agitation, or loss of control. These risks remain inherent within patient care and are subject to ongoing monitoring and review.

Blood and bodily fluid contamination or inoculation injuries often occur during or immediately after patient care activities. These may be linked to unpredictable patient movement during procedures such as phlebotomy or may arise during the disposal of used sharps, particularly where safety mechanisms have not been fully or correctly activated. These incidents continue to be monitored through established governance arrangements.

Infection Prevention & Control (IPC)

13.3 Antimicrobial resistance (AMR) is a growing threat to health and impedes the safe provision of all healthcare services. The impact of AMR has increased in Leeds over recent years,

in line with the rest of the UK, and is increasingly recognised as a healthcare-associated risk. The Director of Infection Prevention leads a diverse programme of improvement to ensure the Trust provides the best leadership, education, laboratory diagnostics, guidance and infection prevention practices to keep patients safe from AMR. Vaccine-preventable diseases such as measles and pertussis (whooping cough) continue to affect the population of West Yorkshire, and teams at the Trust work closely with public health, city council, occupational health and clinical experts to prevent harm from these infections. The reduction of healthcare associated infections (HCAIs) remains a key priority, this year, our annual plan and the IPC Board Assurance Framework continued to reflect the key work streams to prevent HCAIs.

In 2025/26 there was a small rise in HCAI's in Leeds, with community infection data reflecting the cases seen in the Trust. The Community and the Trust IPC teams continue to work very closely to identify how best to prevent infection in the Leeds population. In summary:

- The Trust recorded 175 cases of Clostridioides difficile infection (CDI), a slight increase in the number of cases seen in 2024/25 (173 cases)
- Ten cases of Meticillin-resistant Staphylococcus aureus (MRSA) blood stream infections (BSI) occurred against a trajectory of zero, one case more than 2024-25
- There is no nationally set objective for Meticillin-sensitive Staphylococcus aureus (MSSA) and, as in previous years, the Trust set an internal quality improvement objective. In 2025/26 the Trust saw 109 cases of MSSA bloodstream infection which is a slight increase on the year before
- The Trust detected 303 Escherichia coli (E. coli) BSI's, a similar rate to the previous year
- There was an increase of Pseudomonas aeruginosa BSI's, with the Trust recording 59 cases compared to 2024/25 with 45 cases
- The Trust recorded a reduction in the number of Klebsiella sp. BSI's of 126 for 2025/26 against 141 for 2024/25

The Trust continues to receive detailed IPC assurance and escalation through the Quality Assurance Committee. The IPC Team has detailed metrics and understanding of HCAI BSI and CDIs following implementation of the Patient Safety Incident Response Framework (PSIRF) in 2024-2025. This year clinical service units (CSUs) have embedded the review processes successfully, and now have strong oversight of HCAI cases, themes and risks which has led to delivery of targeted action and improvement projects. The process also facilitates improvement in standard IPC practices as per the national IPC manual. The HCAI Improvement Group was launched in January 2026 providing a forum for CSUs to share IPC learning and lead trust-wide improvements at scale. During 2025-26 we welcomed a patient partner to the Infection Prevention and Control Sub-Committee and HCAI Improvement Group providing a patient perspective within the IPC decision making arena.

Summer 2025 saw the Trust launch new 'Antimicrobial Guidance for Children and Neonates' on the Eolas platform, providing rapid access to diagnostic advice and antimicrobial treatment advice at the touch of a button. This complements the 'Adult Antimicrobial Guidance', where additional guidance on infection prevention, high-consequence infectious diseases and prescribing advice is now also available.

Careful use of antimicrobials is an essential aspect of controlling AMR and our approach to monitor the safe use of antibiotics, "#CARES", is an important element of antimicrobial stewardship. The Trust Vascular Access Device Group has made excellent progress in 2025/26 and oversees improvement initiatives including a proposal for standardisation of Aseptic Non-Touch Technique (ANTT) training which was purchased in March 2026 and a strategy for online ANTT training is underway.

In February, the Director of Infection Prevention and Control launched a trust-wide month-long focus campaign on reduction strategies for Staphylococcus aureus (MRSA and MSSA). This was supported by the trust's infection prevention, microbiology and communications team. The campaign included:

- Educational webinars
- Educational 5 slide set – disseminated through clinical leaders to CSU workforce
- Posters and promotional materials
- 99+ ward visits with questionnaires and bedside education
- Ward poster board competition
- Suite of educational resources
- Weekly operational updates for ward teams

In 2026/27 we will continue to provide tailored interventions to prevent infection to those at greatest risk immediately from the time of arrival in hospital. The IPC Team will be supporting Clinical Teams with their improvement programmes focused on clinical themes and infections of concern in their area and lead a collaborative approach to reduction in healthcare associated infections (HCAIs).

Aging Estate

13.4 The Trust is mitigating ongoing, significant challenges associated with the historic legacy of underinvestment in its built infrastructure. This resulting in one of the highest backlog maintenance levels in the NHS, a significant proportion being critical infrastructure.

There are a number of high-level risks within the Corporate Risk Register described as; insufficient capital resources, unserviceable critical IT infrastructure and resilience issues, power failure, limited and/ or dated ventilation systems, and lack of IPS/UPS resilience. Significant capital resources have also been diverted to repairing Brotherton Wing roof.

In 2019/20 the Trust Board approved the five-year financial plan including capital expenditure. The Trust has delivered a record-breaking capital programme in recent years, but limited capital in future years will undoubtedly impact on our ability to maintain or reduce this level of growing backlog and deteriorating estate.

Backlog maintenance has grown significantly and is now in excess of £230m, largely due to inflation and aging infrastructure.

Around 50% of our maintenance backlog was planned to be addressed by the redevelopment of the LGI site, as part of our hospitals of the future scheme within the New Hospitals Programme (NHP). Delays on progressing this scheme have placed additional pressures on our maintenance teams, revenue, and limited capital resources, with an increasing need for us to repair and maintain older assets which are no longer fit for purpose.

The lack of investment and delays to the NHP will also impact on our ability to meet our Net Zero requirement by 2040 and ability to maintain our listed buildings to a compliant state.

Compliance to other regulatory bodies

13.5 It is a legal requirement of all organisations sponsoring and hosting Clinical Trials of an Investigational Medicinal Products (CTIMPs) to comply with UK medicines for human use (clinical trials) regulations (2004). The Medicines and Healthcare Products Regulatory Agency (MHRA) carried out a Good Clinical Practice (GCP) system inspection of the Trust and University of Leeds in November 2022 which had no critical findings.

A recent unannounced inspection of the Human Tissue Authority (HTA) postmortem licence occurred in April 2026 which involved visits to the mortuaries at LGI and SJUH. The HTA found that the Trust had met the majority of the HTA's standards, with three major (a non-critical shortfall) and one minor shortfall found against standards for traceability processes and

premises, facilities and equipment. These shortfalls relate to our coding and recording systems and matters relating to the estate. The HTA has assessed the establishment as suitable to be licensed for the activities specified, subject to corrective and preventative actions being implemented to meet the shortfalls identified during the inspection. The HTA has made six recommendations in its final response which will be picked up as part of the corrective and preventative action plan and progress will be monitored through the Trust HTA Working Group and will report to Quality and Safety Assurance Group.

The Trust delivers one of the largest medical education programmes in the country, and in the past academic year delivered almost 3,000 high quality clinical placements across the organisation for medical students from the University of Leeds, supported 1,100 Trust-based resident doctors with their training, 90 SAS Grade doctors and a number of Physician Assistants. The Medical Education Team delivered a range of local, regional and national clinical skills and simulation courses. Quality continued to be assessed by NHS England, under the Education Funding Agreement. This is done through a combination of self-assessment and Senior Leader Engagement (SLE) and Monitoring the Learning Environment (MLE) events. Training issues, as they arise, are managed through proactive engagement with training leads across the Trust. Both NHS England and the General Medical Council are satisfied with the Trust's quality management of medical education. The library service underwent a positive NHS England led quality review in December 2025 and January 2026.

In recent years, there has been a marked increase in the number of learners with additional needs in both the undergraduate and postgraduate arenas. The Undergraduate Team have continued to deliver a range of innovative support measures for students, including enhanced teaching, more support for examination preparation and with placement leads. The Trust's Professional Support and Wellbeing Team (PSWT) specifically focuses on resident doctors experiencing difficulties (e.g. through ill health, problems relating to their training, etc.). Over the last five years, the team has supported more than 700 individuals. In addition, the Trust continues with its engagement programme, e.g. the Resident Doctor Body (led by the chief registrars), the Resident Doctor Forum (run in collaboration with the Guardians of Safe Working). In May, the Trust holds an annual Resident Doctor and Dentist Appreciation Week, which concludes with a conference and awards ceremony.

We continue to develop partnerships with institutions in other parts of the world, which open up alternative supply routes for our medical workforce. Our relationships with Jordan, Malta and Pakistan are thriving with increasing numbers of Fellows being placed in Leeds.

The Trust has a highly rated Library and Knowledge Service, with facilities located at the LGI, St James's and Wharfedale hospitals. On average, more than 2,000 staff per month make use of the facilities in Bexley Wing and 2,100 use the LGI. The team is part of a pan-Leeds network of libraries, where NHS, academic and local authority services collaborate to ensure all users have access to all facilities and services. The team continue to develop dedicated resources in support of the inclusion and belonging agenda, especially in terms of resources for BME, LGBTQ+ staff as well as colleagues with neurodiversity.

14. Conclusion

In June 2025, the CQC completed an inspection against the Well-led quality statements. The CQC rated the Trust as 'requires improvement' and identified the Trust were in breach of regulations relating to Complaints, Good Governance and Staffing. A Trust Improvement Plan was developed and is being delivered with oversight of NHS England. Following the publication of the Trust Well-led report and entry into the Maternity Support Programme, NHS England put in place enforcement undertakings (as per section 106 of the Health and Social Care Act 2012) to underpin and guide the actions required in response to breaches, or suspected breaches, of the NHS Provider Licence principles, systems and standards of good corporate governance.

I confirm that there are no further significant breaches of internal control that have been brought to my attention in respect of the financial year ended 31 March 2026 not already cited within the Annual General Statement. This statement aims to capture the priorities of risks and controls for Leeds Teaching Hospitals NHS Trust.

Signed

Brendan Brown, Chief Executive

Date: 25 June 2026

Salary and pension entitlements of Senior Managers

A) Salaries and allowances - Chair and Non-Executive Directors

	2025-26					2024-25				
Name and title	Salary	Expense Payments (taxable)	Other Payments	All Pension-related Benefits	TOTAL	Salary	Expense Payments (taxable)	National Clinical Excellence Award	All Pension-related Benefits	TOTAL
	(bands of £5000) £000	Rounded to the nearest £100	(bands of £5000) £000	(bands of £2,500) £000	(bands of £5000) £000	(bands of £5000) £000	Rounded to the nearest £100	(bands of £5000) £000	(bands of £2,500) £000	(bands of £5000) £000
Dame L. Pollard DBE DL Hon LLD - Chair (to 31 July 2025)	20-25	11	0	0	**20-25**	60-65	37	0	0	**65-70**
A Kildare - Chair (from 1 August 2025 – Note 1)	40-45	10	0	0	**45-50**	n/a	n/a	n/a	n/a	**n/a**
M Baker CBE - Non Executive Director and Senior Independent Director	10-15	16	0	0	**10-15**	10-15	5	0	0	**10-15**
G Taylor - Non Executive Director and Joint Deputy Chair	10-15	26	0	0	**10-15**	10-15	10	0	0	**15-20**
C Schofield - Non Executive Director and Joint Deputy Chair (to 31 July 2025)	0-5	0	0	0	**0-5**	10-15	0	0	0	**10-15**
M Burton - Non Executive Director	10-15	0	0	0	**10-15**	10-15	0	0	0	**10-15**
P Corrigan - Non Executive Director (to 31 March 2026)	10-15	1	0	0	**10-15**	10-15	6	0	0	**10-15**
Prof J Nixon - Non Executive Director (to 31 July 2025)	0-5	0	0	0	**0-5**	10-15	0	0	0	**10-15**
S Le Clerc - Non Executive Director (from 22 November 2025)	0-5	0	0	0	**0-5**	n/a	n/a	n/a	n/a	**n/a**
A Greenwood - Non Executive Director (from 1 October 2025)	5-10	0	0	0	**5-10**	n/a	n/a	n/a	n/a	**n/a**
Prof A Graves - Non Executive Director (from 1 September 2025)	5-10	0	0	0	**5-10**	n/a	n/a	n/a	n/a	**n/a**
R Simpson - Non Executive Director (to 31 January 2025)	n/a	n/a	n/a	n/a	**n/a**	10-15	0	0	0	**10-15**
S Clark - Non Executive Director (to 30 September 2024)	n/a	n/a	n/a	n/a	**n/a**	5-10	0	0	0	**5-10**
Prof J Brown - Non Executive Director (to 31 May 2024)	n/a	n/a	n/a	n/a	**n/a**	0-5	0	0	0	**0-5**
J Koroma - Associate Non Executive Director	10-15	2	0	0	**10-15**	10-15	3	0	0	**10-15**
A Stainton - Associate Non Executive Director	10-15	2	0	0	**10-15**	10-15	8	0	0	**10-15**
Prof L Stroud - Associate Non Executive Director	10-15	0	0	0	**10-15**	10-15	3	0	0	**10-15**
R Singh - Associate Non Executive Director	0-5	0	0	0	**0-5**	n/a	n/a	n/a	n/a	**n/a**
R Woodman - Associate Non Executive Director (to 31 August 2024)	n/a	n/a	n/a	n/a	**n/a**	5-10	5	0	0	**5-10**

Executive Directors

	2025-26					2024-25				
Name and title	Salary	Expense Payments (taxable)	Other Payments	All Pension-related Benefits	TOTAL	Salary	Expense Payments (taxable)	National Clinical Excellence Award	All Pension-related Benefits	TOTAL
	(bands of £5000) £000	Rounded to the nearest £100	(bands of £5000) £000	(bands of £2,500) £000	(bands of £5000) £000	(bands of £5000) £000	Rounded to the nearest £100	(bands of £5000) £000	(bands of £2,500) £000	(bands of £5000) £000
Prof P Wood - Chief Executive (to 14 September 2025 - Note 2)	145-150	4	0	0	**145-150**	275-280	8	5-10	235-237.5	**520-525**
Brendan Brown - Chief Executive (from 15 September 2025)	150-155	15	0	85-87.5	**235-240**	n/a	n/a	n/a	n/a	**n/a**
J Ehrhardt - Director of Finance (from 5 August 2024)	225-230	14	0	65-67.5	**290-295**	140-145	5	0	0	**140-145**
J Gamble - Interim Director of Finance (from 15 July 2024 to 4 August 2024)	n/a	n/a	n/a	n/a	**n/a**	5-10	4	0	0	**5-10**
Dr M Harrison - Chief Medical Officer	265-270	8	0	65-67.5	**330-335**	255-260	8	0	180-185	**440-445**
Dr P Jones - Chief Digital and Information Officer	190-195	74	0	45-47.5	**245-250**	185-190	63	0	57.5-60	**250-255**
J Goodyear - Director of Planning and Strategy (to 29 November 2024)	n/a	n/a	n/a	n/a	**n/a**	95-100	12	0-5	0	**100-105**
C Richardson - Director of Estates and Facilities	165-170	29	0	37.5-40	**205-210**	160-165	21	0	22.5-25	**185-190**
J Lewis - Director of Human Resources and Organisational Development (to 28 September 2025)	95-100	2	0	30-32.5	**125-130**	190-195	4	0	n/a	**190-195**
C Smith - Chief Operating Officer and Deputy Chief Executive (to 21 November 2025)	135-140	5	0	82.5-85	**215-220**	200-205	8	0	35-37.5	**240-245**
R Tindale - Chief Nurse	110-115	5	0	102.5-105	**215-220**	170-175	8	0	282.5-285	**455-460**
K Sims - Interim Chief People Officer (from 29 September 2025 to 19 December 2025)	40-45	0	0	22.5-25	**60-65**	n/a	n/a	n/a	n/a	**n/a**
S Dunkley - Chief People Officer (from 5 January 2026)	45-50	6	0	12.5-15	**60-65**	n/a	n/a	n/a	n/a	**n/a**
T Hiles - Chief Operating Officer (from 10 November 2025)	60-65	29	0	0	**60-65**	n/a	n/a	n/a	n/a	**n/a**
B Geary - Interim Chief Nurse (from 29 September 2025)	90-95	0	0	0	**90-95**	n/a	n/a	n/a	n/a	**n/a**
S Worthington - Director of Finance (to 14 July 2024)	n/a	n/a	n/a	n/a	**n/a**	60-65	2	5-10	n/a	**70-75**

Note 1: A Kildare was appointed Chair by NHS England in June 2025 with a start date of 1 August 2025 and joined the Trust in July 2025 for induction and handover.

Note 2: The exiting Chief Executive has claimed pension benefits in 2025. As a consequence, there are no pension benefits to disclose.

- The Trust is compliant with the Very Senior Management (VSM) pay framework. Changes in year to the Executive Team for the secondment arrangements for Brendan Brown, Kate Sims and Beverley Geary against the VSM criteria for those earning over £170k were approved by NHS England. Also, the substantive appointment in year for 2025/26 for Suzanne Dunkley followed the VSM process was with confirmation by NHS England.
- Expense payments are rounded to the nearest £100 in the above table. Pension related benefits are shown in bands of £2,500. All other remuneration is shown in bands of £5,000.
- Includes all amounts paid and payable in respect of the period the individual held office.
- Taxable expenses for the Chief Executive Officer, Chief Operating Officer, the Director of Finance, Chief Digital and Information Officer, and the Director of Estates and Facilities include the value of lease cars paid via salary sacrifice. All other taxable expenses are in respect of taxable business mileage, car parking and telephone costs.
- The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide.
- The NHS Pension Scheme is a "defined benefits" scheme based on final salary and/or career average earnings. Thus, where a senior manager's salary increases this results in a larger movement in the overall value of their pension entitlement. Similarly, where there is a limited increase in the value of the pension payable relative to inflation and the employees' contributions, then the HMRC calculation can show a "negative pensions benefits" figure for the year which is then shown as a "nil" figure in the table. These factors mean that year on year there can be significant volatility in the reported pensions' benefits for an individual. Where a director retires or where a retirement scheme matures during the year, it is not possible to calculate pension related benefits for the year.
- There are no long-term performance pay or bonuses for senior managers in the current or preceding financial years.
- All pension-related benefits are calculated using the HMRC method as set out in Section 229 of the Finance Act 2004. The Department of Health and Social Care has clarified that for NHS bodies this is the "real increase in pension multiplied by 20 plus the real increase in lump sum less contributions made by the individual equals Accrued Pension Benefits." The NHS Pension Scheme is a "defined benefits" scheme based on final salary and/or career average earnings. Thus, where a senior manager's salary increases this results in a larger movement in the overall value of their pension entitlement. Similarly, where there is a limited increase in the value of the pension payable relative to inflation and the employee's contributions, then the HMRC calculation can show a "negative pensions benefits" figure for the year which is then shown as a "nil" figure in the table. These factors mean that year on year there can be significant volatility in the reported pensions benefits for an individual.
- The pension benefit table provides further information on the pension benefits accruing to the individual.

B) Pension benefits

Name and title	Real increase in pension at pension age	Real increase in lump sum at pension age	Total accrued pension at pension age as at 31 March 2026	Lump sum at pension age related to accrued pension at 31 March 2026	Cash Equivalent Transfer Value at 01 April 2025	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2026
	(bands of £2,500) £000	(bands of £2,500) £000	(bands of £5000) £000	(bands of £5000) £000	£000	£000	£000
Prof P Wood - Chief Executive (to 14 September 2025) - (Note 1 & 2)	0	0	5-10	0	2,405	0	109
B Brown - Chief Executive (from 15 September 2025)	2.5-5	0	40-45	0	577	36	675
J Ehrhardt - Director of Finance (from 5 August 2024)	2.5-5	0	40-45	0	577	36	675
Dr M Harrison - Chief Medical Officer	2.5-5	0-2.5	75-80	170-175	1,367	56	1,451
Dr P Jones - Chief Digital and Information Officer (to 29 November 2024)	5-7.5	0-2.5	70-75	185-190	1,609	70	1,713
J Lewis - Director of Human Resources and Organisational Development (to 28 September 2025)	2.5-5	0-2.5	45-50	60-65	896	47	963
C Richardson - Director of Estates and Facilities	0-2.5	0	10-15	0	179	11	213
C Smith - Chief Operating Officer and Deputy Chief Executive (to 21 November 2025)and Organisational Development (Note 1)	0-2.5	0-2.5	35-40	80-85	697	0	659
R Tindale - Chief Nurse (to 9 November 2025)	2.5-5	0	55-60	0	854	41	936
K Sims - Interim Chief People Officer (from 29 September 2025 to 19 December 2025)	5-7.5	7.5-10	85-90	225-230	150	24	213
S Dunkley - Chief People Officer (from 5 January 2026)	0-2.5	0	20-25	0	245	11	299
T Hiles - Chief Operating Officer (from 10 November 2025)	0-2.5	0	45-50	115-120	888	80	1,112
B Geary - Interim Chief Nurse (from 29 September 2025)	0	0	10-15	0	162	19	221

Note 1: Where a member has reached normal retirement age for membership of one of the schemes during the year, the CETV at the end of the year reflects only the continuing scheme. Where the Director is not yet drawing benefits from such a scheme, the accrued pension and lump sum are disclosed.

Note 2: The exiting Chief Executive Prof. Phil Wood has claimed his pension in year 2025. The exiting Director of Human Resources and Organisational Development Jenny Lewis claimed pension benefits the previous year.

- The Trust is a member of the NHS Pension Scheme, which is a defined benefit Scheme, though accounted for locally as a defined contribution scheme. The Trust does not operate nor contribute to a stakeholder's pension scheme. Non-Executive Directors are not members of the Trust pension scheme. Disclosure is made in respect of pension benefits for those Directors who were active members of the NHS Pension Scheme during 2025/26. Where a director temporarily suspends their membership and subsequently rejoins the Scheme, their increases in pension benefits and a Cash Equivalent Transfer Value (CETV) can be significant as they will cover the period where membership was suspended.
- A CETV is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.
- Real Increase in CETV - This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

The Public Sector Pension Scheme Remedy (McCloud)

On 1 April 2015, the government made changes to public service pension schemes which treated members differently based on their age. The Public Service Pensions Remedy puts this right and removes the age discrimination for the remedy period, between 1 April 2015 and 31 March 2022. Part 1 of the remedy closed the 1995/2008 Scheme on 31 March 2022, with active members becoming members of the 2015 Scheme on 1 April 2022. For Part 2 of the remedy, eligible members had their membership during the remedy period in the 2015 Scheme moved back into the 1995/2008 Scheme on 1 October 2023. This is called 'rollback'.

Where a member who is a senior manager is affected by rollback the benefits in respect of their pensionable service during the remedy period are valued as being in the 1995/2008 Scheme. As a result, there may be a difference between the benefits and Cash Equivalent Transfer Value (CETV) disclosed for this year as compared to the benefits and CETV disclosed for the year ending 31 March 2025.

Where this results in negative real increase in pension, lump sum or CETV, this is shown as a "nil" figure in the table for the senior managers affected by the Public Service Pensions Remedy. Rollback may also result in a substantial upward revaluation of pension benefits in year.

2.5 Staff costs and numbers (subject to audit)

Staff Costs

Employee Benefits - Gross Expenditure	2025/26			2024/25
	Permanent £000	Other £000	Total £000	Total £000
Salaries and wages	951,747	52,548	**1,004,295**	949,925
Social security costs	119,616	-	**119,616**	91,650
Apprenticeship levy	4,879	-	**4,879**	4,714
Employer's contributions to NHS Pension Scheme	192,320	-	**192,320**	181,883
Pension costs - other	1,006	-	**1,006**	1,282
Termination benefits	108	-	**108**	245
Temporary staff	-	21,656	**21,656**	15,492
Total gross staff costs	**1,269,676**	**74,204**	**1,343,880**	**1,245,191**
Recoveries in respect of seconded staff	-	-	-	-
Total staff costs	**1,269,676**	**74,204**	**1,343,880**	**1,245,191**
Of which				
Costs capitalised as part of assets	4,326	1,250	**5,576**	6,241

Staff Numbers

Average staff numbers (WTE basis)	2025/26			2024/25
	Permanent Number	Other Number	Total Number	Total Number
Medical and dental	2,857	71	**2,928**	2,830
Administration and estates	2,944	37	**2,981**	3,151
Healthcare assistants and other support staff	3,781	511	**4,292**	4,322
Nursing, midwifery and health visiting staff	5,397	272	**5,669**	5,514
Nursing, midwifery and health visiting learners	2	0	**2**	2
Scientific, therapeutic and technical staff	2,355	21	**2,376**	2,369
Healthcare science staff	1,258	36	**1,294**	1,250
Social care staff	3	0	**3**	3
Other	800	0	**800**	768
TOTAL average numbers	**19,397**	**948**	**20,344**	**20,209**
Of which				
Number of employees (WTE) engaged on capital projects	65	27	**92**	98

Average staff numbers (WTE basis)	2025/26	2024/25
Number of permanently employed staff	19,397	19,405
Other staff	948	804
Total average number of staff (wte)	**20,345**	**20,209**
Staff engaged on capital projects	**92**	98

Since 2024/25 the Trust calculates staff numbers based on contracted hours.

Staff Turnover Percentage

Up to date information on Leeds Teaching Hospitals' staff turnover figures can be found on www. digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics. The series is an official statistics publication complying with the UK Statistics Authority's code of practice. Data is provided in groups.

Staff sickness and ill health retirement

Staff sickness data and ill health retirements	2025/26	2024/25
Total days lost	226,996	220,218
Total staff years	19,216	19,295
Average working days lost (per WTE)	**11.8**	**11.40**
Number of early retirements on the grounds of ill-health	18	23
Value of early retirements on the grounds of ill-health	1,059	2,433

Details of staff sickness and absence data can be found via NHS England Digital publication services: www.digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates

Reporting of compensation schemes - exit packages 2025/26

	2025/26			2024/25		
Reporting of compensation schemes - exit packages	No. of compulsory redundancies	No. of other departures agreed	Total no. of exit packages	No. of compulsory redundancies	No.of other departures agreed	Total no. of exit packages
Exit package cost band (including any special payment element)						
<£10,000	1	7	**8**	2	1	**3**
£10,000 - £25,000	-	-	-	1	-	**1**
£25,001 - 50,000	2	2	**4**	1	-	**1**
£50,001 - £100,000	2	-	**2**	1	-	**1**
£100,001 - £150,000	1	-	**1**	1	-	**1**
£150,001 - £200,000	-	-	-	-	-	-
>£200,000	-	-	-	-	-	-
Total number of exit packages by type	**6**	**9**	**15**	6	1	**7**
Total cost (£)	£342,000	£102,000	**£444,000**	£263,000	£8,000	**£271,000**

Exit packages: other (non-compulsory) departure payment

Expenditure on consultancy	2025/26		2024/25	
	Payments agreed Number	Total value of agreements £000	Payments agreed Number	Total value of agreements £000
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	9	102	-	-
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT / DHSC approval	-	-	1	8
Total	**9**	**102**	**1**	**8**
Of which:				
Non-contractual payments requiring HMT / DHSC approval made to individuals where the payment value was more than 12 months' of their annual salary	-	-	-	-

2.6 Fair Pay Multiples (subject to audit)

In accordance with HM Treasury requirements, reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the 25th percentile, median and 75th percentile remuneration of the organisation's workforce. Total remuneration is to be further broken down to show the relationship between the highest paid Director's salary component of their total remuneration against the 25th percentile, median and 75th percentile of salary components of the organisation's workforce. Total remuneration comprises salary and allowances, performance pay and bonuses and all taxable benefits. It does not include any severance payments, employer pension contributions and the cash equivalent transfer value of pensions. Remuneration is calculated on the annualised full-time equivalent staff of the Trust at the reporting date (31 March 2026). The highest paid Director in 2025/26 and 2024/25 is the Chief Executive. In year 2025/26 there are no clinical excellence award or other taxable benefit to report. (in 2024/25 the Chief Executive Prof. Phil Wood received a clinical excellence award and a taxable benefit).

Highest paid Director	2025/26 Bands of £5k £'000	2024/25 Bands of £5k £'000
Salary	295-300	275-280
Clinical Excellence Award	0	5-10
Total Remuneration	**295-300**	**280-285**

As mandated by the GAM 2025/26 section 3.109, from this financial year, Non-Executive Directors are outside of the scope of fair pay disclosures. The average percentage change in average employee remuneration of the Trust (based on total for all employees on an annualised basis divided by full-time equivalent number of employees) between 2025/26 and 2024/25 is an increase of 7.2% (2024/25 - increase of 4.4%). This reflects pay awards and changes in the skill mix of the workforce.

The percentage change in respect of the salary of the highest-paid Director is an increase of 7.2% (2024/25 – increase of 7.8%). There was no clinical excellence award to report in 2025/26 which makes a percentage change of -100% in comparison to previous year (2024/25 -57.1%).

The relationship to the remuneration and salary of the organisation's workforce is disclosed in the tables below:

	25th percentile	Median	75th percentile
2024-25			
Total Remuneration (£)	27,991	38,688	52,674
Salary component of total remuneration (£)	27,991	38,688	52,674
Pay ratio information	10.6	7.7	5.6
2023-24			
Total Remuneration (£)	26,530	36,622	49,220
Salary component of total remuneration (£)	26,530	36,222	49,220
Pay ratio information	10.6	7.7	5.7

Remuneration ranged from £25-£30k to £295-300k in 2025/26 (2024/25 £10-15k to £285-290k). The difference from 2024/25 to 2025/26 on the lowest remuneration range is due to the non-inclusion of Non-Executive Directors as part of the calculations from 2025/26. No employee received remuneration in excess of the highest paid Director in 2025/26 (2024/25 – 1). Payments made to agency staff have been excluded where these mainly relate to payments made to cover absences of existing employees whose whole-time, full-year equivalent remuneration has already been included in the calculation of the median.

Agency staff covering vacancies at the reporting date have been included. In these cases, only the remuneration paid to the employee is included; where this is not readily available a reasonable estimate has been ascertained and included.

2.7 Off-payroll engagements (not subject to audit)

Length of all highly paid off-payroll engagements

For all off-payroll engagements as of 31 March 2026, for more than £245[1] per day:

	Number
Number of existing engagements as of 31 March 2025	7
Of which, the number that have existed:	
for less than one year at the time of reporting	5
for between one and two years at the time of reporting	2
for between two and three years at the time of reporting	-
for between three and four years at the time of reporting	-
for four or more years at the time of reporting	-

Off-payroll workers engaged at any point during the financial year

For all off-payroll engagements between 1 April 2025 and 31 March 2026, for more than £245[1] per day

	Number
Number of temporary off-payroll workers engaged between 1 April 2025 and 31 March 2026	8
Of which	
Number not subject to off-payroll legislation	-
Number subject to off-payroll legislation and determined as in-scope of IR35	1
Number subject to off-payroll legislation and determined as out of scope of IR35	7
Number of engagements reassessed for compliance or assurance purposes during the year	-
Of which	
Number of engagements that saw a change to IR35 status following review	-

Note (1) the £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

2.8 Regulatory ratings

In 2025/26 we continued to work with partners, including commissioners at NHS England, the West Yorkshire Integrated Care Board and Leeds Place and the Care Quality Commission.

The Trust was required to register with the Care Quality Commission (CQC) under Section 10 of The Health and Social Care Act 2008 from 1 April 2010.

The Trust is required to be compliant with the fundamental standards of quality and safety. The Care Quality Commission has not taken enforcement action against Leeds Teaching Hospitals NHS Trust during 2025/26. However, following the inspection of Maternity Services CQC issued a section 29A warning notice in relation to staffing.

In 2025/26 the CQC published inspection reports following reviews of two of our core services; maternity and neonatal services undertaken in 2024/25, alongside a Trust-wide Well-Led review conducted in June 2025. These inspections have provided important opportunities for reflection and learning.

The CQC's service inspection of maternity and neonatal services at St James's University Hospital and Leeds General Infirmary identified the Trust was in breach of legal regulations relating to learning following incidents, risk management, safe environment, infection prevention and control, medicines management and some governance processes. A Perinatal Improvement Plan was developed and is being delivered with oversight of NHS England.

During 2025/26 the Trust has worked constructively with NHS England and key stakeholders to respond to the findings providing regular oversight of delivery of the Perinatal and Trust Improvement Plans and measures of performance, finance and quality to the Integrated Quality Improvement Group.

In June 2025 the CQC completed an against the Well-Led quality statements. The CQC rated the well led key question as requires improvement and identified the Trust was in breach of legal regulations relating to complaints, good governance and staffing. A Trust Well-led Improvement Plan was developed and is being delivered with oversight of NHS England.

The Trust has continued to engage with the CQC and has kept them informed of changes to the Statement of Purpose reflecting the changes to the Executive team and alignment of registered managers to regulated services.

2.9 Modern Slavery Act

Leeds Teaching Hospitals NHS Trust is fully committed to the Government's goal of eradicating modern slavery and human trafficking. We have zero tolerance for slavery and human trafficking and are fully aware of our responsibilities towards our service users, employees and local communities. We expect that all companies we do business with to share the same ethical values. Our procurement processes and procedures support us in conducting business in an ethical manner. We work collectively across the NHS on this important objective and align our commitment to the national NHS statement provided via www.england.nhs.uk/safeguarding/slavery-human-trafficking-statement

2.10 Our People

Organisational Development and Culture

The Organisational Development and Culture (OD&C) team leads on an array of education, learning and developmental opportunities for Trust colleagues, beginning on the day they start their career in our hospitals.

Induction

The Trust's Induction Policy mandates that all colleagues must undertake a Corporate Induction on their first day of employment.

Corporate Induction is delivered weekly in collaboration with stakeholders consisting of the Executive Leadership Team and mandatory training leads. The day begins with a warm welcome from the Chief People Officer, alongside presentations on our Leeds Way values and behaviours, followed by clinical and non-clinical mandatory training sessions.

From April 2025 to March 2026, 2,515 employees completed Corporate Induction with a compliance rate of 84%. This does include medical colleagues who attend a separate event. (2024 figures: 1,840 completed with a compliance rate of 84%).

Additionally, within their first 28 days of employment, all colleagues are required to undertake a local induction. The responsibility for delivering local induction lies with managers and Clinical Service Units (CSUs), with the OD&C team taking the lead on policy formulation, process management, and documentation.

During local induction sessions, newly onboarded colleagues acquaint themselves with local operational protocols and key work priorities are established. Recording of the completion of local induction covers the appraisal requirement for that calendar year.

Over the financial year 2025/26, 2,119 employees completed local induction with a compliance rate of 76%.

(2024/25 figures:1,881 employees completed Local Induction with a compliance rate of 70%).

Agenda for Change appraisal

The OD&C team leads on policy formulation, process development, assurance and practice development concerning the Agenda for Change (AfC) appraisal. The AfC appraisal applies exclusively to those colleagues employed on AfC terms and conditions, and it excludes Medical and Dental appraisal.

AfC appraisal is completed using an online digital form with paper form facility available for colleagues without online access, chiefly colleagues in the Estates & Facilities CSU.

In the 2025 appraisal season, 16,030 colleagues completed their appraisal which equated to 93% of the Trust AfC workforce.

(2024 figures 18,127 colleagues completed their appraisal, which equates to 93% of the Trust AfC workforce)

Although appraisal compliance has increased in comparison to previous years, data on the appraisal's impact on performance yields mixed results. Encouragingly, 98% of participants in the 2025 appraisal season stated that their appraisal was a 'valuable conversation' through a mandatory feedback question. However, findings from the Staff Survey and the voluntary survey responses requested on

completion of the appraisal present a varied perspective, albeit the response rates were lower and in the case of the Staff Survey included medical and dental staff feedback. For the first time since the pandemic, our result for appraisal on the Staff Survey dropped below the average result.

The delivery of the 2025 appraisal season was supported with a series of direct CSU engagement sessions and 90-minute learning bursts focused on holding quality appraisal conversations. In addition, online training and guidance was made available to provide support for the online appraisal system.

Following the 2025 appraisal season, analysis of 2,261 voluntary post survey evaluations was completed. Appraisals carried out in the earlier part of the season were felt by appraisees to be a much more positive process than those conducted towards the end. The numbers of appraisals completed rose substantially in the final weeks, and this information is now included in the appraisals learning burst to support improvements.

Mandatory Training

Mandatory and priority training provision is governed under the Trust Training Policy. OD&C leads on the policy, assurance, compliance monitoring and process development for mandatory and priority training. Additionally, OD&C manages the Training Interface which is used to access mandatory/priority training alongside the ESR platform.

Assurance and compliance relating to each individual training topic is managed by the respective Training Leads and their executive sponsors. OD&C leads on the governance and assurance of mandatory/priority training through a number of Learning, Education and Training Committee subgroups. This includes the Training Leads Group and the Mandatory Learning Oversight Governance Group (MLOGG) which has superseded the Learning and Development Group. These groups are made up of relevant representatives for mandatory training/priority training and appropriate professional leads.

MLOGG is a multidisciplinary group that has been set up at the request of NHS England as part of the MOU linked to the Core Skills Training Framework (CSTF) to oversee the outcomes for all nationally mandated training, and review requests from local subject matter experts for any training to be mandated locally. It also acts as an escalation point for any concerns around the resourcing, accessibility to, or compliance rates of any mandatory or priority training topic. The new national people policy framework for mandatory learning provides local organisations with a consistent approach for how nationally and locally mandated learning is determined and managed. The CSTF is expected to be replaced during the spring of 2026 and some colleagues from Leeds Teaching Hospitals are part of the national conversations and project groups facilitating this.

OD&C leads on the Annual Executive Assurance process which facilitates an informed discussion between the responsible executive for each mandatory training topic and the recognised training lead, which addresses any deficits in resource, training needs analysis or compliance – particularly where distinct groups are not compliant.

Around 41 training topics are classified as mandatory with an additional 36 topics classified as priority. In addition, the Training Interface has 100 local compulsory topics (an increase of 24 across the year) which learners select and add to their profile as required by their role, location and/or personal interest.

Overall, Trust performance for mandatory training fluctuated between 88-91% throughout the 2025/26 financial year, which is marginally higher than the Trust compliance standard of 85%. For priority training overall, the compliance rate ranged from 84-86% which is in line with the Trust 85% standard, but there are still some challenges in increasing compliance so it aligns more closely with that for mandatory training. These are overall figures, and some topics have not achieved the required rates of compliance. Where that is the case, the relevant training leads are supported by OD&C to identify issues and address them and where compliance or delivery is a serious concern, the issue can be raised with MLOGG.

Learning and Development

The Trust's commitment to workforce empowerment is headlined by our Digital Learning Prospectus. This resource is designed for colleagues to find the training they need to grow, from clinical skills to leadership development.

Our prospectus offers leadership, resilience, and digital training based on appraisal data. We also expanded our NHS Elect partnership, giving nearly 400 colleagues virtual learning in quality improvement, career planning, and psychological safety to strengthen our culture of improvement and belonging.

In the year 2025/26, the team successfully delivered 113 Learning and Development sessions, attended by 1,076 colleagues.

The most attended courses were:

- Effective Appraisal Training
- Manager Essentials
- Advanced Communication Skills
- Facilitation Skills Masterclass

The Mary Seacole Leadership Development Programme

Our 2025/26 partnership with the National Leadership Academy further established our position as one of the leading local providers of the Mary Seacole Leadership Development Programme. Facilitated by our own accredited colleagues, this six-month programme is instrumental in embedding compassionate, effective leadership throughout the Trust, achieving a 98% pass rate across 123 delegates this year.

Well-Led Governance Insights programme

This programme is designed to demystify corporate structures and build the psychological safety necessary for robust, transparent assurance. By empowering colleagues to navigate committee cycles with confidence, we strengthen our collective ability to manage risk and escalate concerns effectively.

The developmental pathway

The programme bridges the gap between theory and practice through a structured three-step approach:

- **Phase 1: Well-led governance insights:** A 90-minute 'learning burst' led by the Director of Corporate Affairs providing a foundational briefing on legal obligations, regulatory frameworks and the mechanics of the Board.
- **Phase 2: Applied observation & reflection:** Colleagues observe live Board Committees, followed by facilitated reflective sessions to analyse governance in action.
- **Phase 3: Simulated committee experience:** Co-facilitated by a Non-Executive Director, this immersive session allows colleagues to present papers and receive peer feedback in a safe, high-challenge environment.

In the reporting period, 76 colleagues completed the pathway. Feedback highlights a significant increase in leadership confidence, citing the value of informal mentorship from senior Board members and the benefit of diverse, cross-functional peer learning.

Coaching

The Trust currently has 34 active coaches, with a further four currently in training, committed to offering their services to colleagues as an extension of their role within the Trust. Colleagues can self-refer via the Organisational Development and Culture intranet site or via the dedicated coaching email. Coaching is promoted widely through Trust communication campaigns as well as through our leadership and development activity to ensure the offer of coaching is available to any member of staff employed at the Trust.

The Coaching Community of Practice (CCoP) is managed and supported monthly by staff from the OD&C team. Those who attend report that the sessions are useful, providing an informal network for coaches to meet and discuss approaches to coaching at the Trust. The community seek collective solutions to the challenges of coaching as an extension of their existing role and take opportunities to raise the profile and value of coaching within the Trust. They also have access to dedicated Continuing Personal Development (CPD) events, including those facilitated across the Leeds system.

Coaching requests continue to rise. In 2025/26 we received 64 requests, ending the year with 30 staff waiting for a coaching match.

Measures are in place to support outstanding requests, including signposting to self-directed learning via the Learning Platforms available for staff, delivery of group coaching opportunities and access to external coaching

During 2025/26, we continued to work in partnership with the Leeds system to develop the coaching offer system-wide and provide the opportunity to share resources to meet demand. The city-wide Coaching Skills for Managers workshops continue to provide additional capacity to strengthen coaching skills across the organisation.

Highlighted activity for coaching for this year is outlined below:

- 14 Trust colleagues received internal coaching support.
- 10 Trust colleagues accessed external coaching support funded through CSUs.
- Four supervision sessions and one CPD Event were facilitated for the Leeds Coaching System network.

Feedback from staff who have engaged in coaching this year includes:

"Inspiration, motivation, enabling and empowering HCWs to be the best they can be in a workplace-based context and thereby ensure the organisation is delivering high quality healthcare for the benefit of our patients."

"Better leadership conversations, improves engagement... people able to take responsibility for their own development. It's a critical leadership skill."

"I think it is a great opportunity for people to talk to someone new about issues they are facing and have dedicated time and space to think about what they want and how to get there."

Work experience, schools engagement and employability

The Trust's work experience, school engagement and employability programmes support the development of a diverse local workforce, with a strong focus on engaging communities from disadvantaged and under-represented areas across Leeds. The programmes aim to improve access to careers, education, training and volunteering, while removing barriers to employment and providing practical support for individuals who may lack formal qualifications or face learning challenges.

School engagement plays a vital role in the Trust's recruitment pipeline, particularly for entry-level roles and apprenticeships. Over the past year, activity has included virtual careers sessions, school and college visits, hospital information stalls and attendance at city-wide apprenticeship events. Work has also been completed to automate parts of the work experience application process, improving accessibility and efficiency.

Quality and innovation in work experience

In April 2025, the Trust achieved Gold accreditation in the NHS Work Experience Quality Standard, demonstrating the high quality of its placements. Clinical Service Units are increasingly offering alternative engagement models, including one-off career taster days in areas such as medicine, radiology and pharmacy. These events raise awareness of NHS careers and are targeted at schools in priority neighbourhoods to widen participation.

In July 2025, the Trust piloted a successful work experience day with Year 10 students from Trinity Academy, delivered with the Leeds Health and Care Academy. Students took part in interactive sessions across nursing, pharmacy, medical engineering and social care, gaining insight into a wide range of healthcare careers and entry routes such as apprenticeships and T-Levels. The positive feedback has led to plans to expand this model to additional schools, groups not in education, employment or training (NEET) and specialist education settings.

Inclusion and SEND engagement

The Trust remains committed to inclusive access to employment pathways, engaging with specialist schools and colleges and linking this work to the Project SEARCH supported internship programme. Project SEARCH supports young people aged 18–25 with learning disabilities and/or autism into employment. The programme continues to grow, with several interns successfully transitioning into Trust roles. New recruitment processes, including shorter applications and video CVs, are helping improve progression into employment.

Apprenticeships and workforce development

The Trust's apprenticeship programme continues to expand across clinical and non-clinical roles, offering development from entry-level to degree-level. The programme supports workforce planning priorities and places a strong emphasis on diversity, inclusion and retention.

In response to national policy changes, the Trust is introducing new and flexible apprenticeship pathways, including an accelerated Level 2 programme for Clinical Support Workers and modular learning aligned to NHS priorities such as digital innovation, AI skills and sustainability. Apprenticeship investment exceeded £4 million this year, supporting both internal programmes and levy transfers across the region.

The Trust engages with more than 70 apprenticeship standards and continues to develop clear career pathways to support long-term progression and retention.

Apprenticeship levy transfers are used to support NHS partners and organisations across Leeds and West Yorkshire. The Leeds Dental Institute remains an Ofsted Outstanding provider for dental nurse apprenticeships and is expanding its offer nationally, delivering the Oral Health Practitioner apprenticeship. Leeds Dental Institute was accredited with main provider status (approved to directly deliver apprenticeship training and assessment, contracting directly with employers).

Interest in T-Level industry placements continues to grow. The Trust's Health T-Level programme was awarded Provider of the Year, and plans are underway to introduce Digital T-Level placements in partnership with the Leeds Health and Care Academy, supporting future entry-level digital roles within the NHS.

Health and wellbeing

As we continue to strengthen and retain our health and wellbeing programme, we now start a new three-year health and wellbeing strategy. Our four drivers; 'communication and engagement', 'empowering supportive action', 'creating a positive wellbeing culture' and 'prevention', will be the baseline of all our emerging work.

2025 saw the re-launch of the Health and Wellbeing Conversations booklet and the new Health and Wellbeing Passport. Our health and wellbeing for managers training has seen over 550 managers attend with positive feedback.

We have over 700 Mental Health First Aiders that provide early intervention and signposting to colleagues across all of our hospital sites and over 400 Health and Wellbeing Champions supporting our teams.

We continue to strengthen our support for working carers, providing support groups and managers training so working carers feel confident to ask for the support the need.

We have continued to build on our financial wellbeing offer with the Employee Support Fund, Money Buddies and various educational sessions on topics such as loan sharks and mortgages.

We have seen the success of our Employee Benefits Programme, increasing the Trust's salary sacrifice schemes and allowing staff access to various discounts on their shopping through our provider Vivup.

The Men's Action & Awareness Network (MAAN) celebrated its fourth birthday, and we begin to explore the implementation of a replicated female network.

Our focused work around preventing stress and burnout using an evidence-based modal (IGLOO) has helped us to shape best practice working environment for our colleagues, including the re-launch of the stress risk assessment guidance. We also saw the opening of our RHS White Rose Wellbeing Garden at St James's Hospital in Summer 2025.

Heading into 2026, we launch the Workforce Health Equity Improvement Plan to implement support for targeted groups such as staff who are neurodivergent. Our wellbeing outreach for staff will be amplified to ensure colleagues get the support and information they need to stay well whilst in work.

Our staff support also includes the Staff Psychology Support Service, the Employee Assistance Programme, Physiotherapy and the Chaplaincy service.

Health and safety

The Health and Safety (H&S) team continues to work collaboratively with CSUs and corporate support departments, alongside colleagues in Human Resources, Infection Prevention and Control, Estates & Facilities, Occupational Health, and staff-side union representatives across the wider Trust.

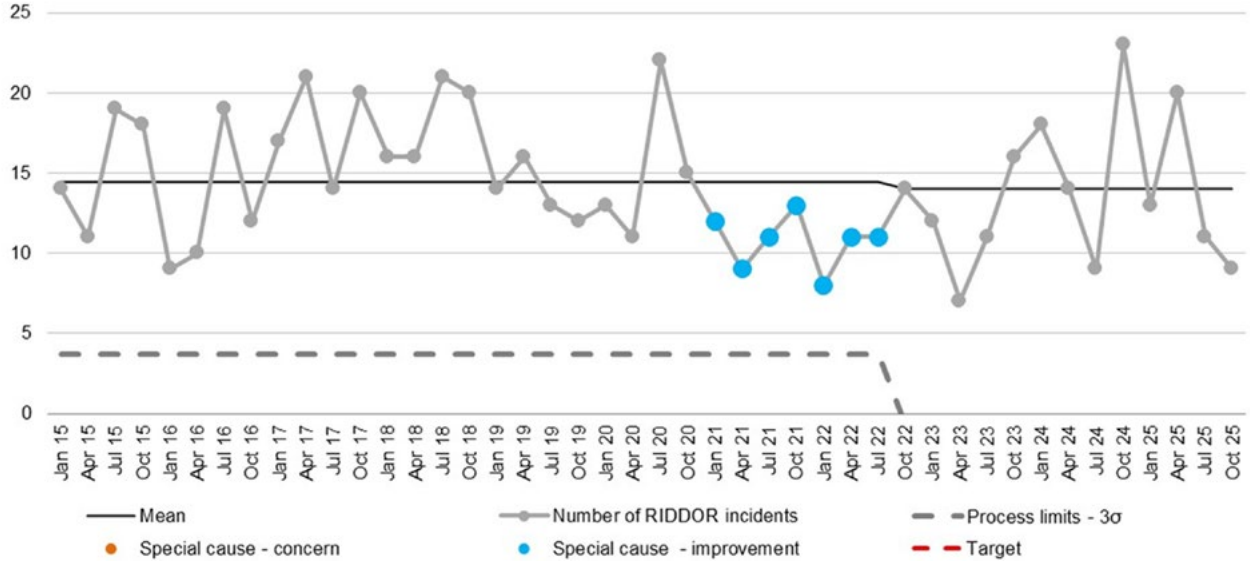
Health and safety within the Trust is overseen by the Risk Management Committee, supported by a number of governance and assurance groups. Staff engagement and consultation are actively encouraged through the Health and Safety Consultation Committee, which meets quarterly. Key updates and resources from these meetings are shared via the Trust's health and safety intranet pages.

Minimum performance standards have been set for all risk categories (Active Monitoring), and every ward and department participates in the annual Health and Safety Controls Assurance process. This is a supportive and developmental process designed to assess local compliance with Trust-wide expectations. The results are shared through the annual Health and Safety Report, which informs future action planning and drives continuous improvement.

In the most recent cycle, approximately 700 wards and departments participated in the Controls Assurance process – a level of engagement consistent with previous years. To complement this, the Health and Safety team undertakes regular 'Gemba'-style site visits, providing practical support, encouraging shared learning, and helping teams identify opportunities for improved safety, compliance, and lean working.

Reactive monitoring of health and safety data, including incidents reported under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR), indicates a continued downward trend in the number of serious health and safety incidents over time. In addition, claims relating to alleged harm under Public and Employers' Liability are also showing a general reduction, providing further evidence of positive progress.

Staff RIDDOR reports are presented by financial quarter on a Statistical Process Control (SPC) chart, displaying data from January 2015 to December 2025



Leeds Teaching Hospitals NHS Trust is one of a small number of NHS trusts to receive recognition through the RoSPA Health and Safety Achievement Awards. In 2025, the Trust was awarded the RoSPA President's Award, recognising ten consecutive Gold Awards for health and safety performance. This internationally recognised award provides independent external validation of the strength, consistency and maturity of the Trust's Health and Safety Management arrangements.

Overall, incident levels have remained broadly stable across the reporting period, with no sustained upward trend. SPC analysis indicates variation remains within expected limits, suggesting that existing control measures are effective.

Staff Survey

Highly engaged colleagues who feel connected to our organisation and involved in their roles are more likely to bring energy, commitment and a sense of purpose to their work. They take initiative, support one another, go the extra mile, and collaborate in ways that strengthen our collective performance as one team.

A significant body of evidence shows that colleague engagement not only creates a more positive and inclusive working environment, but also directly enhances the quality of care we provide and improves patient outcomes. NHS organisations with higher levels of colleague engagement (as reflected in the annual NHS Staff Survey) consistently report lower patient mortality, better use of resources, and stronger financial performance (West and Dawson 2012, cited in The King's Fund 2015).

This is why building an engaged and inclusive workforce is central to our Trust People Priorities. It underpins our commitment to support and develop all our people, ensuring we create a consistent, high-performing and sustainable workforce where every colleague feels they belong and can thrive.

We measure colleague engagement through the annual NHS Staff Survey; a national tool used across all NHS providers. The survey gives us valuable insight into the experiences of our 21,000-strong workforce. Every eligible colleague can take part, ensuring that everyone has a voice and can tell us what it is like to work at Leeds Teaching Hospitals - what is working well, where we can improve, and how we can continue building an inclusive culture where we all feel part of one team.

In 2025 the Trust achieved a response rate of 47%, with over 10,000 of our people participating, alongside a Staff Engagement Score of 6.7 (/10) in line with the national average also at 6.7.

The NHS Staff Survey aligns to the NHS People Promise, which is the promise we all make to each other to improve the experience of working in the NHS for everyone.

The themes are:

- We are compassionate and inclusive
- We are recognised and rewarded
- We each have a voice that counts
- We are safe and healthy
- We are always learning
- We work flexibly
- We are a team
- Staff engagement
- Morale

These themes provide a valuable tool to measure our progress against and provide context for our progression compared to national benchmarks.

Findings

The Trust compares well nationally, with the results showing scores in line across the majority of the nine People Promise themes when benchmarked against the national benchmark for acute and Community Trusts. 'We are always learning' slightly above and 'We are a team' slightly below the national average.

Staff Survey Findings 2025/26

People Promise	National Average	LTHT 2025	LTHT 2024
We are compassionate and inclusive	7.2	**7.2**	7.3
We are recognised and rewarded	5.8	**5.8**	5.9
We each have a voice that counts	6.6	**6.6**	6.8
We are safe and healthy	6.0	**6.0**	6.1
We are always learning	5.5	**5.6**	5.8
We work flexibly	6.2	**6.2**	6.3
We are a team	6.7	**6.6**	6.7
Staff Engagement	6.7	**6.7**	6.9
Morale	5.8	**5.8**	5.9

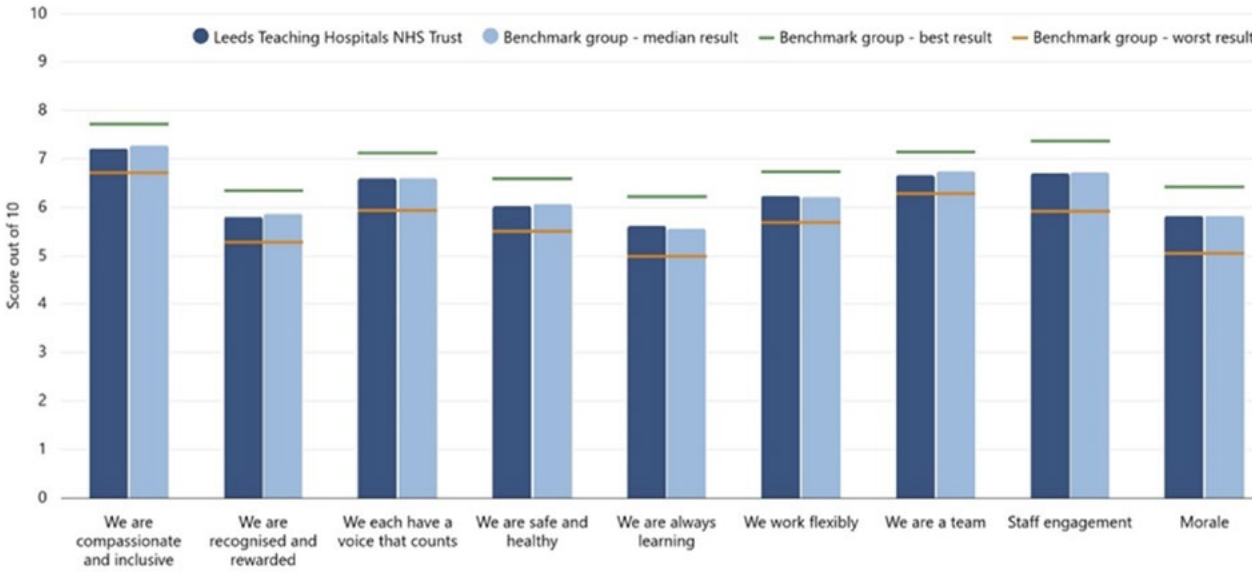
Priority areas of focus for 2026

Following analysis of the Trust level results, the key priority areas to be focused on this year have been developed. These are:

- Promote positive behaviours and act on colleague feedback
- Strengthen wellbeing support to help colleagues stay healthy at work
- Reinforce our organisational values to guide inclusive and collaborative behaviours
- Equip leaders with tools and skills to engage and support their teams
- Improve appraisal processes to enhance colleague recognition and development
- Provide focused improvement support to areas and staff groups with lower engagement

Underpinning the priority areas, the following action is taking place:

- Engagement with key stakeholders on the survey findings, along with support for their use, has begun across senior leadership, engagement forums, operational leads and HR Business Partners
- A High Impact Action Plan has been created, outlining joint priorities and actions at Clinical/Corporate Service Unit level and actions for how the People Function can support on delivering the priority areas
- Departments are being supported to use the findings, alongside wider workforce insights, to inform and strengthen their operational workforce plans



- Work is underway to translate High Impact Actions into clear visual communication materials to support consistent messaging across all staff groups
- The development and communication of the High Impact Actions will be guided and assured through established improvement and accountability frameworks
- Trust-wide communications have begun on the results and how they will be used, supported by a year-round communications plan
- Access to a new results dashboard for all colleagues to view and analyse results, supports wider distribution, engagement, and involvement

We will continue to use the annual NHS Staff Survey results alongside our quarterly Pulse Survey results to focus and drive improvement across the Trust and within CSUs on the areas that are most important to our people. We'll continue to communicate to all on our improvement activity progress using corporate communications methods and through localised and bespoke messages and formats within CSUs.

2.11 Equality, Diversity and Inclusion (EDI)

The Trust is committed to creating an inclusive culture where every colleague and patient feels valued, respected, and has a strong sense of belonging. We actively challenge discrimination and promote inclusive behaviours through our values, recognising that inclusion is shaped by everyday experiences, relationships, kindness, and civility. We expect all colleagues to be self-aware and proactive in making sure their actions are respectful and inclusive. While the Trust recognises and values all protected characteristics under the Equality Act 2010, we also acknowledge its limitations. In the interests of fairness, we therefore look beyond protected characteristics to understand and respond to the full range of identities, experiences, and needs within our workforce and communities.

Supporting our diverse workforce

At the Trust, we aim to be a fully inclusive organisation where everyone feels they belong, enjoys coming to work, and has fair access to learning, development, and career progression. We want colleagues to feel safe and confident to share their experiences, raise concerns, and use their voice. We recognise that every colleague plays an important role in delivering high-quality patient care and in creating an inclusive working and care environment.

We collect and report workforce equality information through national frameworks including the NHS Workforce Race Equality Standard, NHS Workforce Disability Equality Standard, Gender Pay Gap Reporting, the Public Sector Equality Duty and the NHS Staff Survey. This information is also monitored locally across Leeds and the wider Yorkshire region. While improvements have been made, we remain committed to going further, to become a truly inclusive organisation.

An annual Inclusion and Belonging Improvement Plan has been developed and co-produced with colleagues from across the Trust. The plan is informed by workforce data and lived experience, and focuses on our strengths as well as areas where further improvement is needed. It remains a live document that evolves in response to emerging evidence, feedback, and organisational change.

The Inclusion and Belonging Improvement Plan is underpinned by the Equality Act 2010 and is approved by the Trust Equality Strategic Group. It follows our three-strand approach: de-biasing processes, embedding a culture of inclusion, and taking positive action.

Responsibility for inclusion and belonging sits with everyone in the Trust. However, the People Function provides leadership and assurance, reporting to the Chief People Officer, while all Board members are accountable for delivery. Board members actively sponsor and support workforce equality networks, helping to remove barriers to equality and promote a sense of belonging.

Equality actions relating to patients are led by the Patient Experience Team, which reports directly to the Chief Nurse and oversees the Equality, Diversity, and Inclusion Patient Action Plan.

Key achievements in 2025/26

- Workforce Equality Networks continue to play a vital role in shaping and supporting equality, diversity, and inclusion activity. Alignment between networks has strengthened, with a greater focus on intersectionality. The Trust continues to fund protected time for network co-chairs, and each network is supported by an Executive Sponsor.
- Positive action programmes remain an important source of targeted development. The Moving Forward Programme for Black and Minority Ethnic colleagues is now in its fifth year, achieving an 82% retention rate and a 22% promotion rate among participants.
- Scope for Growth career conversations have been introduced as a refreshed approach to supporting personal and professional development. These conversations sit alongside appraisals and are designed to support fair access to learning, progression, and promotion opportunities.
- Inclusive Recruitment Training is mandatory for all staff involved in recruitment, in line with the Recruitment and Selection Policy. To date, 4,179 colleagues have completed this training, and uptake continues to increase.
- Progress has been made in expanding the network of Inclusion and Belonging Champions across Clinical Service Units. This work has been supported through collaboration between Equality, Diversity and Inclusion, Staff Engagement, Freedom to Speak Up, and local teams. There are currently 276 trained champions, including allies, advocates, and facilitators supporting respectful and inclusive workplaces.
- A workforce health inequalities situational analysis was completed in early 2025. This informed the development of the Trust's first Workforce Health Equity Improvement Plan for 2026/27. Actions include embedding health equity into wellbeing conversations, launching new training through the Leeds Health and Care Academy, and training more than 500 managers in inclusive health and wellbeing practice.

Following the annual NHS Equality Delivery System assessment, the Trust moved from 'Achieving' to 'Developing'. This reflects learning from several external reviews and reinforces the Trust's commitment to improvement through targeted actions in the Inclusion and Belonging Action Plan.

Our aims for 2026/27

The Trust will continue to improve workforce equality outcomes and strengthen accountability for belonging and equality across all levels of the organisation. We will build on progress to date while responding to new evidence, feedback, and national priorities.

The following provide detailed insight into our inclusion, belonging and equality successes and identified areas for improvement, aiming to continue to progress against the national Workforce Race Equality Standards, Workforce Disability Equality Standards, Public Sector Equality Duty, NHS Equality Delivery System, NHS England's Six High Impact EDI Actions, and Gender Pay Gap Reporting:

- Inclusion and Belonging Metrics: www.leedsth.nhs.uk/wp-content/uploads/2025/10/LTHT-Workforce-EDI-Metrics-2025.pdf
- Inclusion and Belonging Improvement Plan: www.leedsth.nhs.uk/wp-content/uploads/2025/10/EDI-Strategy-v2-31_10_25.pdf
- NHS Equality Delivery System: www.leedsth.nhs.uk/about/trust/equality-diversity/equality-delivery-system-eds

Trade Union Facility Time Publication Requirements

The Trust fully complies with the requirements of the Trade Union (Facility Time Publication) Regulations 2017. The most recent published data can be found on the Government website (www.gov.uk/government/statistical-data-sets/public-sector-trade-union-facility-time-data).

2.12 Medical Education

Leeds Teaching Hospitals delivers one of the largest medical education programmes in the country. Working with the University of Leeds, the Trust hosted 2,700 high quality clinical placements across all five of the year groups of the MBChB (medical degree) programme. Postgraduate medical education provides placements and teaching sessions for 1,172 resident doctors who are based in the Trust (plus support for an additional 340 for whom the Trust is lead employer), 365 locally employed doctors and 41 physician assistants. The Medical Education team delivered 126 local, regional and national clinical skills and simulation courses and the Trust continued to support fellowship and other medical programmes in collaboration with international partners.

Our undergraduate medical education provides dedicated teaching and pastoral support to students in "The Hub" at St James's Hospital. More than 3,700 students attended small group teaching, one-to-one sessions and practice examinations delivered by a dedicated team of clinical teaching fellows, themselves resident doctors taking time out of their programmes to develop teaching experience. The team continues to innovate learner-centred teaching including better use of technology and has been working on innovations such as a virtual consultation programme. Feedback across placements and Hub-based teaching continues to be excellent.

Health and wellbeing remains a focus across the whole of medical education. Working with colleagues in HR, estates & facilities and finance, as well as the Freedom to Speak Up Guardian and Guardians of Safe Working, the team has worked to further improve rest and changing facilities, as well as the availability of healthy food out of hours. We have a Professional Support & Wellbeing Team (PSWT), which proactively provides targeted support for resident doctors experiencing difficulties in terms of their employment and/or training. In the last five years, around 700 individuals have been supported through this process. Leeds Teaching Hospitals is a pioneer in this field, being one of only a handful of trusts providing dedicated professional support to resident doctors. In undergraduate medical education, there has been an increase in the number of students requiring additional support with their placements.

There are two chief registrars working closely with the medical education team. In addition to coordinating the Resident Doctor Body, they also arrange the annual Resident Doctor & Dentist Conference and Awards Ceremony. Throughout the year, the senior education team and chief registrars have undertaken monthly ward visits, to talk with resident doctors in situ about their experiences.

The Library and Knowledge Service continues to grow and develop. On average, more than 2,000 colleagues per month use the facilities on each of our main sites. The team utilised 'UX', a user experience model, to better understand the needs of library users. The high quality of the Library and Knowledge Service was recognised by NHS England who carried out a routine review in December and January and made reference to many of the innovations in the final report. The team are working hard to engage colleagues across the Trust, many of whom would not routinely make use of a library. Examples include a book club, randomised coffee trials, and a growing stock of books supporting inclusion and belonging (e.g. dedicated sections on LGBTQ+, BME, and neurodiversity). In collaboration with the Research & Innovation team, the team launched a new repository in which published work generated in the Trust can be stored and made available inside and outside the organisation.

Medical education continues to collaborate with other education teams, through the Learning, Education & Training Committee, in delivering the strategy and improving inter-professional learning.

Signed

Brendan Brown, Chief Executive

Date: 25 June 2026

Section 3

Patient care and experience

Section 3 - Patient care and experience

3.1 Patient experience priorities

Background

We have continued this year to build the support provided to Trust frontline teams so they are able to deliver an improved experience for patients. To do this, alongside listening to patients we have listened to staff colleagues and undertaken surveys to understand where there are opportunities for improvement.

Key achievements in 2025/26

Objective: We will support colleagues to have access to information and support which enables them to confidently undertake involvement and engagement activities to inform improvement programmes.

Throughout 2025/26 the patient, care and public involvement team expanded their support to colleagues to enable them to grow confident in undertaking involvement and engagement activities. This included:

- Supporting multiple teams directly to deliver engagement activities, including Listening events
- Enabling access to an insight library to assist in planning interventions
- Facilitating the Trust Patient Reference Group meetings
- Developing and delivering an annual training programme
- Offering coaching sessions for colleagues
- Supporting the delivery of the Trust patient story programme

Objective: We will act upon the findings from National Patient Surveys and seek to drive improvements where these are needed.

The results of the Adult Inpatient Survey 2024 were published in September 2025. and the Maternity Survey 2025 was published in December 2025.

Results for both surveys have been shared at the Trust Patient Experience and Engagement Group (PEEG) and with responsible teams within the Trust, such as the Nutrition Mission group, Heads of Nursing and Maternity CSU, to take forward actions to address the findings.

The focus of improvement for the inpatient survey relates to food and dietary provision, and for the maternity survey relates to postnatal care at home after birth.

Objective: We will publish the Trust policy for unpaid carers and use this as an opportunity to engage colleagues to consider carers within the assessment of patient care and planning process.

An Unpaid Carers Policy has been developed with support from the Trust Carers Working Group and has been reviewed by external stakeholders, including Carers Leeds and Healthwatch Leeds.

The policy will complement the Paid Carers Procedure in the Trust and sets out expected standards for supporting the carers of patients.

The policy was shared at the Trust Patient Experience and Engagement Group in October 2025 in preparation for publication.

Objective: We will test our new remunerated Partner role and expand our work to support Partners to align with CSUs.

In 2025/26, a Senior Partner remunerated role was embedded into the Trust and completed all safety checks and Trust induction. Objectives have been agreed for the role and the postholder is supporting work to assist in aligning Partners with CSUs, including becoming a CSU Partner themselves. Their first job has been to review the partner handbook.

Currently Partners are actively supporting:

- Adult Therapies CSU
- Head and Neck CSU
- Urgent Care CSU

During Q3 2025/26, Partners have been introduced into the following CSUs:

- Cardio-Respiratory
- Abdominal Medicine and Surgery

A further four CSUs will have Partners introduced following recruitment planned for 2026.

Objective: In line with one of the Trust annual commitments, we will focus on supporting outpatient areas to engage with FFT feedback to support their individual improvement programmes.

To increase the amount of FFT feedback we receive about our outpatient services, so that colleagues have access to more detailed information to support their improvements, in January 2026, we began to test a new way of capturing outpatient feedback.

We selected an outpatient clinic that was receiving a FFT response rate of 0.4% using traditional methods of capturing feedback and developed a survey that we embedded into our outpatient appointment system.

The survey was automatically deployed by the system to all patients, after a clinic appointment had occurred.

Within two days of switching on the survey, 20% of patients had responded to the request for feedback.

Objective: We will work with Healthwatch Leeds and our Trust partners to review our complaint and PALS processes.

The Head of Patient Experience attended the Healthwatch complaints group this year to support complaint managers across Leeds to consider how best to capture the themes arising from complaints across organisations, to encourage system learning. It is recognised that it is important to analyse the experience of people who may have complaints that relate to more than one organisation, so that we can understand how well organisations work together to provide co-ordinated care. This work links to the city-wide 'How Does It Feel For Me' programme, to which the Trust is a core contributor.

The Trust complaints panel has also been restored. The panel brings members of the public (Trust Partners) together with colleagues to review complaint processes, consider complainant experience and to advise on improvements that could be tested. The panel are currently reviewing the Trust PALS leaflet.

Objective: We will develop a Trust PALS action plan.

A Trust PALS action plan has been developed and was first presented to PEEG in August 2025.

To date, key developments have included:

- Supporting CSUs to improve their reporting of PALS outcomes
- Allocation of work in the team to improve the service user experience
- Reallocating responsibility for reviewing PALS resolution letters to a senior member of the CSU
- Introducing the choice of an online meeting with a PALS case handler for people who would like to raise a concern
- Working more closely with Chapel Allerton and Urgent Care CSUs to find quicker ways for people raising concerns to receive a response

Aims for 2026/27

1) We will deliver a complaints improvement programme which:
   - Focuses on improving the timeliness of our complaint responses.
   - Helps people who have a concern achieve a quick resolution by offering the opportunity of a discussion with a senior colleague.
   - Will have the oversight of a new complaints working group which will report to PEEG.

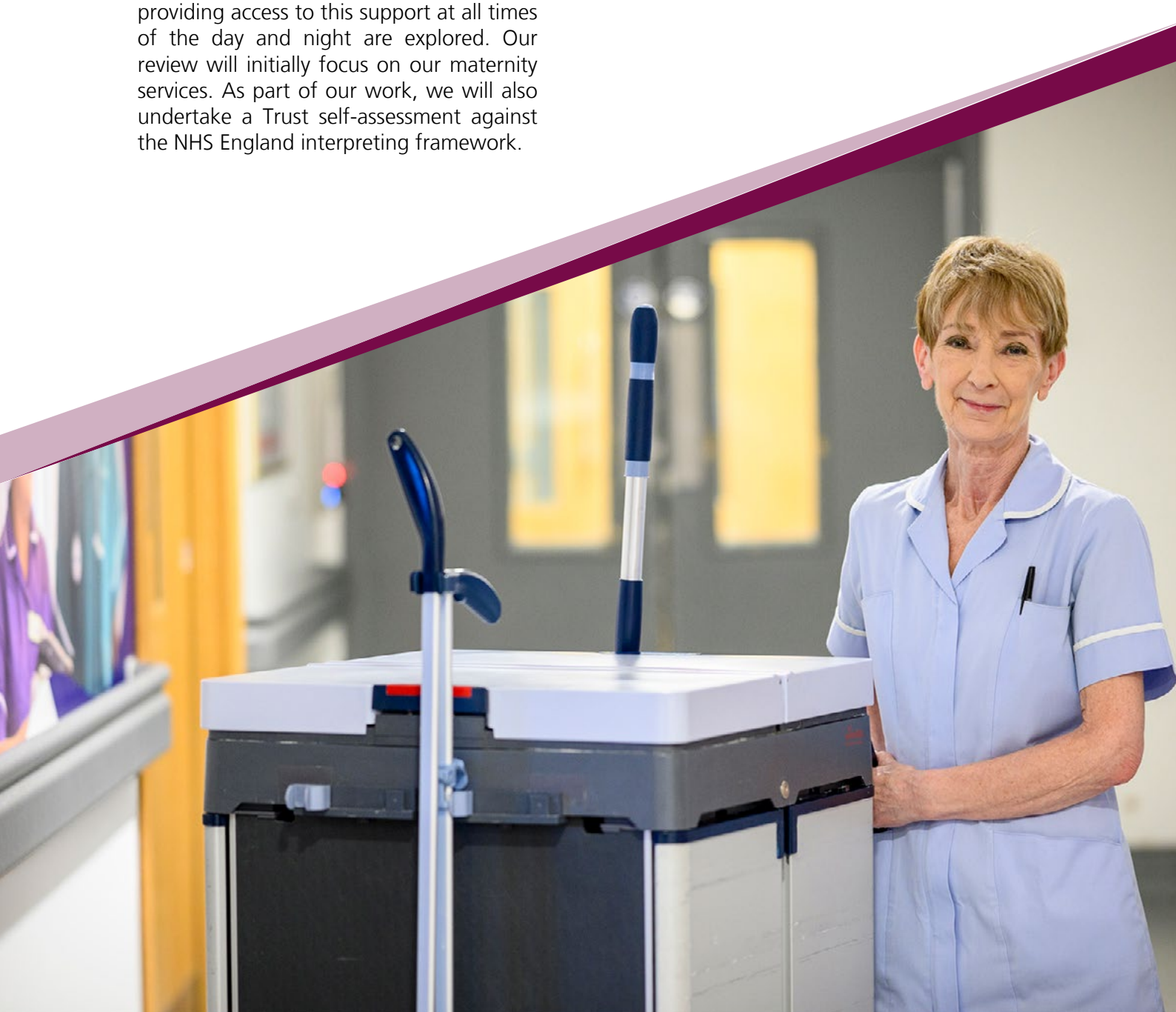
2) We will review our PALS information and service experience and take action to respond to feedback.

3) We will review our interpreting provision and ensure that available solutions for providing access to this support at all times of the day and night are explored. Our review will initially focus on our maternity services. As part of our work, we will also undertake a Trust self-assessment against the NHS England interpreting framework.

4) We will review our Friends and Family Test service and implement a new system for supporting our patients to provide their feedback.

5) We will undertake a Trust self-assessment against the National Chaplaincy Guidelines and will develop a Trust improvement plan to improve compliance, which will be reported to PEEG.

6) We will review the work of our Trust volunteers and identify priority roles for recruitment, which will focus on working alongside colleagues to improve the experience of patients.



3.2 Involving patients and the public

Patient Carer and Public Involvement (PCPI)

Background

2025 was the second year of the PCPI Strategy 2024-2027 which has been developed alongside patients and members of the public. The aims of this strategy are:

- **Aim 1:** It will be clear to patients and the public how their lived experience has influenced Trust strategies.
- **Aim 2:** Colleague will be equipped to deliver outstanding involvement activity.
- **Aim 3:** People will help tackle health inequalities across our services.

Key achievements in 2025/26

2025/2026 saw the team involving patients and communities in a range of strategic initiatives including the creation of the Trust Strategy, Mental Health Strategy, LTHT Dementia strategy and providing support to the national consultation concerning the NHS 10 Year Plan. The involvement of people and communities in the decisions made and improvements to Trust services has increased in demand, however this demand has been met because:

- The team has developed a strong foundation of methods to engage a range of people and communities (including those experiencing health inequalities).
- Patients, carers and members of the public have gifted their time and experience to support these changes and decisions made.

Key methods include using existing patient insight (held within the Leeds Insight Library), Listening Events, the Patient Reference Group and Community Connectors. The team also provides a yearly programme of training and development opportunities to enable staff to complete their own engagement activity with the training offered becoming popular with organisations outside the Trust.

Highlights

Trust Strategy

584 people supported the development of the Trust strategy. Participants were provided with an accessible resource to better understand the draft aims of the document. People contributed to the work via existing insight captured within the Leeds Insight Library, face to face interviews completed by Trust colleagues, Leeds Teaching Hospitals and Healthwatch Leeds volunteers. These interviews were conducted onsite and beyond, targeting areas of deprivation. 124 patients/visitors were interviewed whilst an electronic survey was distributed across the city. Members of the Patient Reference Group provided an independent review of insight captured throughout the process. Insight captured provided assurance to Trust Board that the draft strategy (with some caveats) was fit for purpose.

Mental Health Strategy

The team adopted a collaborative approach in terms of involving patients and communities in the development of this strategy. Leeds and York Foundation Trust and associated Service User Network were instrumental in this. 207 patients and members of the public supported the creation of this strategy via listening events and workshops which included targeted efforts to capture the insight of young people experiencing mental ill health and those with experience of being detained under the Mental Health Act. The Trust was grateful for their contribution leading to the creation of the Trust's first Mental Health strategy.

Community Connectors

The team has tested a new area of work for its Community Connector programme. This involved a Trust volunteer utilising her existing relationships with older people in receipt of health and social care support within their home. These individuals are often excluded from traditional engagement activity. The initial focus of this work was to understand their thoughts regarding digitalisation in health care. However, due to its success, this work will progress into the new year including a focus on product design.

Staff training and development

The team provides a range of development opportunities for Leeds Teaching Hospitals colleagues to support skills training in involvement and engagement, and this includes learning bursts training, head-to-head mentoring support and bespoke team support programmes. Some highlights include:

The delivery of the team's first session focussing on the development of 'patient groups'. This session included understanding the benefits and challenges of patient groups, addressing recruitment and support, creating inclusive environments and developing accessible documentation.

A 'Working in partnership with people and communities' session was co-delivered in Sept 2025 with the Health Inequalities team. This learning burst focussed on the Trust's public sector duty to involve people and communities in service improvement and Equality Health Inequality Impact Assessments to help consider 'inclusive methods' of engagement.

86 members of staff attended PCPI learning bursts across the year with a further 70 patient and public involvement initiatives supported with head-to-head sessions.

The Patient Story programme continues to thrive at Leeds Teaching Hospitals with short films provided to strategic committees on a range of topics. Most films capture the story of a patient in our care and are used for sharing what works well and as learning opportunities.

Aims for 2026/2027

- Improve our collation and distribution of patient and public insight within the Trust to support service improvement.
- Improve how we demonstrate the impact made by patient and public involvement activity in Trust decision making and service design.
- Work with those experiencing health inequalities to share their experience of digital health care and support product design.

3.3 Improving patient experience

Equality Delivery System

Background

The NHS Equality Delivery System (EDS) is the foundation of equity/equality improvement within the NHS, acting as an accountability and improvement tool for NHS organisations - in active conversations with patients, public, colleagues, staff networks and trade unions - to review and develop their services, workforce, and leadership.

Domain 1 of the EDS relates to commissioned or provided services to patients and requires that organisations consider and improve the following outcomes:

- Service users have required levels of access to the service
- Individual services users' health needs are met
- Service users are free from harm
- Service users report a positive experience

In order to comply with Domain 1 of NHS England's Equality Delivery System (EDS22) process, Leeds ICB and Leeds-based NHS providers agreed to focus on services providing care to people living with long-term conditions.

The three services selected were:

- Cystic Fibrosis – Cardio-Respiratory CSU
- Dementia in Older Adults – Specialty Integrated Medicine – (SIM) CSU
- Patient Experience - British Sign Language (BSL) Interpretation Service – Chief Nurse CSU

Good practice

Each service had the opportunity to present evidence to demonstrate how they meet the four outcomes within Domain 1. A Peer Review took place in September 2025 between organisations in Leeds where work taking place in the selected services was showcased, some examples are:

- Adjustments are made for patients with Learning Disabilities and/or autism which include home visits. Environmental adjustments are also made prior to attending clinic if this is required.

- Easy read letters are now in use as standard to support People Living With Dementia (PLWD).
- Patients and service users in the community now have access to a virtual service which helps them contact the Trust using BSL.

Aims for 2026/27

- To improve awareness of colleagues and patients about the availability of remote BSL interpreters to assist patients to contact the hospital, when they need to do this.
- Reduce the DNA rate for young people using the Cystic Fibrosis service.
- Improve understanding and recording of reasonable adjustments for PLWD.
- Identify and support PLWD in Outpatient areas.
- All demographic information to be recorded on EMIS records for Cystic Fibrosis patients.
- Increase use of personalised documents to provide individualised care for PLWD.
- Improve the number of responses in the National Audit of Dementia (NAD) to obtain richer feedback.

Interpreting

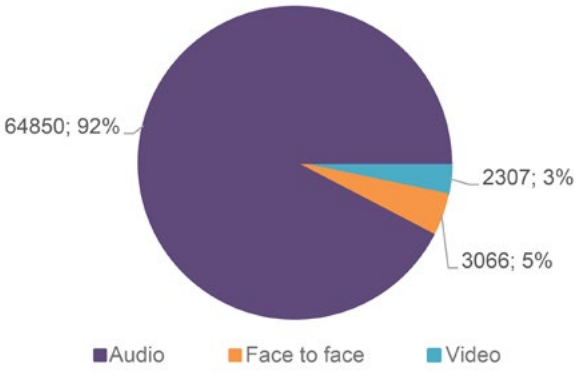
Background

The Trust aims to provide interpreting for all patients when this is required.

We provide patients with spoken interpreting, BSL interpreting and deaf/blind communicator guide support.

Virtual interpreting (video or audio) is available across the Trust via apps on Trust iPads or via the web (including on Trust laptops). This on-demand service continues to be encouraged for spoken language interpreting, unless it is clinically inappropriate, in which case a face-to-face interpreter can be requested. In the case of BSL interpreting, it is always clinically appropriate to book a face-to-face interpreter as preferred choice. Virtual BSL interpreting via the app can be used where no in-person support is present.

Interpreting sessions by delivery method 2025



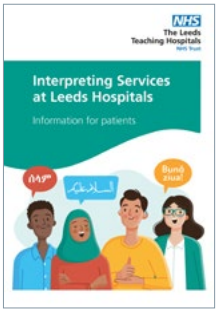
Telephone interpreting (where the interpreter, clinician and patient join a call together) continues to be the most frequently used method of accessing the service across the organisation.

Interpreting via video link can be provided during a consultation on site or during a remote consultation, such as when using Attend Anywhere, Microsoft Teams or Zoom.

Key achievements in 2025/26

The service recognises that whilst on-demand virtual interpreting is the most frequently used form of accessing the service, colleagues have experienced, on occasions, delayed connection to an interpreter. The Trust's contracted spoken language provider, LanguageLine Solutions (LLS), has put in place a facility to pre-book a telephone call, whereby interpreters for rare (or rarely requested) languages have advance notice to make themselves available. This has been extended to include eight more languages than were available during the year to March 2025.

Having the interpreter available on the call at the start of the interaction with the patient reduces patient harm, risk of misunderstanding and delays in clinics and results in a positive patient experience.



A patient information leaflet has been developed to inform patients prior to attending Trust services of the interpreting options that will be available to them. The leaflet invites patients to contact the Trust ahead of their appointment if they have any concerns about provision of interpreting, prior to their attendance. This leaflet has also been produced in Easy Read format.

Maternity services have reported gaps in delivery of the interpreting service, most often in cases where patients attend in emergency or acute situations and/or out of hours. This is due to increasing demand for rare or rarely requested languages, with the variety of dialects requested also growing. The Interpreting team is collaborating with maternity colleagues to explore the market for products that may supplement existing provision and enhance delivery of care and patient safety.

Collaboration with the Trust's spoken interpreting provider (LLS), under their social value initiative, has delivered translation of three Maternity Services information videos, each into five non-English languages, including transcripts and audio.

Details of how these were created can be seen in this video: www.youtube.com/watch?v=UjDNqGv0AKo.

Aims for 2026/2027

The 2026-2028 Interpreting strategy and action plan has been finalised and published.

Actions include:

Working to minimise the risk of patients not being supported with either face-to-face interpreters or virtually on-demand - the Interpreting team will monitor activity to identify where intervention and support would be beneficial. The team is implementing a system of support whereby colleagues can inform the interpreting team if face-to-face bookings are at risk of being unfilled. The Lead for Interpreting will escalate the concern to the provider and work with the provider's specialist team to fill the request.

The Interpreting team will further promote the use of video remote interpreting for BSL users via the Convo (previously SignLive) app.

QR codes will be displayed at key entrances to Trust hospital premises and Reception areas which direct BSL users to a video interpreter on demand, enabling them to communicate from the moment they arrive at the hospital.

Patient information leaflets

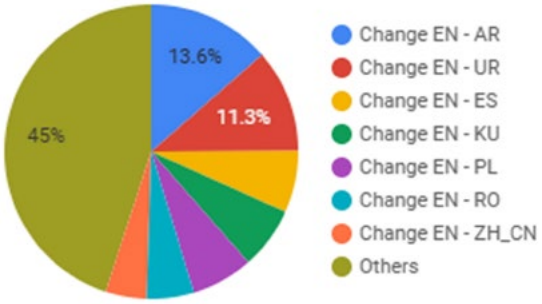
Background

The Trust aims to ensure that all patient information leaflets (PIL) made available to patients, carers and the public are in date, clearly written and accessible. PIL are available on the Trust website under 'Patient Resources'. On the landing page these are categorised into Easy Read, Children's and Maternity, with a further search facility for specific topics or PIL titles.

In March 2026 there were 1,732 published patient information resources available on the Trust website. This included 198 PIL in Easy Read format, 33 videos and 63 links to external sources.

The Trust website contains assistive technology that improves access to the content of the site. Patients and members of the public can access the Trust website in their preferred language, including access to PIL. The tool translates content either in written form or via audio file. Audio files can be downloaded by the patient and retained for future use.

Top languages translated via the online tool, during the six months to 31 December 2025



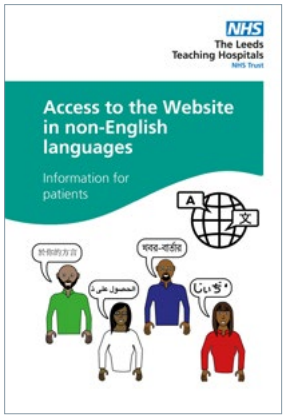
The top languages searched for translation were Arabic, Ukrainian, Spanish, Kurdish, Polish and Romanian.

This assistive technology offers other accessibility features such as text enlarger, screen mask, read aloud and picture dictionary.

In the six-month period to December 2025 this technology was accessed 25,848 times.

Key achievements in 2025/26

- The number of out-of-date PIL for all the Trust has decreased from 13.5% in March 2025, to 6.5% in March 2026. The Trust target of <30% out-of-date PIL was reduced in December 2025 to 15%.
- Activity to review and re-issue out-of-date leaflets has increased significantly, along with requests from CSUs to use patient information in non-leaflet format, such as external web links and videos.
- A patient information leaflet and a flyer have been created to demonstrate how the assistive technology on the website can be accessed. These contain only images and symbols, so that they are understood by patients and others who have no or very little English language.



- A video has been created and shared Trust wide, demonstrating how to access the toolbar on the website to translate patient information leaflets and other content. The video contains a FAQ section and invites CSUs to get in touch if support is required: https://youtu.be/cy-VAv4RXtw

Aims for 2026/2027

Guidance provided to CSUs will be reviewed, updated and enhanced to incorporate toolkits and best practice guidance for all patient information formats. This will include guidance around the use of externally created videos, links to other Trusts' content, internal use of posters/QR codes and updated guidance around accessibility. This will support CSUs to offer patient information in a variety of formats that will adhere to the same principles and guidelines, creating uniformity across the Trust.

Friends and Family Test

Background

The Friends and Family Test (FFT) is a brief, anonymous survey designed to help healthcare providers understand patients' experiences and perceptions of the care they have received. Patients can complete the FFT through a range of flexible options, including SMS text messaging, interactive voice messages (IVM), postcards, QR codes, or digital devices such as ward iPads.

Throughout 2025, more than 130,000 patients shared their feedback. This valuable insight plays a crucial role in shaping service improvements, enhancing patient experience, and supporting the continued delivery of high quality, compassionate care across our organisation.

Key Achievements in 2025/26

3 Cs - Communication, Compassion and Co-ordination

Through an extensive city wide listening programme, the Trust has a clear understanding of what truly matters to patients and their families. This engagement has highlighted the importance of the '3 Cs' - a set of core principles that consistently shape positive experiences of care - Communication, Compassion and Co-ordination. These values reflect what people in Leeds say matters most to them, and they now support how we provide compassionate, high quality support across all our services.

FFT Team Fabulousness Awards

In April 2025, the FFT team introduced a new colleague recognition initiative, *FFT Fabulousness for Teams*. The scheme highlights exceptional patient feedback that reflects the Trust's core values of Compassion, Communication, and Co-ordination (the 3 Cs). Each month, a selection of outstanding patient comments is shortlisted and reviewed by the senior management team, who score the entries. The team receiving the highest scoring feedback is awarded the Winner's Certificate, while the teams in second and third place receive Highly Commended certificates.

A senior representative from the Patient Experience Team presents an A3 certificate to the winning team during an in person visit to their ward or department. Photographs from the presentation are shared with the Trust Communications team for inclusion in Our Week and on Leeds Teaching Hospitals' social media channels, including Facebook and Instagram. Highly Commended teams are also featured to ensure their achievements are recognised and celebrated across the organisation.

FFT Team Fabulousness Award Winners

- Emergency Department LGI
- Ward L40
- Ward L24
- Ward L23
- Neuro Critical Care
- Ward L47
- Ward C03
- Ward J03
- Ward L17
- Breast Imaging
- Ward J27 HOBS

"You Said, We Did" (YSWD)

Wards and departments are encouraged to routinely review patient feedback and implement actions that address identified themes for improvement. Communicating these improvements to patients is essential, and one effective method for doing so is through a "You Said, We Did" (YSWD) poster.

The examples below highlight improvement initiatives undertaken during 2025 on Ward C03 at Chapel Allerton Hospital and within Adult Critical Care at Leeds General Infirmary (LGI). These examples demonstrate our ongoing commitment to listening to patients, acting on feedback, and enhancing the quality of care across our services.

A patient on Ward C03, CAH) left the following FFT feedback:

You said...

"I was left from after the pre op routines until 4pm no one checked in. The area got colder as the day went on. There were no pillows on the bed. I was cold! Uncomfortable and tired from no food or water! Then…. my op was cancelled for a good reason and that is fine. But please don't leave patients so long without checking in and avoiding basic comforts. I was on Ward C03 at Chapel Allerton. I am going back there for my op when it comes. Please don't repeat this for me."

The ward has responded to this feedback by putting the following measures in place:

We did...

"We have set standard working practices for colleagues to be present in pre-wait areas at all times, checking patients are comfortable and updated relating to their planned care. Pillows and blankets are available. We are also in the process of training colleagues across the Trust to feel effective within the pre-wait area and escort patients into theatre. The training should provide further opportunities for enabling positive experiences for patients."

Adult Neuro Critical Care -

You said...

"Patients have reported that the ward environment can feel loud and bright at night.

Patients have also shared that their days can feel long, particularly between visiting times."

We did...

"To help reduce boredom and enhance experience, the team has introduced the following initiatives:

Bedside lamps have been introduced to avoid bright, overhead lighting.

Sleep champions take a lead in ensuring the unit is as quiet as possible overnight for every shift.

The ward has increased the number of TVs and radios available within the ward and the team has created a distraction box to help patients with long days.

An Amazon wish list has also been introduced so the ward can buy items to improve the patients' stay."

Promotion of FFT

The team continues to work closely with the Trust Communications department to promote patient feedback across a range of social media channels on a weekly basis. Alongside this ongoing activity, the team is also exploring new and innovative methods to further enhance visibility and engagement with the Friends and Family Test (FFT) among all patient groups. This includes identifying opportunities to broaden reach, strengthen messaging, and encourage greater participation in providing valuable patient experience insights.

Improving internal awareness of FFT

Internal promotion continues to be a key driver in strengthening colleague engagement with the Friends and Family Test (FFT). Throughout 2025, the team delivered a proactive programme of visibility and outreach, hosting information stalls at several organisational events. These included the Cardio Respiratory Patient Safety & Sustainability Summits held in June, July, and September 2025, where colleagues were able to learn more about FFT processes, ask questions, and explore how patient feedback supports service improvement.

In addition, FFT stalls were featured at the Trust wide "Hello My Name Is…" campaign event in July 2025 and the LTHT Safety Conference in September 2025. These platforms provided valuable opportunities to raise awareness, promote best practice, and encourage greater participation among colleagues across clinical and non clinical areas. Collectively, these engagement activities helped reinforce the importance of the FFT as a tool for continuous improvement.

A quarterly internal FFT Newsletter is developed and shared to ensure all colleagues remain informed, engaged, and motivated in gaining FFT patient feedback. Its purpose is to highlight key insights, celebrate achievements, and reinforce the importance of giving every patient a meaningful voice in their hospital experience.

Additional surveys

The FFT team has the flexibility to include additional, bespoke questions within the standard FFT survey framework, enabling services to gather more nuanced insights when needed. Throughout 2025, the team delivered a series of supplementary surveys across the Trust to capture targeted feedback on specific initiatives and areas of care.

One of these surveys was developed to support the rollout of the newly launched Martha's Law campaign within Leeds Children's Hospital. As the Trust is part of the national NHS England pilot, the survey played an important role in understanding how effectively the campaign was being embedded. In particular, it sought to assess whether patients and families felt listened to and heard during their time in our care – an essential measure of the campaign's impact and alignment with its core aims.

The first question asked was:

"Did you feel listened to during your child's stay?"

Of the 118 parents who responded to this question:

- 100 (85%) felt listened to all of the time
- 15 (13%) said most of the time
- 2 (2%) said some of the time
- 1 (1%) said rarely

The findings were presented to the Martha's Law Working Group to support the development and implementation of improvements across the Trust. These actions aim to ensure that every child's parent or carer is listened to and meaningfully involved in all aspects of their treatment and care whilst their children are in hospital.

Aims for 2026/27

- Collaborate with outpatient clinics to promote increased FFT feedback through patients' preferred methods.
- Develop and implement a mechanism for capturing FFT feedback from non-clinical teams, such as administration and booking departments.
- Continue enhancing opportunities for patients to provide feedback in their preferred language.

National Patient Surveys 2025/26

Background

The Trust received two CQC nationally mandated survey reports during 2025/26. These were the Adult Inpatient Survey 2024, published in September 2025 and the Maternity Survey 2025, published in December 2025. In both surveys the results for the Trust were 'about the same' as results for other Trusts.

Adult Inpatient Survey 2024

The Inpatient Survey 2024 involved 131 NHS Trusts in England. Patients were eligible for the survey if they were aged 16 years or older and had spent at least one night in hospital at the Trust during November 2024. 447 Leeds Teaching Hospitals patients responded to the survey giving a response rate of 39%. This was slightly lower than the national average response rate for the survey which was 41%.

Benchmark results

The Trust's results were about the same as other Trusts for all 46 questions, not being statistically significantly better or worse on any question. In comparison to the Trust's survey results for the previous year, there was no difference in responses to 34 questions, but performance was significantly worse for the following four questions:

- How long do you feel you had to wait for a bed on a ward after you arrived at hospital?
- Did you feel able to talk to members of hospital staff about your worries and fears?
- Were you able to get a member of staff to help you when you needed attention?
- Overall, did you feel you were treated with kindness and compassion while you were in the hospital?

The CQC survey report provides an illustration of the Trust's performance, which highlights the five questions against which the Trust scored best when compared with the national average, and the five questions against which the Trust scored worst when compared to the national average.

Questions where the Trust scored best when compared with the national average

- Did the hospital staff explain the reasons for changing wards during the night in a way you could understand?
- Were you ever prevented from sleeping at night by any of the following?
- Hospital lighting.
- Were you ever prevented from sleeping at night by any of the following?
- Noise from other patients.
- How did you feel about the length of time you were on the waiting list before your admission to hospital?
- Before being admitted onto a virtual ward, did hospital staff give you information about the risks and benefits of continuing your treatment on a virtual ward?

Questions where the Trust scored worse when compared with the national average

- Were you able to get hospital food outside of set mealtimes? This could include additional food if you missed set mealtimes due to operations/procedures or another reason.
- Thinking about your care and treatment, did hospital staff take into account the following individual needs? Dietary needs (e.g. medical, allergy, vegan).
- Did you get enough help from staff to eat your meals?
- In your opinion, were there enough nurses on duty to care for you in hospital?
- Were you able to get a member of staff to help you when you needed attention?

Maternity Survey 2025

The maternity survey involved 119 NHS trusts in England, and women over the age of 16 who had a live birth in February 2025 were surveyed. The response rate for this survey was 37%. This was higher than last year but slightly lower than the national average response rate of 39%.

Results were **significantly better** for three questions, compared with the previous year. These were:

- During labour and birth, were you able to get a member of staff to help you when you needed it?
- During your labour, were you ever sent home when you were worried about yourself or your baby?
- Do you think your healthcare professionals did everything they could to help manage your pain during labour and birth?

Feedback **requiring improvement** related to:

- Postnatal care, specifically care at home after birth.

The following five areas show where the maternity patient experience was **considered to be best when compared to the national average**:

Antenatal care:
Start of pregnancy: Being offered a choice about where to have their baby.

Care in the ward:
Partner or someone else close being able to stay as much as they wanted.

Labour and birth:
Being given appropriate information and advice on the associated risks with induced labour.

Labour and birth:
Not being sent home when worried about themselves or their baby.

Labour and birth:
Feeling that they were given appropriate advice and support when they contacted a midwife or the hospital.

Responding to survey findings

Patient survey results are reported at the Trust Patient Experience and Engagement Group (PEEG) and clinical services act upon the findings by undertaking improvements in their areas to respond to what patients have said.

The maternity team works with the Maternity Voices Partnership to develop an action plan in response to the feedback for maternity services and progress on achieving the agreed actions is monitored through the team's governance processes.

Aim for 2026/27

Areas requiring improvement based on the Adult Inpatient Survey results include:

- Improving food provision outside of mealtimes.
- Better consideration of dietary needs.
- Receiving help from colleagues to eat meals.
- Patients being able to get help from colleagues when needed.

The area requiring improvement based on the Maternity Survey results related to postnatal care, specifically care at home after birth.

During 2026/27, reports will continue to be received into PEEG, outlining the progress that is being made to improve experience in these areas.

3.4 Resolving complaints

Patient Advice and Liaison Service (PALS)

During 2025/26 the Trust recorded 8,074 PALS contacts. The table below shows the reasons for the different types of contact.

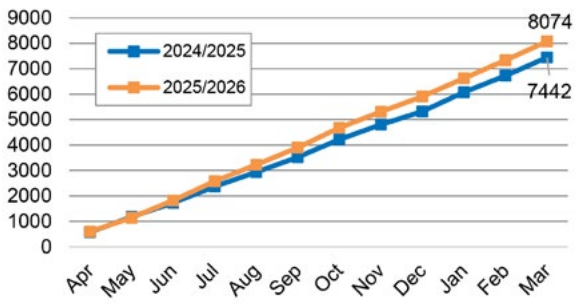
PALS activity in 2024/25 and 2025/26

PALS activity type	2025/26	2024/25
PALS concern (including out-of-time complaints)	**6,382**	5,585
Advice/enquiry	**899**	1,092
Signposting	**32**	43
Compliment	**544**	633
Other	**217**	89
Total	**8,074**	7,442

During 2025/26 there were 6,382 concerns and enquiries requiring input from clinical teams, all of which were passed to the relevant service within two working days of receipt to be investigated; a further 163 concerns were resolved by the PALS team on the same day. 8.5% of the concerns received by the team were complex and required input from more than one clinical service, which is the same as the previous year.

Overall activity increased from 7,442 in 2024/25 to 8,074 in 2025/26, a rise of 632 PALS (+8.5%). PALS concerns (including complaints which were received outside of the timeframe for investigation through the formal complaint process) rose from 5,585 to 6,382 (+797, +14.3%). In contrast, advice/enquiries fell from 1,092 to 899 (-193, -17.7%), signposting decreased from 43 to 32 (-11, -25.6%), and compliments reduced from 633 to 544 (-89, -14.1%). Other types of PALS activity increased from 89 to 217 (+128, +143.8%).

PALS contacts received by month



PALS activity increased in the last financial year. The table below outlines the subjects arising (multiple subjects can be recorded per case). The top four subjects recorded for PALS in 2025/26 were communication, admin/access/patient flow, treatment and colleague interaction:

Change in PALS Subjects 2024/25 and 2025/26

Subject	25/26	24/25	Change	% Change
Communication	5258	4574	684	15%
Administration, access, admission, transfer and discharge	3081	2615	466	18%
Staff interaction	1747	1600	147	9%
Treatment	2000	1428	572	40%
Medication	611	569	42	7%
Patient care and nutrition	472	421	51	12%
Staffing Resources	325	260	65	25%
Facilities, buildings, hazardous substances and systems	195	203	-8	-4%
Health Records / Documentation	257	203	54	27%
Personal property	166	189	-23	-12%
Emergency Department	107	115	-8	-7%
Consent, Confidentiality, Information Governance	165	104	61	59%
Equipment	95	90	5	6%
Infection	99	88	11	13%
Observation and monitoring	66	64	2	3%
Slips, trips, falls, moving and handling	40	57	-17	-30%
Safeguarding	65	57	8	14%

Subject	25/26	24/25	Change	% Change
Unacceptable behaviour, disruption, self harm, missing patient, aggression	43	40	3	8%
Obstetrics	63	37	26	70%
Pressure Ulcer	11	22	-11	-50%
Specimens	23	15	8	53%
COVID-19	6	9	-3	-33%
Intra-operative (theatres)	8	9	-1	-11%
Radiology	11	7	4	57%
Mortality/ Mortuary	6	5	1	20%
Blood Transfusion	3	5	-2	-40%
Compliment	1	1	0	0%
Carer experience (new subject added during 2025/26)	12	0	12	--
Laboratory Investigation	5	0	5	--
Total	**14941**	**12787**	**2154**	**17%**

Communication remains the most frequently raised subject, increasing by 684 (15%). Administration, access, admission, transfer and discharge also saw a notable rise of 466 (18%), continuing to be a key area of concern.

Treatment recorded a significant increase of 572 (40%), representing one of the largest proportional rises. Staff interaction also increased to 1,747, up 147 (9%) from the previous year.

Several areas experienced notable percentage growth, including: consent, confidentiality and information governance (+59%), health records/documentation (+27%) and staffing resources (+25%).

A small number of subjects saw reductions, including personal property (-12%), facilities (-4%), and emergency departments (-7%), while slips, trips and falls (-30%) and pressure ulcers (-50%) showed the largest proportional decreases.

A new subject category of carer experience was introduced during the year.

Each subject recorded is attributed a sub-subject, which gives more detail about the nature of the concern. The top 10 sub-subjects that were linked to PALS concerns in 2025/26 are shown in the table below.

Top 10 PALS Sub-subjects

Sub-Subject	25/26	24/25	Change
Waiting list time (outpatient)	1291	1180	111
Communication - difficulty contacting department	700	677	23
Undesirable staff behaviour	703	663	40
Communication with patient regarding future treatment plan/care	733	558	175
Delay/failure in treatment/procedure	710	405	305
Communication - delay in giving information/results	535	462	73
Lack of compassion	511	415	96
Communication with patient regarding diagnosis/condition	543	355	188
Communication with patient - telephone call/text	427	456	-29
Communication - appointment/ cancellation letter not received	483	257	226

In keeping with the previous year, the top sub-subject for 2025/26 by far was waiting list time for outpatients. This sub-theme was raised 111 more times than in the previous six months (9% increase). Most of the other top sub-subjects relate to patient interactions with colleagues, communication difficulties and delays in diagnostic and treatment pathways.

At the time of writing 6,799 concerns and enquiries received in 2025/26 were resolved. Everyone using the service is contacted to ask them what method of resolution they would

prefer. The most prominent resolution method (not including reopened case resolutions) was telephone, with 65% of cases resolved via this method, followed by email for 19% of cases. Other core concern resolution methods (highlighted in bold) included discussions with complainants on the ward or in clinic (5%), letters (2%), appointment arranged to discuss further (2%), resolution meetings (0.5%), escalated to formal complaints (0.4%).

Key achievements in 2025/26

The team has changed its daily working practices for first-time call handling and implemented new processes to improve efficiency. Early benefits of the changes include a reduction in voicemails, as PALS officers have been more able to answer calls. In addition, management of concerns received by email has improved.

It is essential to maintain the accuracy of dates and information recorded in the PALS system, as inaccuracies may result in delays in closing cases. To address this issue, the PALS team has initiated regular meetings with clinical teams to review overdue cases.

Following a request from CSUs, the PALS team has developed a new training package which focuses on resolving concerns before they become a PALS. The package is suitable for all grades of colleagues and all professional groups and can be customised for individual CSUs. It has been very well received, and the team has received requests for copies of the presentation to be shared for local training. Early local resolution of concerns benefits our patients by providing a timelier response to concerns as they occur.

80% of PALS concerns and enquiries were resolved within the 10-working day target. This led to an improved experience for our patients who raised concerns. A fortnightly report has been produced which is sent to CSUs informing them of the remaining PALS cases open over 10 working days from the date received. This has helped teams manage their PALS where the deadline for resolving the concern has passed. Since this focus on the most overdue unresolved cases, the number of open overdue cases has fallen every two weeks from 4 February (125 overdue cases) to 15 April 2026 (81 overdue).

To reduce the number of PALS escalations that result in formal complaints, a trial is currently being conducted that involves an additional review by the PALS manager. This initiative is designed to ensure that complainants are appropriately engaged in the correct process from the beginning. Furthermore, cases that have already been through the PALS process and where complainants are dissatisfied with the resolution will also be assessed by the PALS manager to explore potential alternative solutions.

In collaboration with Urgent Care, new template response letters for addressing the top five PALS concerns that are frequently reported for emergency departments have been completed. For these reported concerns (long waits in emergency care, prolonged bed waits in the emergency department, mental health and wellbeing, noise, and nutrition and hydration), responses will now be sent directly from the PALS team to the complainants. This change aims to eliminate delays in communication.

Following two workshops and a full day event with the support of the Trust improvement team, the PALS service is working with the complaints and spinal surgery teams to try to reduce the number of PALS received relating to waiting times and related enquiries. The aim is to provide reassurance that patients are on the waiting list for surgery and to provide information on likely wait times and what the CSU is doing to reduce these. In addition, the PALS team will provide advice on the best times of day to contact the clinical service by telephone, and they will provide a generic email address for enquiries. This approach will be extended to other surgical specialties where patients may worry about long waiting times for appointments and surgical procedures.

Review of Quality Programme aims for 2025/26

During 2025/26 there were 273 PALS concerns converting to a formal complaint, which has increased by 55 (25% increase) from 218 escalations in 2024/25. The latest available benchmarking data from Model Hospital for the financial year 2024/25 shows Leeds Teaching Hospitals has a comparably higher (in Q4) proportion of PALS contacts converted to a formal complaint at 3.2%, compared to peer acute trusts (2.3%) and nationally (1.5%).

Data regarding performance on cases open over 10 working days is shared within the CSU Patient Experience Assurance programme (PEAP) data pack for CSUs. CSUs attend the Patient Experience and Engagement group to describe what actions they are taking to reduce the number of PALS open past the target time. The number of PALS remaining open for more than 10 days has demonstrated an improving trend from February to April 2026.

In 2025/26, PALS received 63 responses to an electronic service satisfaction survey. When asked if they would recommend using the PALS service to family or friends, 53 of 63 (84%) respondents said they would (this is slightly down from the 85% the previous financial year). It is clear from the feedback received that there are some areas where improvements could be made to the service to improve the user experience. The primary reason given for not recommending the service included a lack of response or ineffective resolution to concerns or dissatisfaction with the outcome. The PALS action plan for the coming year includes interventions to respond to user feedback.

The plan for 2026/27 includes:

- Extending the opportunities for the PALS team to provide responses and the provision of other information on behalf of CSUs for commonly occurring concerns, such as waiting list enquiries.
- Working with CSUs to reduce the number of PALS that remain open for extended periods.

3.5 Working with partners

Improvement Partner Programme

Founded in 2019, the Partner Programme recruits members of the public and embeds them into work that aims to improve experience, quality and safety of our services.

The programme successfully supports the organisation to meet the requirements of NHS England's National Patient Safety Strategy, Involving Patients in Patient Safety Framework, part B.

Key achievements in 2025/26

It was a successful first year in the delivery of the new Partner Strategy (2025-2027). The team is making good progress in achieving the three strategy pillars, which are:

1. To sustain successes in embedding partners (members of the public) in Trust improvement programmes.
2. To support partners to become embedded within CSU teams supporting local priorities, which may include topics such as health inequalities, local experience, and quality and safety risks.
3. To develop partners and staff to enable successful partnering.

The priority has been to embed partners into clinical service units (CSUs) this year with the number of CSUs supporting a partner rising from two to five: AMS, Adult Therapies, Head and Neck, Urgent Care and Cardio-Respiratory. The team is learning what works and where CSUs can best use the valuable contribution of partners directly in their work. The partners are members of the CSUs' monthly Quality Assurance Group meetings, and support work on improving patient experience, quality and safety. An example of this has been one partner participating in a review of a 'never event' within their CSU, offering an independent, patient centred view of the incident and learning.

Partners continue to be involved in Trust Quality Improvement Collaboratives which are priority areas for the organisation and NHS overall, and include concentrated work of reducing falls, earlier identification of deterioration, and the management of sepsis.

Partners continue to support the work of the Trust Improvement Team and are directly involved in improvement work taking place, focusing on complaints, 'never events', patient transport and the patient meal service.

The Trust continues to test host a senior partner role which attracts an honorarium in line with NHS England guidance. The senior partner has acted as a link between partners and the Trust management team. Objectives for the role are set and will be used to evaluate impact. Funding has been secured for 2026/27.

The Trust continues to exceed the contractual requirement to have two or more partners supporting patient safety activity across the organisation.

Partners support a range of activities across the 36 groups and workstreams they contribute to, examples include:

- Offering their guidance in work to revise and update the information shared in patient letters, partners were key to the Trust including an easy read version of every outpatient letter sent out.
- A partner joined an Infection Prevention Committee helping to focus on the outcome for patients in the discussions and actions agreed.
- Supporting the Senior Nurse clinical leadership walkarounds.
- Joining the work in the Paul Sykes centre to implement national guidance for a one stop shop for Urology patients.

Aims for 2026/27

- Continue to prioritise integrating partners into CSUs within the organisation.
- Develop the Trust Complaints Panel to include six partners, supported by the senior partner role.
- Continued commitment to and evaluation of the senior Patient Safety Partner role, while ensuring compliance with the NHS Patient Safety Strategy. Further expansion of the programme through targeted recruitment to meet increasing demand for partner involvement.

Carers

The Trust continues to make progress to support unpaid carers in our hospitals. Work to deliver improvements is guided by a Trust carers action plan 2025-27.

The Carers Working Group meets regularly, membership includes Leeds Teaching Hospitals colleagues, external colleagues, carers and improvement partners. The Trust supports John's Campaign and has a 'Carers Passport' scheme which is associated with additional benefits for carers.

Key Achievements in 2025/26

A policy to support unpaid carers in hospital has been developed to strengthen the requirement for welcoming and supporting carers and this will be launched in the coming year.

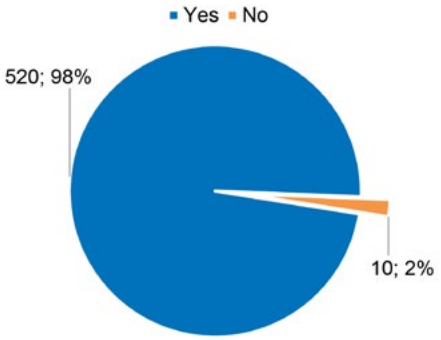
Three 'Carer and Young Carer Awareness' training sessions were co-delivered by Family Action, Carers Leeds and the Trust's Unpaid Carers Lead. Additionally, bespoke training sessions for ward clerks were designed and delivered twelve times during 2025/6 with 45 ward clerks in attendance. There are a further three training sessions planned for 2026/7 and three sessions for ward clerks taking place in June 2026 to coincide with Carers Week.

During Carers Week in June 2025, Trust staff were invited to take part in a Carers' quiz with a chance to win a hamper generously donated by Carers Leeds. The competition received over 130 entries, and team members were delighted to present the hamper to the winner on J43.

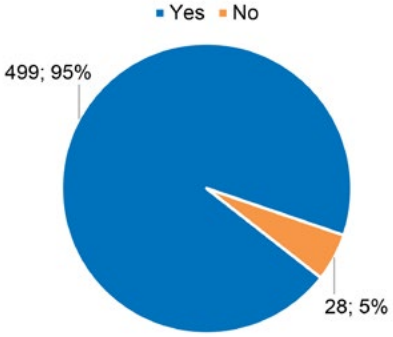
In July 2025, additional questions were added to the Friends and Family Test (FFT) to understand the carer's experience. This was made available on ward iPads, and those completing the FFT online or via a QR code. Feedback suggests that of the carers who completed the survey, most were made to feel welcome and felt involved in discussions about the person they care for.

Carers Leeds supports unpaid carers in the Trust and has recently recruited an additional Carer Support Worker (CSW) to support carers at Chapel Allerton Hospital, with the support of Leeds Hospitals Charity. This is in addition to two CSWs, are already based at St James's and also covering the Leeds General Infirmary.

Were you made to feel welcome?



Did you feel involved in discussions about patient care?



The Leeds Dental Institute has been awarded Leeds Young Carers Support Services (LYCSS) 'Young Carer Friendly' Quality Mark, in recognition of the creation and implementation of their new young carer pathway.

Trust colleagues and Family Action completed an exercise with the "Leeds Young Carers, Engaged, Active, Participating" (LEAP) group, to understand what is important to young carers when accompanying or visiting their loved one in hospital. This exercise will support the development of a young carers passport that can be used in Leeds Teaching Hospitals settings to help with identification and support.

Aims for 2026/27

- Develop a new Carer Passport to better support young carers.
- Launch the Supporting Unpaid Carers in Hospital Policy to raise awareness of the importance of supporting carers among staff and drive further improvements.
- Develop a John's Campaign Ambassadors programme.
- Develop the Unpaid Carers Conversation sheet in a digital format.

Volunteering

The number of volunteers who gifted their time and skills in Q4 2025/26 has increased to 292 volunteers, 80 more than in Q2 2025/26. This has resulted in an increase in the hours gifted to 11,509, a 7% increase. Our volunteers are a diverse community in age and ethnicity.

Volunteers are active in a variety of roles that support our patients, staff and the organisation. This year we have prioritised recruiting volunteers into patient-facing roles.

Over 200 of our volunteers have expressed that they plan to have a career in healthcare. Volunteers are supported into their roles with mandatory and role specific e-learning modules, including training on food hygiene, learning disability and autism and how to support patients with visual impairments.

Key Achievements in 2025/26

To support the Trust-wide Nutrition Mission campaign, a new role was launched to support patients at mealtimes. The Meal Mate role was piloted in three wards and is now spreading to a fourth. This role provides practical, friendly support to patients at mealtimes. In addition, volunteers have been recruited to support patients and colleagues in the emergency department at St James's University Hospital. This team provides a warm welcome, refreshments and keeps people company whilst they wait for assessment and treatment, reducing anxiety.

Joy and Janette, two new volunteers in the emergency department at St James's University Hospital

The number of volunteers has continued to grow at Chapel Allerton Hospital and extend the support of the Rehab Rangers working there to six days per week.

The team has been working in partnership with Leeds Hospitals Charity to increase the number of volunteers in the organisation. This has seen a transition of the Welcome volunteers working in reception spaces to the responsibility of Leeds Hospitals Charity, which has allowed focus on recruitment on much needed patient-facing roles.

Frankie the therapy dog

Following the opening of The Rob Burrow Centre for Motor Neurone Disease, complementary therapists were invited as part of the holistic offer for families. In addition, Frankie the therapy dog is a popular addition to the team and his calm, friendly nature is a big support to patients and families.

Aims for 2026/27

- Grow the number of volunteers and expand the Meal Mate role onto additional wards.
- Following success with a funding bid and a partnership with Marie Curie, develop a volunteer scheme that supports patients and families that are in end-of-life care.
- Monitor the impact our volunteer schemes have on patient outcomes and staff wellbeing.

3.6 Chaplaincy

The Chaplaincy Department is responsible for facilitating the pastoral, spiritual, and religious care of patients, colleagues, students and visitors of Leeds Teaching Hospitals. The team contributes specialist knowledge and skills in matters relating to spiritual and religious beliefs and pastoral and cultural practices in the context of healthcare and the diverse communities served by Leeds Teaching Hospitals.

The last year has been one of change behind the scenes; long-serving colleagues retiring, organisational change, and new colleagues joining. The mission stays the same and the commitment to providing excellent and effective pastoral, spiritual, and religious care is core. The team are contributing to national work on chaplain recruitment and training, seeking to develop a workforce that will be in the best place possible to deliver care now and in the future.

Support from Leeds Hospitals Charity with funding has facilitated a specialist chaplain and pastoral care practitioner, who was also an experienced researcher, working with the Leeds Cancer Centre for two years. The research project they have undertaken has yielded important insights, particularly the feedback that patients who engage with a chaplain or pastoral care practitioner are able to have better conversations with the multidisciplinary team about their care needs and goals.

Within the project, work has also been undertaken on reviewing an international spiritual distress assessment and applying this to a UK setting. It is hoped some of this work can be published and to embed this knowledge and learning into our practice.

Unfortunately, the Trust experienced a faith hate crime in the last year. With the support of the Trust board, several actions have been taken in response to ensure patients and colleagues feel safe. Presently, work is progressing in the Faith and Belief centre in Bexley Wing at St James's University Hospital to make it more secure, but also accessible and inclusive. All quiet and prayer spaces are being reviewed across the hospitals, and work will start soon on the other areas. Other work that has been progressed has included considering food menus from a faith and belief perspective for patients on wards and in the hospital retail outlets.

The team continues to be grateful for the support of Leeds Hospitals Charity which enables more to be done for patients and colleagues; whether this is through providing items to help people explore and practice their faith or belief or supporting faith and belief celebrations. The team would also like to express gratitude to private donors, who have enabled the Trust Sikh prayer day and Eid celebrations to take place.

3.7 Emergency preparedness, resilience and response (EPRR)

The Trust maintains a statutory duty to remain prepared for a range of hazards and threats that could disrupt patient care, colleague safety, or service delivery. Our EPRR arrangements are governed by the following primary legislation and national standards:

- Civil Contingencies Act (2004): Designates the Trust as a Category 1 Responder, mandating our participation in local resilience forums and the maintenance of robust emergency plans.
- Health and Social Care Act (2012): Explicitly requires the Trust, as an NHS-funded provider, to maintain a resilient response to emergencies and service disruptions.
- NHS England EPRR Framework: Adheres to the latest national standards, ensuring our "Business Continuity Management System" (BCMS) is aligned with ISO 22301 and the NHS EPRR Core Standards.

In alignment with these requirements, the Trust operates a comprehensive "Integrated Emergency Management" (IEM) cycle. This ensures a robust system for anticipation, assessment, prevention, preparation, response, and recovery. This programme is designed to achieve our Triple Aim: Harm Reduction, Business Resilience, and Regulatory Assurance.

To validate these arrangements, the Trust maintains a rolling 12-month programme of Training and Exercising, ensuring all on-call colleagues meet the Minimum Occupational Standards (MOS) required for their respective roles.

The Accountable Emergency Officer (AEO), Tim Hiles, holds executive responsibility for the Trust's EPRR obligations at Board level, as mandated by the NHS EPRR Framework. The AEO is supported by a specialist Resilience Team tasked with the operational delivery of the EPRR Work Programme. This team comprises of a Head of Resilience, a Resilience Manager (Senior Resilience Advisor), a Resilience Officer (Emergency Planning Officer) and a Resilience Support Administrator. Together, they ensure the Trust maintains the necessary capacity and capability to respond to incidents while meeting all statutory assurance requirements.

Strategic oversight of the Trust's resilience is maintained through the Emergency Preparedness Coordinating Group (EPCG). This group provides a formal platform for multi-disciplinary collaboration, governing four specialist workstreams:

- High Consequence Infectious Diseases (HCID)
- Major Incident & Trauma
- Business Continuity
- Climate Adaptation

The Trust matured its approach to managing EPRR risks by adopting a tiered management framework. This ensures our preparedness is not isolated but is instead part of a wider resilience ecosystem. We utilise horizon scanning to review and align risks across three distinct levels:

1. National: Reviewing the National Security Risk Assessment (NSRA) to ensure Trust plans account for broad national threats.
2. Regional: Working in partnership with the West Yorkshire Local Resilience Forum (LRF) and the Integrated Care Board (ICB) to align with the regional Community Risk Register.
3. Local: Managing Trust-specific operational and clinical risks through the Datix Corporate Risk Register.

The Trust operates a "closed-loop" assurance system. Any action plans arising from the activation of plans are tracked via a centralised Continuous Improvement Log. This ensures that "Lessons Identified" are systematically embedded as "Lessons Learned" and reflected in updated policies.

In accordance with national requirements, the Trust undertakes an Annual Self-Assessment against the NHS England EPRR Core Standards. This process is subject to external peer review and final sign-off by the West Yorkshire Integrated Care Board. For the 2025/26 cycle, the Trust's self-assessment achieved substantial assurance, with the majority of core standards assessed as compliant and two areas identified as partially compliant. These

two areas relate to preparedness for new and emerging pandemics and supplier business continuity arrangements. The assessment provides assurance of a high level of institutional readiness, while also identifying areas for continued improvement.

To ensure specialist rigour, the Trust also participated in an independent audit of Domain 10 (chemical, biological, radiological and nuclear (CBRN) and hazardous materials (HAZMAT)), conducted by the Yorkshire Ambulance Service (YAS). This technical review identified the Trust as Partially Compliant. In response, the Resilience Team has established a dedicated Continuous Improvement Plan to address the specific recommendations regarding equipment maintenance and specialist training. Progress against this plan is monitored by the Emergency Preparedness Coordinating Group (EPCG) to ensure the Trust reaches full compliance in this domain during the 2026/27 period.

The Trust remains committed to enhancing the skills of on-call managers and directors. While the strategic intent for 2024/25 was to transition from a single annual session to a regular "Deep Dive" programme, significant changes within the Resilience Team necessitated a period of consolidation, which impacted the delivery of this expanded schedule.

Consequently, the full implementation of this programme, specifically designed to align technical and non-technical command skills with the EPRR National Occupational Standards (NOS), has been carried forward as a primary objective for the 2026/27 work programme. Work is already underway to ensure a robust competency-based assessment framework is in place to verify responder readiness against these national benchmarks.

Following the pilot of the new Business Continuity Management System (BCMS) in 2024/25, the full organisational roll-out has been impacted by changes in the Resilience Team's staffing structure. Consequently, the comprehensive embedding of the BCMS, aligned with ISO 22301, remains a priority focus for 2026/27.

To mitigate operational risk in the interim, the Trust has significantly improved its approach to Planned Works. A strengthened gateway process ensures that estates and IT projects are subject to rigorous impact assessments, ensuring business continuity is designed into the works rather than managed as an afterthought.

The Trust's resilience was tested through a variety of activations this year:

- Major Incident (Infrastructure): A Major Incident was declared following a failure in building infrastructure which necessitated the relocation of a clinical ward. The incident was effectively managed through our command-and-control structures, ensuring patient safety and clinical continuity were maintained throughout the transfer.
- Rising Tide Events (Supply Chain): The Trust successfully managed a number of "rising tide" events, particularly those affecting critical supply chains. Proactive monitoring and the timely activation of business continuity arrangements ensured that disruptions to essential supplies did not impact frontline patient care.

For all formally declared incidents, a structured debrief is conducted. The resulting actions are managed via a centralised Continuous Improvement Log, ensuring vulnerabilities are addressed. A key objective for 2026/27 is to further embed this "lessons learned" model across smaller-scale business continuity and rising tide events to ensure a consistent approach to organisational learning.

3.8 Leeds Hospitals Charity

Leeds Hospitals Charity is the charity of Leeds Teaching Hospitals NHS Trust. We're the charity that champions, supports and gives thanks to the NHS, bringing together thousands of donors so we can make a real difference to the people and patients of Yorkshire. We do this by funding life-saving equipment, treatments, research into rare diseases and home comforts – whatever will make the biggest impact to the people who need it most.

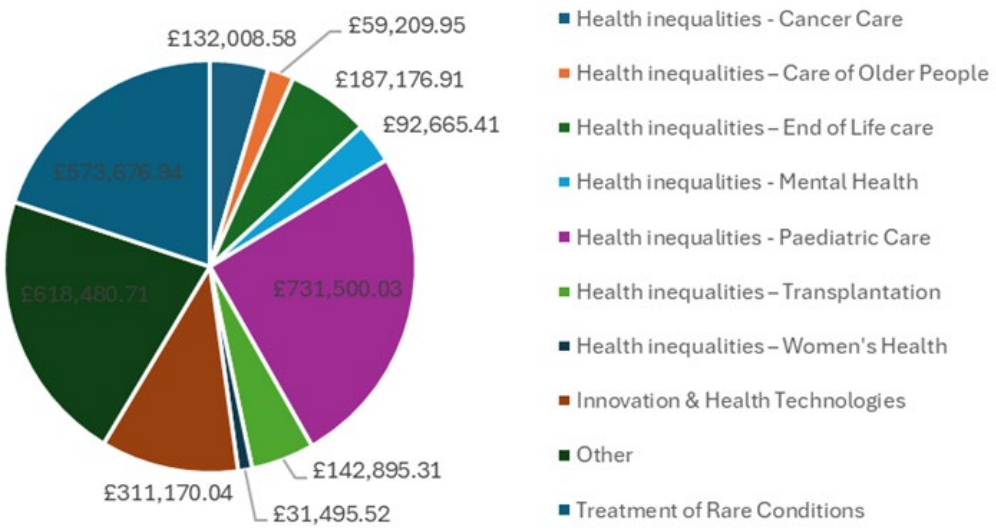
The charity is independent of the Trust and is governed by a Board of Trustees, with Dr Yvette Oade CBE DL as the Chair. Esther Wakeman is the Chief Executive Officer, and she is supported by a small Executive Team and a further 81 paid staff and 405 volunteers.

Grant funding

Thanks to donations and Gifts in Wills, we have provided £3.1 million of additional support in the financial year 2025-26 to Leeds Teaching Hospitals. We are dedicated to providing funding for ongoing projects that support patients, families and staff across all hospitals, such as the Patient and Volunteer Fund, Chaplaincy services and staff recognition.

Throughout the year we provided opportunities for staff to apply for funding via themed funding rounds in innovation, research, patient experience and enhancing the healing environment.

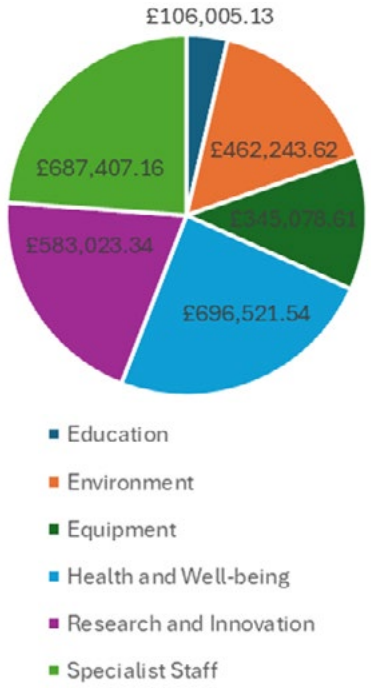
Funding split by Impact Area



Impact Area Breakdown

Impact Area	Tackling Health Inequalities	Innovation & Health Technologies	Treatment of Rare Diseases	Other
No. of Applications	98	18	15	21
Funding (£)	£1.3m	£311k	£573k	£618k

Funding spilt by Funding Priority



The Rob Burrow Centre for Motor Neurone Disease (MND)

The charity appeal for the Rob Burrow Centre for MND reached its fundraising target of £6.8 million in December 2024, thanks to over 17,000 incredible donors. Five years after an idea was first shared between Rob Burrow and his consultant, Dr Agam Jung, that dream became a reality and the new centre opened its doors in November 2025.

His Royal Highness the Prince of Wales officially opened The Rob Burrow Centre for Motor Neurone Disease at Seacroft Hospital on 20 November 2025.

The new centre is a world-leading facility in Leeds, dedicated to the diagnosis, research and care of Motor Neurone Disease. Named after our late Patron and rugby league player Rob Burrow CBE, who sadly passed away in June 2024 after his own battle with MND, the centre aims to lead the way in transforming MND diagnosis and care. Supporting all aspects of the patient's journey, the new facility creates comfortable and peaceful surroundings for patients and their families.

It is the first purpose-built centre dedicated entirely to MND care, research, education and holistic support in the UK, and stands as a trailblazer for other centres around the country.

Leeds Cancer Appeal

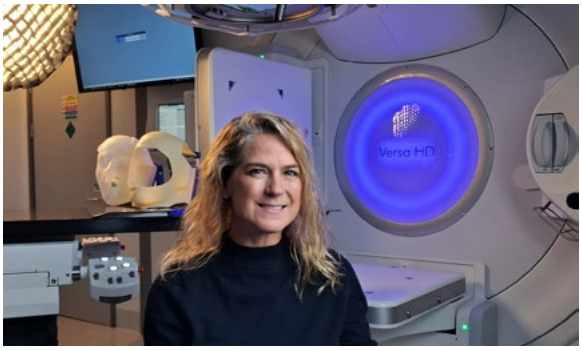
To mark World Cancer Day on 4 February 2026, we launched a new £1 million fundraising appeal to improve treatment and care for cancer patients at Leeds Cancer Centre.

The appeal will fund the expansion of Surface Guided Radiotherapy Technology (SGRT) and install MapRT software in the radiotherapy department, making Leeds the first radiotherapy centre in England to use the software and offering a unique experience for patients.

This could mean patients no longer need to wear closed face masks during treatment and will eliminate the need for permanent radiotherapy tattoos.

Joanna, patient at Leeds Cancer Centre said: "The mask was one of the hardest parts of treatment. It can be a really frightening experience, and I found the mask very claustrophobic. It caused me a huge amount of anxiety going in every day for treatment. I found it overwhelming to not be able to see much through the mask, but I was grateful to have the staff there to talk me through the process each day.

"Having an open face mask - or no mask at all - would have changed the whole experience for me, and I'm sure for many patients going through a similar experience."



Joanna, patient at Leeds Cancer Centre

By bringing SGRT and MapRT to Leeds, we can reduce trauma and anxiety for patients and significantly improve their treatment experience.

Thanks to previous charity funding, SGRT is already available for all breast cancer patients in Leeds. With further support, this innovative technology could be extended to patients with head and neck cancer, and to children and young people undergoing radiotherapy.

Making a difference in our hospitals

Throughout the year, Leeds Hospitals Charity was really proud to have provided significant funding to a range of projects to Leeds Teaching Hospitals to make a real difference for millions of patients, families and staff. Here are just a few examples of projects we've supported throughout the year:

Tackling Health Inequalities

7 Days of Play

We funded the Play Team at Leeds Children's Hospital for a second year, ensuring that this vital service continues to run seven days a week, supporting seriously ill children and their families throughout the most difficult time of their lives.

Thanks to our generous donors, the Play Team were able to expand their team to 42 Play Staff, covering 20 medical areas across the hospital. On average the Play Team is now able to provide 338 therapeutic specialised play sessions a week, including weekends, enhancing the hospital experience for young patients and their families.

After weeks of illness, five-year-old Reggie was diagnosed with B-cell acute lymphoblastic leukaemia and spent three months on the children's oncology ward. For seven of those weeks, he was completely isolated. No shared spaces, no visitors beyond his parents, and no chance to play with other children. He was also too unwell to leave his bed.

Reggie, patient at Leeds Children's Hospital

Chris, Reggie's Dad said: "Those early days were really hard, but even then, the Play Team would pop in a few times a day to bring him toys or crafts. They got to know his favourite things and that really meant a lot."

Zoe, a Play Specialist on ward L31, had a lasting impact on the whole family. She didn't just entertain Reggie - she connected with him. From building dinosaur lands out of scrap materials to dancing under disco lights during Friday 'parties' complete with music and bubbles, Zoe made hospital feel like a place where Reggie could still laugh, play and be himself.

That play made a huge difference. Chris said: "He used to shout 'no' whenever doctors or nurses came near him. Now he's playful with them. That makes meds and checks so much easier.

"Just seeing him laugh and smile during all this has meant everything."

Expanding our Charity Trolley across Leeds Teaching Hospitals

In September 2024, we launched our first volunteer-run Charity Trolley across Leeds Children's Hospital. This service provides snacks, drinks and toiletries to patients and families who need a little extra support during their hospital stay. Thanks to generous donations, all items on our trolley are free of charge.

In recent months we have been able to expand this service to more areas across our hospitals, supporting more patients and families. Our Charity Trolley now runs across wards in Leeds Children's Hospital, Chapel Allerton Hospital, Beckett Wing, Gledhow Wing and in post-natal care.

Care bags for patients with learning disabilities & autism

Staff recognised that patients with Autism or Learning Disabilities struggled with the unpredictable environment in the Emergency Department, so developed an idea to create care bags for these patients.

We provided funding for a pilot scheme back in May 2022, which benefitted over 250 eligible patients, helping to combat the health inequalities they can face.

The tote bags contain sensory items, including noise cancelling headphones, as well as items to help occupy and distract patients, like stress balls and colouring books. Patients are also provided with information about the hospital in an accessible format, and a visible tag so clinical staff can refer them to the Acute Liaison team.

Following the success of the initiative, pioneered by the Trust, the team applied for additional funding from Leeds Hospitals Charity to roll out the project across even more departments.

Now, the care packs are available across all acute hospital departments for patients with learning disabilities and autism, with an average of 30 bags being given out a week, amounting to around 1,500 a year.

Patient Kai and the Learning Disabilities and Autism Team at Leeds Teaching Hospitals

Innovation and Health Technology

Investment in AI technology for stroke patients

People who have experienced a stroke are at risk of having another stroke, which could cause a significant disability. Currently, one in ten people who attend Leeds Teaching Hospitals with a stroke will have another stroke within one year.

Atrial fibrillation (AF), an irregular heart rhythm, is a common cause of a stroke, and if this was detected earlier, the risk of another stroke could be reduced. This project will use an AI tool, developed by doctors and researchers at Leeds Teaching Hospitals and the University of Leeds, to identify people with a higher risk of atrial fibrillation.

Thanks to charity funding, the team will provide 60 high risk people with a patch to wear for 14 days after a stroke to look for atrial fibrillation. This patch will monitor heart rhythm, which will increase the chance of identifying this condition. If AF is detected, they will be treated to reduce their risk of another stroke.

Supporting patients in Neuro Critical Care

Thanks to a heartfelt donation from the Tobias Crowther Foundation to Leeds Hospitals Charity, two specialist chairs were purchased to support patients with life-threatening neurological conditions.

The Tobias Crowther Foundation was created in Toby's memory after the 18-year-old tragically passed away in a car crash in 2023. It raises funds to support the work of several charities, including Leeds Hospitals Charity, in recognition of the care that Toby received before he died.

Laura Sedgley, Matron in Neuro Critical Care, said: "We are overwhelmed by the generosity of Toby's family. These chairs will enable our therapists to offer highly specialised seating to the most dependent patients.

"This supports the ethos of early rehabilitation after brain injury, which makes a real difference to patient outcomes. We are delighted to work with Toby's family to honour his memory."

Rare Diseases

New team members join The Rob Burrow Centre for Motor Neurone Disease

Thanks to generous donors, we have funded specialist clinical roles to strengthen patient care and support services within the new centre. Gary Jevon, the new centre manager, is funded by Leeds Hospitals Charity.

He said: "This is a really exciting opportunity to be involved at the beginning of something new and innovative. The Rob Burrow Centre for Motor Neurone Disease has such a high profile, locally and nationally, and I'm keen to play a part in ensuring it provides the best care, holistic support, education and research for the benefit of patients and their families.

"The vision is to make it a globally recognised, international centre of excellence for MND. It's

not just about how we treat MND, it's about making it a holistic care centre, looking after families and carers, looking at the bigger picture and doing things differently.

"It's an incredible building and the facilities and new technology are fantastic. This will have a huge positive impact on the sort of care we can offer for people with MND and their families."

Supporting NHS staff

The charity is committed to funding projects that support staff across Leeds Teaching Hospitals. We have continued to support annual staff award events, including Time to Shine and Leeds Children's Hospital Kite Awards.

Working in partnership with Leeds Teaching Hospitals we hosted a new 'Spin to Win' initiative across the hospitals, recognising and thanking staff for their hard work, as well as our support for staff at multi-faith events across the Trust. We also continued to support staff during the festive period, funding Christmas dinners, Christmas Day taxis and chocolate, creating small moments of joy for staff during the busiest time of the year.

We have continued funding initiatives like the Patient and Volunteer Fund, investing £60,500 to support patients and volunteers experiencing financial hardship. We also invested £20k to support the Staff Welfare and Amenities Fund, which provides funding for practical items such as kettles and toasters for staff rest spaces.

Thanks to donations, we have also been able to provide another year of free tea and coffee in staff rooms for staff across all hospital sites.

Sharing our work

Throughout the year we have also expanded our support across Leeds Teaching Hospitals by opening the new Bexley Charity Hub in Leeds Cancer Centre. This new space was designed as a place of calm for patients, visitors and staff to use. There is a book nook for people to enjoy, along with comfy chairs and greenery, creating a calm and safe space.

We also recruited new Welcome Volunteers across the hospitals, who support patients and families with finding their way around the hospital sites, ensuring they reach their appointments and visits. Throughout 2025-26 our Welcome Volunteers supported over 11,000 patients and visitors across Leeds Teaching Hospitals.

We have also expanded our retail function in the local community, opening an additional four charity shops across Leeds, in Horsforth, Guiseley, Ilkley and Morley. Our retail volunteers have also expanded across the four new sites, with a total of 232 retail volunteers across the charity.

In June, we collaborated with Marie Curie, the UK's leading end-of-life charity, on a research grants scheme. This partnership brought a funding opportunity for researchers aiming to improve hospital care and discharge processes for people with palliative and end-of-life care needs in Leeds.

We have also partnered with Carers Leeds to fund a Carer Support Worker at Chapel Allerton Hospital.

Earlier this year on World Kidney Day, we announced our partnership with Kidney Research Yorkshire, working together to develop research and tackle health inequalities across Yorkshire. We'll be working together, alongside Leeds Teaching Hospitals NHS Trust and the University of Leeds, to work towards transforming care for renal patients and their families.

Section 4

Financial Statements

Section 4: Financial Statements for 2025/2026

4.1 Statements of responsibility

Statement of the Chief Executive's responsibilities as the Accountable Officer of the Trust

The Chief Executive of NHS England has designated that the Chief Executive should be the Accountable Officer of the trust. The relevant responsibilities of Accountable Officers are set out in the *NHS Trust Accountable Officer Memorandum*. These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;
- value for money is achieved from the resources available to the trust;
- the expenditure and income of the trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;
- effective and sound financial management systems are in place and;
- annual statutory accounts are prepared in a format directed by the Secretary of State to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, other items of comprehensive income and cash flows for the year.

As far as I am aware, there is no relevant audit information of which the Trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

Signed

Brendan Brown, Chief Executive

25 June 2026

Statement of Directors' responsibilities in respect of the accounts

The Directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of HM Treasury, directs that these accounts give a true and fair view of the state of affairs of the Trust and of the income and expenditure, other items of comprehensive income and cash flows for the year. In preparing those accounts, the Directors are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;
- make judgements and estimates which are reasonable and prudent;
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts and;
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The Directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the Trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

The Directors confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS Trust's performance, business model and strategy.

By order of the Board

Brendan Brown,
Chief Executive

25 June 2026

Jenny Ehrhardt,
Finance Director

25 June 2026

4.2 Independent Auditor's Report to the Directors of the Leeds Teaching Hospitals NHS Trust

Opinion on the financial statements

We have audited the financial statements of The Leeds Teaching Hospitals NHS Trust ('the Trust') for the year ended 31 March 2026, which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows, and notes to the financial statements, including material accounting policy information.

The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards as interpreted and adapted by HM Treasury's Financial Reporting Manual 2025/26 as contained in the Department of Health and Social Care Group Accounting Manual 2025/26, and the Accounts Direction issued by the Secretary of State with the approval of HM Treasury as relevant to NHS Trusts in England.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2026 and of its income and expenditure for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2025/26; and
- have been properly prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the "Auditor's responsibilities for the audit of the financial statements" section of our report. We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

In auditing the financial statements, we have concluded that the Directors' use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, and taking into account the requirements of the Department of Health and Social Care Group Accounting Manual, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Directors with respect to going concern are described in the relevant sections of this report.

Other information

The other information comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. The Directors are responsible for the other information. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Responsibilities of the Directors and the Accountable Officer for the financial statements

As explained more fully in the Statement of Directors' Responsibilities, the Directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. The Directors are required to comply with the Department of Health and Social Care Group Accounting Manual 2025/26 and prepare the financial statements on a going concern basis, unless the Trust is informed of the intention for dissolution without transfer of services or function to another public sector entity. The Directors are responsible for assessing each year whether or not it is appropriate for the Trust to prepare its accounts on the going concern basis and disclosing, as applicable, matters related to going concern.

As explained in the Statement of the Chief Executive's Responsibilities as the Accountable Officer of the Trust, the Accountable Officer is responsible for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error. The Accountable Officer is responsible for ensuring that the financial statements are prepared in a format directed by the Secretary of State.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud.

Based on our understanding of the Trust, we did not identify any laws and regulations that have an indirect effect on the preparation of the financial statements where non-compliance might have a material effect on the financial statements.

To help us identify instances of non-compliance with laws and regulations, and in identifying and assessing the risks of material misstatement in respect to non-compliance, our procedures included, but were not limited to:

- gaining an understanding of the legal and regulatory framework applicable to the Trust, the environment in which it operates, and the structure of the Trust, and considering the risk of acts by the Trust which were contrary to the applicable laws and regulations, including fraud;
- inquiring with management and the Audit Committee, as to whether the Trust is in compliance with laws and regulations, and discussing their policies and procedures regarding compliance with laws and regulations;
- inspecting correspondence, if any, with relevant licensing or regulatory authorities;
- reviewing minutes of relevant meetings in the year; communicating identified laws and regulations throughout our engagement team and remaining alert to any indications of non-compliance throughout our audit; and considering the risk of acts by the Trust which were contrary to applicable laws and regulations, including fraud.

We also considered those laws and regulations that have a direct effect on the preparation of the financial statements, such as the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012).

In addition, we evaluated management's incentives and opportunities for fraudulent manipulation of the financial statements (including the risk of override of controls) and determined that the principal risks were related to posting manual journal entries to manipulate financial performance, management bias through judgements and assumptions in significant accounting estimates, in particular in relation to the risk of fraud in revenue recognition (which we pinpointed to the cut-off, existence and valuation assertion), the risk of fraud in expenditure recognition (which we pinpointed to the cut-off, completeness and valuation assertion), and significant one-off or unusual transactions.

Our audit procedures in relation to fraud included, but were not limited to:

- making enquiries of management, Internal Audit and the Audit Committee on whether they had knowledge of any actual, suspected or alleged fraud;
- gaining an understanding of the internal controls established to mitigate risks related to fraud;
- discussing amongst the engagement team the risks of fraud; and
- addressing the risks of fraud through management override of controls by performing journal entry testing.

There are inherent limitations in the audit procedures described above and the primary responsibility for the prevention and detection of irregularities including fraud rests with both management and the Audit Committee. As with any audit, there remained a risk of non-detection of irregularities, as these may involve collusion, forgery, intentional omissions, misrepresentations or the override of internal controls.

We are also required to conclude on whether the Directors' use of the going concern basis of accounting in the preparation of the financial statements is appropriate. We performed our work in accordance with Practice Note 10: Audit of financial statements and regularity of public sector bodies in the United Kingdom, (Revised 2024) and Supplementary Guidance Note 01, issued by the Comptroller and Auditor General in November 2024.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at www.frc.org.uk/auditorsresponsibilities.

This description forms part of our auditor's report.

Report on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

Matter on which we are required to report by exception

We are required to report to you if, in our opinion, we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2026.

On the basis of our work, having regard to the guidance issued by the Comptroller and Auditor General in March 2026, we have identified the following significant weakness in the Trust's arrangements for the year ended 31 March 2026:

Significant weakness in arrangements

In June 2025 the Care Quality Commission (CQC) undertook a Well-led assessment at the Trust. The results were published in September 2025, giving the Trust a 'requires improvement' rating.

Subsequently, NHS England issued an Enforcement Notice as they deemed the Trust to be in breach of its Provider Licence.

In our view, this is evidence of a significant weakness in arrangements in relation to the Trust's governance arrangements.

Without addressing the weaknesses in arrangements, there is a risk the Trust will be unable to provide safe care to its patients and may lose the ability to deliver some services.

Recommendation:

The Trust should continue to implement the actions identified in its Well-led Improvement Plan, ensuring there are robust arrangements in place to monitor, evaluate and report on the effectiveness of those actions in addressing the issues identified by the CQC.

In June 2025 we identified a significant weakness in relation to improving economy, efficiency and effectiveness for the 2024/2025 year. In our view this significant weakness remained for the year ended 31 March 2026:

Significant weakness in arrangements - issued in a previous year

Significant weakness in arrangements

In June 2025 the Care Quality Commission (CQC) undertook a Well-led assessment at the Trust. The results were published in September 2025, giving the Trust a 'requires improvement' rating.

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In our view, this is evidence of a significant weakness in arrangements in relation to the Trust's governance arrangements.

Without addressing the weaknesses in arrangements, there is a risk the Trust will be unable to provide safe care to its patients and may lose the ability to deliver some services.

Recommendation:

The Trust should monitor the implementation and efficacy of the action plans developed to address the areas for improvement identified by the CQC.

Responsibilities of the Accountable Officer

As explained in the Statement of Accountable Officer's responsibilities, the Accountable Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibilities for the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We are required under section 21 of the Local Audit and Accountability Act 2014 (as amended) to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources, and to report where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our work in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in March 2026.

Report on other legal and regulatory requirements

Opinion on other matters prescribed by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the Accounts Direction made under the National Health Service Act 2006; and
- the other information published together with the audited financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception under the Code of Audit Practice

We are required to report to you if:

- in our opinion the Annual Governance Statement does not comply with the guidance issued by NHS England; or
- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act; or
- we issue a report in the public interest under section 24 and schedule 7(1) of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the Trust under section 24 and schedule 7(2) of the Local Audit and Accountability Act 2014.

We have nothing to report in respect of these matters.

Use of the audit report

This report is made solely to the Board of Directors of The Leeds Teaching Hospitals NHS Trust, as a body, in accordance with part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Directors of the Trust those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Directors of the Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate until we have received confirmation from the NAO that the group audit of the Department of Health and Social Care has been completed and that no further work is required to be completed by us.

Suresh Patel, Key Audit Partner

For and on behalf of Mazars LLP (Local Auditor)

30 Old Bailey, London, EC4M 7AU

25 June 2026

4.3 Leeds Teaching Hospitals NHS Trust Annual Accounts 2025/26

Statement of Comprehensive Income for the year ended 31 March 2026

	Note	2025-26 £000	2024-25 £000
Operating income from patient care activities	3	1,951,671	1,822,986
Other operating income	4	316,604	301,740
Operating expenses	6, 8	(2,285,069)	(2,113,759)
Operating surplus/(deficit) from continuing operations		**(16,794)**	**10,967**
Finance income	10	5,777	4,573
Finance expenses	11	(26,212)	(23,855)
PDC dividends payable		(9,402)	(8,807)
Net finance costs		**(29,837)**	**(28,089)**
Other gains / (losses)	12	174	(229)
Surplus/(deficit) for the year from continuing operations		**(46,457)**	**(17,351)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	7	-
Revaluations	**14**	4,561	-
Total other comprehensive income for the period		**4,568**	-
Total comprehensive income / (expense) for the period		**(41,889)**	**(17,351)**

*The adjusted financial performance for 2025/26 is a surplus of £0.04m (2024/25 surplus of £19.9m) and is disclosed in note 39

Statement of Financial Position as at 31 March 2026

	Note	31 March 2026 £000	31 March 2025 £000
Non-current assets			
Intangible assets	13	24,240	10,847
Property, plant and equipment	14	759,183	778,139
Right of use assets	17	24,840	25,930
Receivables	20	14,494	12,532
Total non-current assets		**822,757**	**827,448**
Current assets			
Inventories	19	29,884	29,402
Receivables	20	94,036	72,262
Cash and cash equivalents	21	134,017	82,181
Total current assets		**257,937**	**183,845**
Current liabilities			
Trade and other payables	22	(239,463)	(198,538)
Borrowings	24	(25,443)	(23,887)
Provisions	26	(3,338)	(7,888)
Other liabilities	23	(41,574)	(16,917)
Total current liabilities		**(309,818)**	**(247,230)**
Total assets less current liabilities		**770,876**	**764,063**
Non-current liabilities			
Borrowings	24	(277,492)	(287,916)
Provisions	26	(8,533)	(9,953)
Total non-current liabilities		**(286,025)**	**(297,869)**
Total assets employed		**484,851**	**466,194**
Financed by			
Public dividend capital		702,309	641,763
Revaluation reserve		4,492	641,763
Income and expenditure reserve		(221,950)	(175,569)
Total taxpayers' equity		**484,851**	**466,194**

The notes on pages 168 to 206 form part of these accounts.

The accounts were approved by the Board of Directors at its meeting on 25 June 2026 and signed on its behalf by:

Name:	Brendan Brown	Jenny Ehrhardt
Position:	Chief Executive	Chief Finance Officer
Date:	25 June 2026	25 June 2026

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2026

	Public Dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2025 - brought forward	**641,763**	**-**	**(175,569)**	**466,194**
Surplus/(deficit) for the year	-	-	(46,457)	**(46,457)**
Other transfers between reserves	-	(76)	76	-
Impairments	-	7	-	**7**
Revaluations	-	4,561	-	**4,561**
Public dividend capital received	60,546	-	-	**60,546**
Taxpayers' equity at 31 March 2026	**702,309**	**4,492**	**(221,950)**	**484,851**

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2025

	Public Dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2024 - brought forward	**597,442**	**-**	**(158,218)**	**439,224**
Surplus/ (deficit) for the year	-	-	(17,351)	**(17,351)**
Public dividend capital received	44,321	-	-	**44,321**
Taxpayers' equity at 31 March 2025	**641,763**	**-**	**(175,569)**	**466,194**

Information on reserves

Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to Trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as the PDC dividend.

Revaluation reserve

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve

The balance of this reserve is the accumulated surpluses and deficits of the Trust.

Statement of Cash Flows for the year ended 31 March 2026

	Note	2025/26 £000	2024/25 £000
Cash flows from operating activities			
Operating surplus / (deficit)		(16,794)	10,967
Non-cash income and expense:			
Depreciation and amortisation	6	56,917	50,820
Net impairments	7	59,271	50,360
Income recognised in respect of capital donations	4	(6,982)	(7,257)
(Increase) / decrease in receivables and other assets		(21,980)	13,919
(Increase) / decrease in inventories		(482)	(837)
Increase / (decrease) in payables and other liabilities		65,650	(9,776)
Increase / (decrease) in provisions		(6,213)	1,624
Net cash flows from / (used in) operating activities		**129,387**	**109,820**
Cash flows from investing activities			
Interest received		5,777	4,573
Purchase of intangible assets		(1,218)	(2,353)
Purchase of PPE and investment property		(101,738)	(85,533)
Sales of PPE and investment property		204	193
Initial direct costs or up front payments in respect of new right of use assets		(131)	(54)
Receipt of cash donations to purchase assets	4	6,982	7,257
Net cash flows from / (used in) investing activities		**(90,124)**	**(75,917)**
Cash flows from financing activities			
Public dividend capital received		60,546	44,321
Movement on loans from DHSC		(2,056)	(2,056)
Capital element of lease rental payments		(4,819)	(4,335)
Capital element of PFI, LIFT and other service concession payments		(17,742)	(16,241)
Interest on loans		(329)	(398)
Interest paid on lease liability repayments		(1,077)	(1,141)
Interest paid on PFI, LIFT and other service concession obligations		(12,819)	(13,020)
PDC dividend (paid) / refunded		(9,131)	(7,030)
Net cash flows from/(used in) financing activities		**12,573**	**100**
Increase/(decrease) in cash and cash equivalents		**51,836**	**34,003**
Cash and cash equivalents at 1 April - brought forward		**82,181**	**48,178**
Cash and cash equivalents at 31 March	21	**134,017**	**82,181**

Notes to the Accounts

1. Accounting policies and other information

1.1 Basis of preparation

The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2025/26 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment and certain financial assets and financial liabilities.

1.2 Going concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

1.3 Interests in other entities

The Trust has no interests in other entities.

1.4 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. Funding envelopes are set at an Integrated Care System (ICS) level. The majority of the Trust's NHS income is earned from NHS commissioners under the NHS Payment Scheme (NHSPS). The NHSPS sets out rules to establish the amount payable to Trusts for NHS-funded secondary healthcare.

Aligned payment and incentive (API) contracts form the main payment mechanism under the NHSPS. API contracts contain both a fixed and variable element. Under the variable element, providers earn income for elective activity (both ordinary and day case), out-patient procedures, out-patient first attendances, diagnostic imaging and nuclear medicine, and chemotherapy delivery activity. The precise definition of these activities is given in the NHSPS. Income is earned at NHSPS prices based on actual activity. The fixed element includes

income for all other services covered by the NHSPS assuming an agreed level of activity with 'fixed' in this context meaning not varying based on units of activity. Elements within this are accounted for as variable consideration under IFRS 15 as explained below.

High costs drugs and devices excluded from the calculation of national prices are reimbursed by NHS England based on actual usage or at a fixed baseline in addition to the price of the related service.

The Trust also receives income from commissioners under the Best Practice Tariff (BPT) scheme. Delivery under this scheme is part of how care is provided to patients. As such BPT payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the overall contract with the commissioner and are accounted for as variable consideration under IFRS 15. Payment for BPT on non-elective services is included in the fixed element of API contracts with adjustments for actual achievement being made at the end of the year. BPT earned on elective activity is included in the variable element of API contracts and paid in line with actual activity performed. Additional payments for specialised services reflecting patient complexity are included within the fixed element of API contracts. This is accounted for as variable consideration under IFRS 15.

Elective recovery funding provides additional funding to commissioners to fund the commissioning of elective services within their systems. From 2024/25, the Trust adopted a national model, under which Trusts do not directly earn elective recovery funding, instead earning income for actual activity performed under API contract arrangements as explained above. The level of activity delivered by the Trust contributes to system performance and therefore the availability of funding to the Trust's commissioners, which is then allocated across the system to all providers based on activity multiplied by price reflective of Market Forces Factor (MFF). In addition, for elective procedures, Specialised top-ups were funded in 2024/25 based on actuals. For 2025/26 the Specialist top-ups are fixed.

In 2024/25, the Trust had Associate contracts with six Integrated Care Boards in Humber and North Yorkshire, South Yorkshire, North East and North Cumbria, Cheshire and Merseyside, Greater Manchester, and Lancashire and South Cumbria. Where the relationship with a particular Integrated Care Board is expected to be a low volume of activity (annual value below £0.5m), an annual fixed payment is received by the provider as determined in the NHSPS documentation. Where a region agreed to delegate Specialised Services to Integrated Care Boards in 2024/25 annual value has a de-minimis level of £2m. Such income is classified as 'other clinical income' in these accounts.

In 2025/26, a significant proportion of Specialised Commissioned services were delegated to Integrated Care Boards for services suitable for delegation. This change has grown the number of Associate commissioners from six to eight with two additional Associate contracts from Midlands based ICBs. The Trust has Associate contracts with eight Integrated Care Boards in Humber and North Yorkshire, South Yorkshire, North East and North Cumbria, Nottingham and Nottinghamshire, Derby and Derbyshire, Cheshire and Merseyside, Greater Manchester, and Lancashire and South Cumbria.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when performance obligations are satisfied. In practical terms, this means that treatment has been given, it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

1.5. Other forms of income

Grants and donations

Government grants are grants from government bodies other than income from commissioners or Trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where grants are used to fund capital expenditure, it is credited to the Statement of Comprehensive Income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's apprenticeship service account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

1.6 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the Trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

National Employment Savings Trust ("NEST") Pension Scheme

The Trust provides certain employees, who are not enrolled into the NHS Pensions Scheme, with retirement benefits from the defined contributions scheme which is managed by the National Employment Savings Trust (NEST). The cost to the Trust is taken as equal to the contributions payable to the scheme for the accounting period.

1.7 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.8 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- the item has cost at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (i.e. operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current value in existing use is defined as market value except where a building is so specialised in nature no active market exists from which to draw satisfactory transactional evidence. In this case a valuer will adopt a depreciated replacement cost (DRC) model on a modern equivalent asset (MEA) basis.

A DRC model estimates current value in existing use as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.

Valuation guidance issued by the Royal Institute of Chartered Surveyors states that valuations are performed net of VAT where the VAT is recoverable by the entity. This basis has been applied to the Trust's Private Finance Initiative (PFI) scheme where the construction is completed by a special purpose vehicle and the costs have recoverable VAT for the Trust.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences in the following quarter when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised. Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition

Assets intended for disposal are reclassified as 'held for sale' once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Private Finance Initiative (PFI) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the Trust. Annual contract payments to the operator (the unitary charge) are apportioned between the repayment of the liability including the finance cost, the charges for services and lifecycle replacement of components of the asset.

Initial recognition

In accordance with HM Treasury's FReM, the underlying assets are recognised as property, plant and equipment, together with an equivalent liability. Initial measurement of the asset and liability are in accordance with the initial measurement principles of IFRS 16 (see leases accounting policy).

Subsequent measurements

Assets are subsequently accounted for as property, plant and equipment and/or intangible assets as appropriate.

The liability is subsequently reduced by the portion of the unitary charge allocated as payment for the asset and increased by the annual finance cost. The finance cost is calculated by applying the implicit interest rate to the opening liability and is charged to finance costs in the Statement of Comprehensive Income. The element of the unitary charge allocated as payment for the asset is split between payment of the finance cost and repayment of the net liability.

Where there are changes in future payments for the asset resulting from indexation of the unitary charge, the Trust remeasures the PFI liability by determining the revised payments for the remainder of the contract once the change in cash flows takes effect. The remeasurement adjustment is charged to finance costs in the Statement of Comprehensive Income.

The service charge is recognised in operating expenses in the Statement of Comprehensive Income.

Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Buildings, excluding dwellings	2	80
Dwellings	2	80
Plant & machinery	5	18
Information technology	3	11

1.9 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance controlled by the Trust. They are capable of being sold separately from the rest of the Trust's business or arise from contractual or other legal rights. Intangible assets are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

Internally generated goodwill, brands, mast-heads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised. Expenditure on development is capitalised where it meets the requirements set out in IAS 38.

Software

Software which is integral to the operation of hardware, e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, e.g. application software, is capitalised as an intangible asset where it meets recognition criteria.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management. From 1 April 2025, subsequent measurement of intangible assets is at cost less amortisation.

Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell.

Impairments

Where indicators of impairment exist, the recoverable amount is assessed as the higher of its fair value and the cost to replace the service capacity. Where this is lower than the carrying value an impairment is recognised in expenditure. The recoverable amount of intangible assets under construction is assessed annually, irrespective of indicators of impairment.

Amortisation

Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Useful lives of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Information technology	5	10
Software licences	2	10

1.10 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method.

1.11 Investment properties

The Trust does not hold any investment properties.

1.12 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

1.13 Financial assets and financial liabilities

Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, i.e. when receipt or delivery of the goods or services is made.

Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through profit and loss. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through leasing arrangements are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets and financial liabilities are classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments, or receipts through the expected life of the financial asset, or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust considers and recognises where appropriate an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

HM Treasury has ruled that central government bodies may not recognise stage 1 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds, and Exchequer Funds' assets where repayment is ensured by primary legislation. The Trust therefore does not recognise loss allowances for stage 1 and stage 2 impairments against these bodies. Additionally, the Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's length bodies and NHS bodies (excluding NHS charities), and the Trust does not recognise loss allowances for stage 1 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Derecognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

1.14 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. As required by the GAM, the Trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

The Trust as a lessee

Recognition and initial measurement

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments includes fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 4.81% applied to new leases commencing in 2025 and 5.32% to new leases commencing in 2026.

Also, the Trust has not applied the above recognition requirements where the lease or rental arrangements do not meet the right of use IFRS16 criteria such as substitution.

Subsequent measurement

As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

The Trust as a lessor

The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Where the Trust is an intermediate lessor, classification of the sublease is determined with reference to the right of use asset arising from the headlease.

Finance leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Operating leases

Income from operating leases is recognised on a straight-line basis or another systematic basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

1.15 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective from 31 March 2026:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	3.64%	4.03%
Medium-term	After 5 years up to 10 years	4.22%	4.07%
Long-term	After 10 years up to 40 years	5.32%	4.81%
Very long-term	Exceeding 40 years	5.07%	4.55%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective from 31 March 2026:

	Inflation rate	Prior year rate
Year 1	2.5%	2.60%
Year 2	2.0%	2.30%
Into perpetuity	2.0%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's post-employment benefits discount rate of 2.95% in real terms (prior year: 2.40%).

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at Note 26.2 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses when the liability arises.

1.16 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in Note 27 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in Note 27.

Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.17 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined by the Department of Health and Social Care.

This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.18 Value added tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.19 Corporation tax

The Trust has no liability for Corporation Tax.

1.20 Climate change levy

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

1.21 Foreign exchange

The functional and presentational currency of the Trust is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

1.22 Third party assets

Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM.

1.23 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are

items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

1.24 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.25 Insurance contracts

IFRS 17 Insurance Contracts has replaced IFRS 4 Insurance Contracts and is effective for periods beginning on or after 1 April 2025. An insurance contract is a contract under which the issuer accepts significant insurance risk from the policy holder by agreeing to compensate the policyholder if a specified uncertain future event adversely affects the policyholder. Having reviewed its contracts in place the Trust has not issued any insurance contracts.

1.26 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2025/26.

1.27 Standards, amendments and interpretations in issue but not yet effective or adopted

The DHSC GAM does not require the following IFRS Standards and Interpretations to be applied in 2025-26.

IFRS 18 Presentation and Disclosure in Financial Statements - The Standard has been adopted by the UK Endorsement Board to be effective for accounting periods beginning on or after 1 January 2027. The Standard has not yet been adopted by the FReM and early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

IFRS 19 Subsidiaries without Public Accountability: Disclosures - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

The following future changes to adaptations and interpretations of IAS 16 for the public sector are also not yet adopted:

Changes to valuation of property, plant and equipment (PPE) assets – The DHSC GAM for 2026/27 and associated consultation response document confirms future changes which will impact on the financial statements.

From 2026/27 NHS bodies' valuation methodology will be a mandated quinquennial revaluation frequency (or rolling programme) supplemented by annual indexation in the intervening years. The requirement in IAS 16 to revalue an asset when its fair value differs materially from its carrying value is being withdrawn for the public sector. Given the variation in PPE valuations in any given year, and future changes in indices, it is not possible to quantify the impact of applying these changes in future periods. PPE and right of use assets currently subject to revaluation have a total book value of £525.5m as at 31 March 2026.

The current accounting policy for property assets measures the cost of replacing the service potential using a 'modern equivalent asset'. This policy is not changing. In deriving the modern equivalent asset, the Trust and its valuers currently adopt an 'alternative site' assumption for all of its specialised buildings, meaning the replaced service potential may be in a different location. The option of using this assumption is being withdrawn for NHS bodies from 1 April 2028. Therefore the hypothetical modern equivalent asset will change to be located on current sites in asset valuations from 2028/29. The Trust is unable to quantify the impact of this change at this time.

1.28 Critical judgements in applying accounting policies

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

- Bexley Wing and Wharfedale Hospital, constructed under the Private Finance Initiative (PFI), meet the criteria for inclusion in the financial statements as assets, as it is probable that future economic benefits associated with these will flow to the Trust; and the cost of the assets can be measured reliably. See Note 1.8 and Note 30 PFI transactions.

As part of the Private Finance Initiative, the Trust is required to pay the operator for lifecycle replacement assets. A judgement was made in the preparation of these accounts of the payment for these assets and this is accounted for annually as a revenue expense. The lifecycle is not charged to revenue on a smoothed basis, but is charged based on the judgement regarding replacement at the time the financial model was developed.

- The Trust follows the Department of Health and Social Care guidance which specifies that the Modern Equivalent Asset (MEA) concept should be applied to the valuation of the Trust's land and buildings. The MEA is defined as "the cost of a modern replacement asset that has the same productive capacity as the property being valued." Therefore, the MEA is not a valuation of the existing land and buildings that the Trust holds, but a theoretical valuation for accounting purposes of what the Trust could need to spend in order to replace the service potential that those assets have. In determining the MEA, the Trust has to make judgements that are practically achievable, however the Trust is not required to have any plans to make such changes.

These judgements include:

- the fair value of an asset is closely tied to the cost of acquiring a replacement;
- a modern equivalent asset is assumed to have the same capacity and ability to deliver the same services as the existing asset and
- the valuation does not consider differences in design or specification of the modern equivalent asset. The valuation is based on the usage of floor space for each block. There is not a specific design or model for the MEA.

The Trust is satisfied that the assumptions underpinning the MEA valuation are practically achievable, would not change the services provided by the Trust, and would not impact on service delivery or the level and volume of service provided. This is because all staff are contracted to work across all sites, and the catchment area for patients using the services has been taken into account when deciding on an appropriate alternative site.

For the purposes of the MEA valuation, the Trust has assumed that the modern equivalent asset would be the provision of services from the St James's site.

The MEA valuations used by the Trust have been provided to the Trust by the external valuers, Cushman and Wakefield. The Trust has used component lives based upon contractual information provided by Cushman and Wakefield to depreciate buildings and dwellings on a component basis. See notes 1.8 and 16.

- Leases have been reviewed in line with IFRS16 to determine whether the Trust has a right of use asset. Note 1.14 describes how the Trust determines the lease term of a right of use asset with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise. The Trust leases a number of buildings from various landlords for the provision of services. In assessing the lease term to apply in relation to IFRS 16, the Trust has reviewed the future planned service delivery for the purpose of calculation of borrowings and the Right of Use valuation. The Right of Use valuation is disclosed in note 17.1.

The Energy Centre development at St James's University Hospital site has been judged to contain a lease. The site was developed under a 15 year contractual arrangement with Vital Energy and following an assessment under IFRIC 4, the arrangement assessed as containing a lease.

1.29 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

- Valuation of Plant, Property and Equipment - Note 1.8 and Note 16.

  The Trust has used valuations carried out at 31 March 2026 and 31 March 2025 by its expert independent professional valuer (Cushman & Wakefield) to determine the value of property. These property valuations and useful lives are based on the Royal Institute of Chartered Surveyors valuation standards insofar as these are consistent with the requirements of HM Treasury and the Department of Health and Social Care.

  A degree of uncertainty is inherent in the valuation, and a relatively small variation could have a material impact on the accounts. For every 5% change, the valuation could differ by £25.0m, with a consequent effect on the PDC dividend payable which would affect the values shown in note 14.1.

2. Operating Segments

The Trust has determined that the Chief Operating Decision Maker (as defined by IFRS 8) is the Board of Directors on the basis that all strategic decisions are made by the Board. The Trust engages in its activity as a single operating segment i.e. the provision of healthcare. Financial results are reported to the Board under the single segment of healthcare. Whilst the Trust operates a number of different clinical services via its clinical service units, they each provide essentially the same service (patient care), have the same customers (commissioners), use similar processes and services and face fundamentally the same risks.

3. Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4.

3.1 Income from patient care activities (by nature)

	2025/26 £000	2024/25 £000
Acute services		
Income from commissioners under API contracts - variable element*	402,365	364,347
Income from commissioners under API contracts - fixed element*	1,053,421	993,945
High cost drugs income from commissioners	394,938	363,643
Other NHS clinical income	11,009	12,453
All services		
Private patient income	3,011	1,502
National pay award central funding**	-	4,768
Additional pension contribution central funding***	76,934	72,733
Other clinical income	9,993	9,595
Total income from activities	**1,951,671**	**1,822,986**

**Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2025/26 NHS Payment Scheme documentation. https://www.england.nhs.uk/pay-syst/nhs-payment-scheme/

**Additional funding was made available directly to providers by NHS England in 2024/25 for implementing the backdated element of pay awards where government offers were finalised after the end of the 2023/24 financial year. NHS Payment Scheme prices and API contracts are updated for the weighted uplift in in-year pay costs when awards are finalised.

***Increases to the employer contribution rate for NHS pensions since 1 April 2019 have been funded by NHS England. NHS providers continue to pay at the former rate of 14.38% with the additional amount being paid over by NHS England on providers' behalf. The full cost of employer contributions (23.7%) and related NHS England funding (9.4%) have been recognised in these accounts.

3.2 Income from patient care activities (by source)

Received from:	2025/26 £000	2024/25 £000
NHS England* **	491,656	895,744
Integrated care boards*	1,444,400	913,276
Other NHS providers	688	731
NHS other	1,710	1,634
Local authorities	-	10
Non-NHS: private patients	3,011	1,502
Non-NHS: overseas patients (chargeable to patient)	3,031	1,919
Injury cost recovery scheme	5,574	6,609
Non NHS: other	1,601	1,561
Total income from activities	**1,951,671**	**1,822,986**
Of which: Related to continuing operations	1,951,671	1,822,986
Related to discontinued operations	-	-

*As part of the national delegation of specialized services from NHS England to ICBs, there has been a shift in the source of income for associated services.

**Income from NHS England includes £76.9m (2024/25 £72.7m) to cover the increase in the cost of employers' contributions to the NHS Pension Scheme (see Notes 8 and 9). The NHS England contribution has remained at 9.4% in 2024/25 and 2025/26.

3.3 Overseas visitors (relating to patients charged directly by the provider)

	2025/26 £000	2024/25 £000
Income recognised this year	3,031	1,919
Cash payments received in-year	362	673
Amounts added to provision for impairment of receivables	1,732	-
Amounts written off in-year	906	759

4. Other operating income

	2025/26			2024/25		
	Contract income £000	Non-contract income £000	Total £000	Contract income £000	Non-contract income £000	Total £000
Research and development	82,078	-	**82,078**	61,570	-	**61,570**
Education and training	113,957	4,154	**118,111**	108,562	4,680	**113,242**
Non-patient care services to other bodies	64,457	-	**64,457**	75,978		**75,978**
Income in respect of employee benefits accounted on a gross basis	20,010	-	**20,010**	17,896		**17,896**
Receipt of cash donations to purchase assets	-	6,982	**6,982**		7,257	**7,257**
Charitable and other contributions to expenditure	-	1,624	**1,624**		1,036	**1,036**
Revenue from operating leases	-	2,949	**2,949**		2,846	**2,846**
Other income*	20,393	-	**20,393**	21,915	-	**21,915**
Total other operating income	**300,895**	**15,709**	**316,604**	**285,921**	**15,819**	**301,740**
Of which: Related to continuing operations			316,604			301,740
Related to discontinued operations			-			-

*Other income incorporates income received for goods and services which are incidental to the Trust's core activity of healthcare, for example, creche fees and catering.

5. Operating leases - the Leeds Teaching Hospitals NHS Trust as lessor

This note discloses income generated in operating lease agreements where The Leeds Teaching Hospitals NHS Trust is the lessor.

The Generating Station Complex at Leeds General Infirmary is licensed to Engie Ltd who supply the Trust and University of Leeds with electricity. Other leases relate to various retail facilities provided across the Trust's sites.

5.1 Operating lease income

	2025/26 £000	2024/25 £000
Lease receipts recognised as income in year:		
Minimum lease receipts	2,949	2,846
Minimum lease receipts	-	-
Total in-year operating lease income	**2,949**	**2,846**

5.2 Future lease receipts

	31 March 2026 £000	31 March 2025 £000
Future minimum lease receipts due in:		
not later than one year	1,194	2,160
later than one year and not later than two year	690	1,171
later than two years and not later than three years	531	677
later than three years and not later than four years	264	520
later than four years and not later than five years	260	253
later than five years	831	1,045
Total	**3,770**	**5,826**

6. Operating expenses

6.1 Operating expenses

	2025/26 £000	2024/25 £000
Purchase of healthcare from NHS and DHSC bodies	16	244
Purchase of healthcare from non-NHS and non-DHSC bodies	13,946	14,117
Staff and executive directors costs	1,301,058	1,204,122
Remuneration of non-executive directors	210	225
Supplies and services - clinical (excluding drugs costs)	252,256	237,951
Supplies and services - general	12,233	10,664
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	343,918	326,296
Consultancy costs	857	462
Establishment	7,034	6,730
Premises	68,637	66,340
Transport (including patient travel)	8,096	7,812
Depreciation on property, plant and equipment	52,096	46,434
Amortisation on intangible assets	4,821	4,386
Net impairments*	59,271	50,360
Movement in credit loss allowance: contract receivables / contract assets	1,912	1,109
Change in provisions discount rate(s)	(123)	7
Fees payable to the external auditor audit services- statutory audit**	218	208
Internal audit costs	265	267
Clinical negligence	51,649	48,549
Legal fees	305	300
Insurance (as a policy holder)	902	1,058
Research and development	43,081	38,671
Education and training	9,595	9,340
Expenditure on short term leases	524	505
Redundancy	108	245
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	10,241	10,562
Car parking & security	703	702
Hospitality	120	145
Losses, ex gratia & special payments	42	51
Other services, eg external payroll***	26,010	13,809
Other****	15,068	12,088
Total	**2,285,069**	**2,113,759**
Of which: Related to continuing operations	2,285,069	2,113,759
Related to discontinued operations	-	-

* Detail on the impairments can be found at Note 7.

** Audit fees include irrecoverable VAT (see Note 1.18). The figure includes £35k in respect of the 2025/26 accounts (£35k 2024/25).

*** Other services incorporates the hosting for the Regional Research Development Network which transferred to Leeds in October 2024. Last year included 6 months of costs (£12.4m), this year includes 12 months of costs (£24.9m).

****Other expenses incorporates the costs for goods and services which are incidental to the Trust's core activity, for example, hosted services or childcare vouchers and lease cars (both recovered through income).

6.2 Other auditor remuneration

There was no other remuneration paid to the external auditor during 2025/26.

6.3 Limitation on auditor's liability

There is no limitation on auditor's liability for external audit work for the years 2025/26 or 2024/25.

7. Impairment of assets

Net impairments charged to operating surplus / deficit resulting from:	2025/26 £000	2024/25 £000
Abandonment of assets in course of construction	-	34,891
Changes in market price	59,271	15,469
Total net impairments charged to operating surplus / deficit	**59,271**	**50,360**
Impairments charged to the revaluation reserve	(7)	-
Total net impairments	**59,264**	**50,360**

The deferral of the national New Hospital Programme (NHP), as it relates to the Trust, has resulted in the write-off of costs incurred up to 31 March 2025 on this project. These are classified as abandonment costs. The changes in market price follow the valuation of the Trust's estate undertaken by an independent valuer. Fuller details on the revaluation can be found in Note 16.

8. Employee benefits

	2025/26 £000	2024/25 £000
Salaries and wages	1,004,295	949,925
Social security costs	119,616	91,650
Apprenticeship levy	4,879	4,714
Employer's contributions to NHS pensions	192,320	181,883
Pension cost - other	1,006	1,282
Termination benefits	108	245
Temporary staff (including agency)	21,656	15,492
Total staff costs	**1,343,880**	**1,245,191**
Of which: Costs capitalised as part of assets	5,576	6,241

The Trust estimates that employer pension contributions will rise by 3.4% in 2026/27 to £202m, of which £80m will be centrally funded.

8.1 Retirements due to ill-health

During 2025/26 there were 18 early retirements from the Trust agreed on the grounds of ill-health (23 in the year ended 31 March 2025). The estimated additional pension liabilities of these ill-health retirements is £1,059k (£2,433k in 2024/25).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

9. Pension costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at

the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2026, is based on valuation data as at 31 March 2024, updated to 31 March 2026 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 at 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

c) National Employment Savings Trust Pension

Under the terms of the Pensions Act 2008 the Trust is required to provide a pension scheme for employees who are not eligible for membership of the NHS Pension Scheme. Qualifying employees are enrolled in the National Employment Savings Trust (NEST) managed scheme.

NEST is a defined contribution scheme managed by a third party organisation. It carries no possibility of actuarial gain or loss to the Trust and there are no financial liabilities other than payment of the 3% employers contribution of qualifying earnings. Employer contributions are charged directly to the Statement of Comprehensive Income and paid to NEST monthly. At 31 March 2026 there were 780 employees enrolled in the scheme (963 at 31 March 2025). Further details of the scheme can be found at www.nestpensions.org.uk. The number of NEST pension members has fallen following changes in the NHS Pension scheme.

10. Finance Income

Finance income represents interest received on assets and investments in the period.

	2025/26 £000	2024/25 £000
Interest on bank accounts	5,777	4,573
Total finance income	**5,777**	**4,573**

11. Finance Expenditure

11.1 Interest Expense

Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing.

	2025/26 £000	2024/25 £000
Interest expense:		
Interest on loans from the Department of Health and Social Care	326	394
Interest on lease obligations	1,077	1,141
Finance costs on PFI, LIFT and other service concession arrangements:		
Main finance costs	12,820	13,020
Remeasurement of the liability resulting from change in index or rate	11,884	9,261
Total interest expense	**26,107**	**23,816**
Unwinding of discount on provisions	105	39
Total finance costs	**26,212**	**23,855**

11.2 The late payment of commercial debts (interest) Act 1998

The Trust has not made any payments under this legislation in either the current or preceding financial year.

12. Other gains / (losses)

	2025/26 £000	2024/25 £000
Gains on disposal of assets	204	193
Losses on disposal of assets	(30)	(422)
Total other gains / (losses)	**174**	**(229)**

Obsolete and surplus items of equipment were also sold during the current and preceding financial year. This resulted in an overall gain of £174K (2024/25 loss of £229k).

13. Intangible assets

13.1 Intangible assets - 2025/26

	Software licences £000	Internally generated information technology £000	Intangible assets under construction £000	Total £000
Cost at 1 April 2025 - brought forward	**8,180**	**19,217**	**4,307**	**31,704**
Additions	-	-	1,218	**1,218**
Reclassifications	2,329	18,345	(3,678)	**16,996**
Disposals / derecognition	(2,596)	(12,682)	-	**(15,278)**
Cost at 31 March 2026	**7,913**	**24,880**	**1,847**	**34,640**
Amortisation at 1 April 2025 - brought forward	**3,107**	**17,750**	**-**	**20,857**
Provided during the year	1,027	3,794	-	**4,821**
Disposals / derecognition	(2,596)	(12,682)	-	**(15,278)**
Amortisation at 31 March 2026	**1,538**	**8,862**	**-**	**10,400**
Net book value at 31 March 2026	**6,375**	**16,018**	**1,847**	**24,240**
Net book value at 1 April 2025	**5,073**	**1,467**	**4,307**	**10,847**

13.2 Intangible assets - 2024/25

	Software licences £000	Internally generated information technology £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2024 - brought forward	**4,333**	**19,217**	**5,801**	**29,351**
Additions	124	-	2,229	**2,353**
Reclassifications	3,723	-	(3,723)	-
Valuation / gross cost at 31 March 2025	**8,180**	**19,217**	**4,307**	**31,704**
Amortisation at 1 April 2024 - brought forward	**2,537**	**13,934**	**-**	**16,471**
Provided during the year	570	3,816	-	**4,386**
Amortisation at 31 March 2025	**3,107**	**17,750**	**-**	**20,857**
Net book value at 31 March 2025	**5,073**	**1,467**	**4,307**	**10,847**
Net book value at 1 April 2024	**1,796**	**5,283**	**5,801**	**12,880**

14. Property Plant and Equipment

14.1 Property, Plant and Equipment - 2025/26

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Information technology £000	Total £000
Valuation/gross cost at 1 April 2025 - brought forward	**12,144**	**487,152**	**871**	**61,044**	**183,771**	**150,129**	**895,111**
Additions	-	49,966	61	27,736	18,106	3,774	99,643
Impairments	-	(62,197)	(29)	-	-	-	(62,226)
Reversals of impairments	-	2,962	-	-	-	-	2,962
Revaluations	-	(13,432)	(30)	-	-	-	(13,462)
Reclassifications	-	48,147	-	(56,258)	1,106	(9,991)	(16,996)
Disposals / derecognition	-	(10)	-	-	(16,737)	(13,844)	(30,591)
Valuation/gross cost at 31 March 2026	**12,144**	**512,588**	**873**	**32,522**	**186,246**	**130,068**	**874,441**
Accumulated depreciation at 1 April 2025 - brought forward	-	-	-	-	**78,546**	**38,426**	**116,972**
Provided during the year	-	18,006	30	-	10,547	18,287	**46,870**
Revaluations	-	(17,993)	(30)	-	-	-	**(18,023)**
Disposals / derecognition	-	(10)	-	-	(16,707)	(13,844)	**(30,561)**
Accumulated depreciation at 31 March 2026	-	**3**	-	-	**72,386**	**42,869**	**115,258**
Net book value at 31 March 2026	**12,144**	**512,585**	**873**	**32,522**	**113,860**	**87,199**	**759,183**
Net book value at 1 April 2025	**12,144**	**487,152**	**871**	**61,044**	**105,225**	**111,703**	**778,139**

14.2 Property, Plant and Equipment - 2024/25

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Information technology £000	Total £000
Valuation/ gross cost at 1 April 2024 - as previously stated	**12,011**	**461,252**	**968**	**152,633**	**213,720**	**103,169**	**943,753**
Prior period adjustments	-	-	-	-	(42,739)	-	**(42,739)**
Valuation/gross cost at 1 April 2024 - restated	**12,011**	**461,252**	**968**	**152,633**	**170,981**	**103,169**	**901,014**
Additions	-	21,502	-	37,694	14,637	559	74,392
Impairments	(12)	(34,344)	(66)	(34,891)	-	-	(69,313)
Reversals of impairments	145	18,808	-	-	-	-	18,953
Revaluations	-	(28,055)	(31)	-	-	-	(28,086)
Reclassifications	-	47,989	-	(94,392)	2	46,401	-
Disposals / derecognition	-	-	-	-	(1,849)	-	(1,849)
Valuation/gross cost at 31 March 2025	**12,144**	**487,152**	**871**	**61,044**	**183,771**	**150,129**	**895,111**
Accumulated depreciation at 1 April 2024 - as previously stated	**-**	**12,984**	**-**	**-**	**112,759**	**22,063**	**147,806**
Prior period adjustments	-	-	-	-	(42,739)	-	**(42,739)**
Accumulated depreciation at 1 April 2024 - restated	**-**	**12,984**	**-**	**-**	**70,020**	**22,063**	**105,067**
Provided during the year	-	15,071	31	-	9,953	16,363	**41,418**
Revaluations	-	(28,055)	(31)	-	-	-	**(28,086)**
Disposals / derecognition	-	-	-	-	(1,427)	-	**(1,427)**
Accumulated depreciation at 31 March 2025	**-**	**-**	**-**	**-**	**78,546**	**38,426**	**116,972**
Net book value at 31 March 2025	**12,144**	**487,152**	**871**	**61,044**	**105,225**	**111,703**	**778,139**
Net book value at 1 April 2024	**12,011**	**448,268**	**968**	**152,633**	**100,961**	**81,106**	**795,947**

Following a review of assets which are fully depreciated, the Trust has identified items which have not been in use for more than two years. The opening cost, and opening accumulated depreciation, of Property, plant and equipment for 2024/25 have been restated to reflect this. There is no impact on the net book value of Property, plant and equipment, nor any other aspect of the accounts.

14.3 Property, plant and equipment financing- 31 March 2026

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Information technology £000	Total £000
Owned - purchased	12,144	359,921	872	32,513	92,529	77,620	575,599
On-SoFP PFI contracts and other service concession arrangements	-	130,935	-	-	8,022	-	138,957
Owned - donated/ granted	-	21,729	1	9	13,309	9,579	44,627
Total net book value at 31 March 2026	**12,144**	**512,585**	**873**	**32,522**	**113,860**	**87,199**	**759,183**

14.4 Property, plant and equipment financing- 31 March 2024

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Information technology £000	Total £000
Owned - purchased	12,144	344,271	871	37,257	83,582	111,666	589,791
On-SoFP PFI contracts and other service concession arrangements	-	133,896	-	-	7,521	-	141,417
Owned - donated/ granted	-	8,985	-	23,787	14,122	37	46,931
Total net book value at 31 March 2025	**12,144**	**487,152**	**871**	**61,044**	**105,225**	**111,703**	**778,139**

15. Donations of property, plant and equipment

During the year the Trust received grants and donations to fund capital assets from the following:

	2025/26 £000	2024/25 £000
Leeds Hospitals Charity (previously Leeds Cares)	5,012	4,349
NIHR	(299)	2,674
Salix	1,845	-
The Childrens Heart Surgery Fund	153	-
Department of Health & Social Care	-	14
Candlelighters	68	-
Northern Pathology Imaging Co-operative	-	(12)
Others	203	232
Total donations for property, plant and equipment	**6,982**	**7,257**

The grants received from Leeds Hospitals Charity funded numerous pieces of medical equipment and the Rob Burrow MND Centre. The grant received from NIHR funded diagnostic equipment.

16. Revaluations of property, plant and equipment

A full 5 yearly cyclical valuation of the Trust's entire estate was carried out during 2024/25. For 2025/26, a desk top valuation was conducted by Cushman and Wakefield, who issued their reports dated 31 March 2026. The valuations were on depreciated replacement cost on a modern equivalent asset basis at an effective date of 31 March 2026. The report for 2024/25, completed in accordance with guidance issued by Royal Institution of Chartered Surveyors ("RICS"), gave a value of the estate of £500.1m. For 2025/26, the report completed in accordance with guidance issued by RICS, gave a value of the estate of £525.5m.

17. Leases - the Leeds Teaching Hospitals NHS Trust as a lessee

The Trust has operating leases for items of medical and non-medical equipment, vehicles and short-term property lets. None of these are individually significant.

17.1 Right of use assets - 2025/26

	Property (land and buildings) £000	Plant & machinery £000	Transport equipment £000	Total £000	Of which: leased from DHSC group bodies £000
Valuation / gross cost at 1 April 2025 - brought forward	30,324	6,745	955	38,024	11,692
Additions	342	424	181	947	-
Remeasurements of the lease liability	2,749	229	73	3,051	2,039
Movements in provisions for restoration / removal costs	138	-	-	138	21
Reclassifications	21	(23)	(2)	(4)	(43)
Disposals / derecognition	(749)	(6)	(419)	(1,174)	-
Valuation/gross cost at 31 March 2026	**32,825**	**7,369**	**788**	**40,982**	**13,709**
Accumulated depreciation at 1 April 2025 - brought forward	**8,595**	**3,014**	**485**	**12,094**	**4,151**
Provided during the year	3,927	964	335	5,226	1,486
Reclassifications	(42)	39	(1)	(4)	(43)
Disposals / derecognition	(749)	(6)	(419)	(1,174)	-
Accumulated depreciation at 31 March 2026	**11,731**	**4,011**	**400**	**16,142**	**5,594**
Net book value at 31 March 2026	**21,094**	**3,358**	**388**	**24,840**	**8,115**
Net book value at 1 April 2025	**21,729**	**3,731**	**470**	**25,930**	**7,541**

Net book value of right of use assets leased from other NHS providers	4,352
Net book value of right of use assets leased from other DHSC group bodies	3,763

17.2 Right of use assets - 2024/25

	Property (land and buildings) £000	Plant & machinery £000	Transport equipment £000	Total £000	Of which: leased from DHSC group bodies £000
Valuation / gross cost at 1 April 2024 - brought forward	28,649	8,573	1,006	38,228	10,252
Additions	934	82	250	1,266	883
Remeasurements of the lease liability	309	(1,833)	13	(1,511)	213
Movements in provisions for restoration / removal costs	432	-	-	432	344
Disposals / derecognition	-	(77)	(314)	(391)	-
Valuation/gross cost at 31 March 2025	**30,324**	**6,745**	**955**	**38,024**	**11,692**
Accumulated depreciation at 1 April 2024 - brought forward	**4,859**	**2,129**	**481**	**7,469**	**2,593**
Provided during the year	3,736	962	318	5,016	1,558
Disposals / derecognition	-	(77)	(314)	(391)	-
Accumulated depreciation at 31 March 2025	**8,595**	**3,014**	**485**	**12,094**	**4,151**
Net book value at 31 March 2025	**21,729**	**3,731**	**470**	**25,930**	**7,541**
Net book value at 1 April 2024	**23,790**	**6,444**	**525**	**30,759**	**7,659**

Net book value of right of use assets leased from other NHS providers	4,475
Net book value of right of use assets leased from other DHSC group bodies	3,066

17.3 Reconciliation of the carrying value of lease liabilities

Lease liabilities are included within borrowings in the statement of financial position. A breakdown of borrowings is disclosed in Note 24.1.

	2025/26 £000	2024/25 £000
Carrying value at 1 April	**30,821**	**35,455**
Lease additions	816	1,212
Lease liability remeasurements	3,051	(1,511)
Interest charge arising in year	1,077	1,141
Lease payments (cash outflows)	(5,896)	(5,476)
Carrying value at 31 March	**29,869**	**30,821**

Lease payments for short term leases, leases of low value underlying assets and variable lease payments not dependent on an index or rate are recognised in operating expenditure.

These payments are disclosed in Note 6.1. Cash outflows in respect of leases recognised on-SoFP are disclosed in the reconciliation above.

17.4 Maturity analysis of future lease payments

	Total 31 March 2026 £000	Of which leased from DHSC group bodies 31 March 2026 £000	Total 31 March 2025 £000	Of which leased from DHSC group bodies 31 March 2025 £000
Undiscounted future lease payments payable in:				
- not later than one year;	7,263	1,344	5,510	1,575
- later than one year and not later than five years;	15,054	3,446	16,494	4,411
- later than five years.	12,391	3,561	12,271	1,510
Total gross future lease payments	**34,708**	**8,351**	**34,275**	**7,496**
Finance charges allocated to future periods	(4,839)	(408)	(3,454)	(289)
Net lease liabilities at 31 March 2026	**29,869**	**7,943**	**30,821**	**7,207**
Of which:				
Leased from other NHS providers		4,416		4,348
Leased from other DHSC group bodies		3,527		2,859

18. Disclosure of interests in other entities

The Trust has no interest in other entities.

19. Inventories

	31 March 2026 £000	31 March 2025 £000
Drugs	10,056	10,513
Consumables	19,249	18,300
Energy	579	589
Total inventories	**29,884**	**29,402**
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £525,438k (2024/25: £492,873k). Write-down of inventories recognised as expenses for the year were £0k (2024/25: £0k).

20. Receivables

20.1 Receivables analysis

	31 March 2026 £000	31 March 2025 £000
Current		
Contract receivables	71,624	52,514
Capital receivables	1,741	1,444
Allowance for impaired contract receivables / assets	(4,375)	(3,743)
Prepayments (non-PFI)	13,566	12,117
PFI lifecycle prepayments	4,970	4,970
PDC dividend receivable	-	269
VAT receivable	5,236	3,889
Other receivables	1,274	802
Total current receivables	**94,036**	**72,262**
Non-current		
Contract receivables	9,156	8,356
Allowance for impaired contract receivables / assets	(2,639)	(2,303)
PFI lifecycle prepayments	6,338	4,610
Other receivables	1,639	1,869
Total non-current receivables	**14,494**	**12,532**
Of which receivables from NHS and DHSC group bodies:		
Current	37,489	24,340
Non-current	1,639	1,869

The majority of trade is with NHS England and Integrated Care Boards. As NHS bodies are funded by Government to buy NHS patient care services, credit scoring of them is not considered necessary.

Non-current other receivables represent costs to be reimbursed by NHS England in relation to the Clinicians' Pension Tax provision (Note 26.1).

20.2 Allowances for credit losses

	2025/26	2024/25
	Receivables and contract assets £000	Receivables and contract assets £000
Allowances as at 1 April - brought forward	**6,046**	**5,695**
New allowances arising	1,912	1,109
Utilisation of allowances (write offs)	(944)	(758)
Allowances as at 31 Mar 2026	**7,014**	**6,046**

20.3 Exposure to credit risk

Since the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has a low exposure to credit risk. The maximum exposure as at 31 March 2026 are in receivables from customers, as disclosed in the contracts receivables note (Note 20.1).

21. Cash and cash equivalents

21.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2025/26 £000	2024/25 £000
At 1 April	**82,181**	**48,178**
Net change in year	51,836	34,003
At 31 March	**134,017**	**82,181**
Broken down into:		
Cash at commercial banks and in hand	19	16
Cash with the Government Banking Service	133,998	82,165
Total cash and cash equivalents as in SoCF	**134,017**	**82,181**

21.2 Third party assets held by the Trust

The Leeds Teaching Hospitals NHS Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties and in which the Trust has no beneficial interest. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2026 £000	31 March 2025 £000
Bank balances	1	1
Monies on deposit	3	6
Total third party assets	**4**	**7**

22. Trade and other payables

22.1 Trade and other payables balances

	31 March 2026 £000	31 March 2025 £000
Current		
Trade payables	82,778	79,787
Capital payables	19,698	19,768
Accruals	90,500	58,013
Social security costs	14,881	12,043
Other taxes payable	14,132	12,805
PDC dividend payable	2	-
Pension contributions payable	16,574	15,523
Other payables	898	599
Total current trade and other payables	**239,463**	**198,538**
Of which payables from NHS and DHSC group bodies:		
Current	4,010	5,265

22.2 Early retirements in NHS payables above

The Trust has no liability to pay for early retirement costs (2024/25 - Nil).

23. Other liabilities

	31 March 2026 £000	31 March 2025 £000
Current		
Deferred income: contract liabilities	41,574	16,917
Total other current liabilities	**41,574**	**16,917**

Deferred income: Contract Liabilities includes, amongst other elements, research projects. In line with IFRS 15 where income is received that relates to a performance obligation that is to be satisfied in a future period the income is deferred and recognised as a contract liability until the performance obligation is delivered.

24. Borrowings

24.1 Borrowings

	31 March 2026 £000	31 March 2025 £000
Current		
Loans from DHSC	2,068	2,071
Lease liabilities	4,823	4,815
Obligations under PFI, LIFT or other service concession contracts	18,552	17,001
Total current borrowings	**25,443**	**23,887**
Non-current		
Loans from DHSC	7,170	9,226
Lease liabilities	25,046	26,006
Obligations under PFI, LIFT or other service concession contracts	245,276	252,684
Total non-current borrowings	**277,492**	**287,916**

24.2 Reconciliation of liabilities arising from financing activities - 2025/26

	Loans from DHSC £000	Lease liabilities £000	PFI and LIFT schemes £000	Total £000
Carrying value at 1 April 2025	**11,297**	**30,821**	**269,685**	**311,803**
Cash movements:				
Financing cash flows - payments and receipts of principal	(2,056)	(4,819)	(17,742)	**(24,617)**
Financing cash flows - payments of interest	(329)	(1,077)	(12,819)	**(14,225)**
Non-cash movements:				
Additions	-	816	-	**816**
Lease liability remeasurements	-	3,051	-	**3,051**
Remeasurement of PFI / other service concession liability resulting from change in index or rate	-	-	11,884	**11,884**
Application of effective interest rate	326	1,077	12,820	**14,223**
Carrying value at 31 March 2026	**9,238**	**29,869**	**263,828**	**302,935**

24.3 Reconciliation of liabilities arising from financing activities - 2024/25

	Loans from DHSC £000	Lease liabilities £000	PFI and LIFT schemes £000	Total £000
Carrying value at 1 April 2024	**13,357**	**35,455**	**276,664**	**325,476**
Prior period adjustment	-	-	-	-
Carrying value at 1 April 2024 - restated	**13,357**	**35,455**	**276,664**	**325,476**
Cash movements:				
Financing cash flows - payments and receipts of principal	(2,056)	(4,335)	(16,241)	**(22,632)**
Financing cash flows - payments of interest	(398)	(1,141)	(13,020)	**(14,559)**
Non-cash movements:				
Additions	-	1,212	-	**1,212**
Lease liability remeasurements	-	(1,511)	-	**(1,511)**
Remeasurement of PFI / other service concession liability resulting from change in index or rate	-	-	9,261	**9,261**
Application of effective interest rate	394	1,141	13,020	**14,555**
Other changes	-	-	1	**1**
Carrying value at 31 March 2025	**11,297**	**30,821**	**269,685**	**311,803**

25. Other financial liabilities

The Trust has no other financial liabilities.

26. Provisions for liabilities and charges

26.1 Provisions for liabilities and charges analysis

	Pensions: early departure costs £000	Pensions: injury benefits £000	Legal claims £000	Redundancy £000	Other £000	Total £000
At 1 April 2025	**2,516**	**1,693**	**4,659**	**1,406**	**7,567**	**17,841**
Change in the discount rate	(50)	(73)	-	-	(133)	**(256)**
Arising during the year	143	49	99	32	1,268	**1,591**
Utilised during the year	(259)	(132)	(4,279)	-	(1,355)	**(6,025)**
Reversed unused	(604)	-	(332)	(309)	(250)	**(1,495)**
Unwinding of discount	57	48	-	-	110	**215**
At 31 March 2026	**1,803**	**1,585**	**147**	**1,129**	**7,207**	**11,871**
Expected timing of cash flows:						
- not later than one year;	250	120	147	1,129	1,692	**3,338**
- later than one year and not later than five years;	1,000	480	-	-	1,137	**2,617**
- later than five years	553	985	-	-	4,378	**5,916**
Total	**1,803**	**1,585**	**147**	**1,129**	**7,207**	**11,871**

Pensions related provisions represent amounts payable to the NHS Business Services Authority - Pensions Division, to meet the costs of early retirements and industrial injury benefits. Amounts are determined by the NHS Business Services Authority - Pensions Division, based on actuarial estimates of life expectancy and there is therefore, a degree of uncertainty regarding the value of future payments.

Legal claims relate to personal injury and other claims where the Trust has received advice that settlement is probable. The final amounts and timings of payments remain subject to negotiation or legal judgement. Included are claims with a value of £147k (£388k in 2024/25) which are being handled on our behalf by NHS Resolution who have advised of their status. The value represents amounts which the Trust may bear as its share of any settlement. The balance of claims are being dealt with directly by the Trust as they represent settlement values likely to fall below NHS Resolution's excess level. Legal claims also includes provision for contractual disputes which are subject to ongoing legal discussions.

Other provisions include those for employment related claims where the Trust disputes liability but recognises some probability of payment.

Other provisions also include clinicians' pension tax reimbursement. During 2019/20 a national decision was made to resolve a taxation issue linked to pensions relating to senior clinical staff. Under this interim arrangement, the NHS Trust incurs the additional tax charge which is then reimbursed by NHS England. This remains the case for 2025/26. A provision is recognised in the Trust's accounts with a corresponding receivable from NHS England (Note 20.1).

Other provisions includes a dilapidations provision. During 2021/22, as part of the preparation for the introduction of IFRS16, a decision was made to assess the potential liability for dilapidation costs that could arise in relation to properties leased by the Trust. Following the introduction of IFRS16 in 2022/23 further dilapidation provisions have been recognised for new property leases. The overall value of the provision for 2025/26 is £3.3m (2024/25 - £4.2m).

26.2 Clinical negligence liabilities

At 31 March 2026, £602,695k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of The Leeds Teaching Hospitals NHS Trust (31 March 2025: £567,621k).

27. Contingent assets and liabilities

	31 March 2026 £000	31 March 2025 £000
Value of contingent liabilities		
NHS Resolution legal claims	(296)	(125)
Other	-	(240)
Gross value of contingent liabilities	**(296)**	**(365)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	(296)	(365)
Net value of contingent assets	-	-

NHS Resolution contingent liabilities consist entirely of claims for personal injury where the probability of settlement is very low. The NHS Resolution have advised on their status. In all cases, quantum has been assessed on a "worst case scenario" and represents the maximum of any payment which may be made. "Other" contingencies relate to personal injury claims which are being managed internally by the Trust. In all cases, the potential payment values have been assessed on a "worst case scenario" basis by reference to independent advice. Settlement of these claims is considered highly improbable but the values quoted represent the Trust's maximum exposure to loss.

28. Contractual capital commitments

	31 March 2026 £000	31 March 2025 £000
Property, plant and equipment	14,035	19,569
Intangible assets	-	311
Total	**14,035**	**19,880**

29. Other financial commitments

The Trust is not committed to making payments under non-cancellable contracts.

30. On-SoFP PFI arrangements

Institute of Oncology at St James's Hospital - Bexley Wing

This is a 30 year contract which expires in 2037. It provides for the construction, maintenance and partial equipping of Bexley Wing by the PFI partner in return for an annual charge to the Trust. The Trust has full use of the facilities to provide healthcare services and will take ownership of the building and equipment at the end of the contract period. The PFI partner is responsible for providing a managed maintenance service for the length of the contract after which the responsibilities revert to the Trust. The contract contains payment mechanisms providing for deductions from the annual charge for any poor performance or unavailability. Future charges to the Trust will be determined by reference to the Retail Price Index.

Wharfedale Hospital

This is a 30 year contract which expires in 2034. It provides for the construction and maintenance of Wharfedale Hospital by the PFI partner in return for an annual unitary charge to the Trust. The Trust has full use of the Wharfedale Hospital to provide healthcare services and will take ownership of the building at the end of the contract period. The PFI partner is responsible for providing a managed maintenance service for the length of the contract after which the responsibilities revert to the Trust. The contract contains payment mechanisms providing for deductions from the annual charge for any poor performance or unavailability. The unitary charge is subject for an annual uplift for future price increases determined by reference to the Retail Price Index.

30.1 On-SoFP PFI, LIFT or other service concession arrangement obligations

The following obligations in respect of the PFI, LIFT or other service concession arrangements are recognised in the statement of financial position:

	31 March 2026 £000	31 March 2025 £000
Gross PFI, LIFT or other service concession liabilities	**344,310**	**359,019**
Of which liabilities are due		
- not later than one year;	30,562	29,281
- later than one year and not later than five years;	122,247	117,124
- later than five years.	191,501	212,614
Finance charges allocated to future periods	(80,482)	(89,334)
Net PFI, LIFT or other service concession arrangement obligation	**263,828**	**269,685**
- not later than one year;	18,552	17,001
- later than one year and not later than five years;	83,058	76,120
- later than five years.	162,218	176,564

30.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

Total future commitments under these on-SoFP schemes are as follows:

	31 March 2026 £000	31 March 2025 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**562,562**	**578,745**
Of which payments are due		
- not later than one year;	49,643	47,007
- later than one year and not later than five years;	198,572	188,029
- later than five years.	314,347	343,709

30.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator:

	2025/26 £000	2024/25 £000
Unitary payment payable to service concession operator	**47,559**	**46,032**
Consisting of:		
- Interest charge	12,820	13,020
- Repayment of balance sheet obligation	17,742	16,241
- Service element and other charges to operating expenditure	10,241	10,562
- Capital lifecycle maintenance	6,756	6,209
Total amount paid to service concession operator	**47,559**	**46,032**

31. Financial Instruments

30.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Due to the continuing service provider relationship that the NHS Trust has with commissioners and the way those commissioners are financed, the NHS Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the Board of Directors. The Trust's treasury activity is subject to review by its internal auditors.

Currency Risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest Rate Risk

The Trust borrows from government for capital expenditure, subject to approval by NHS England. The borrowings are for 1 - 25 years, in line with the life of the associated assets. Interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

Credit Risk

Since the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2026 are in receivables from customers, as disclosed in the contracts receivables note (Note 20.1).

Liquidity risk

The Trust's operating costs are incurred under contracts with NHS commissioning organisations, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds obtained within its Capital Resource Limit. The Trust is not, therefore, exposed to significant liquidity risks.

31.2 Carrying values of financial assets

	Held at amortised cost £000	Total book value £000
Carrying values of financial assets as at 31 March 2026		
Trade and other receivables excluding non financial assets	78,420	**78,420**
Cash and cash equivalents	134,017	**134,017**
Total at 31 March 2026	**212,437**	**212,437**
Carrying values of financial assets as at 31 March 2025		
Trade and other receivables excluding non financial assets	58,939	**58,939**
Cash and cash equivalents	82,181	**82,181**
Total at 31 March 2025	**141,120**	**141,120**

31.3 Carrying values of financial liabilities

	Held at amortised cost £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2026		
Loans from the Department of Health and Social Care	9,238	**9,238**
Obligations under leases	29,869	**29,869**
Obligations under PFI, LIFT and other service concession contracts	263,828	**263,828**
Trade and other payables excluding non financial liabilities	183,757	**183,757**
Total at 31 March 2026	**486,692**	**486,692**
Carrying values of financial liabilities as at 31 March 2025		
Loans from the Department of Health and Social Care	11,297	**11,297**
Obligations under leases	30,821	**30,821**
Obligations under PFI, LIFT and other service concession contracts	269,685	**269,685**
Trade and other payables excluding non financial liabilities	148,917	**148,917**
Provisions under contract	4,190	**4,190**
Total at 31 March 2025	**464,910**	**464,910**

31.4 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	31 March 2026 £000	31 March 2025 £000
In one year or less	223,898	190,284
In more than one year but not more than five years	144,203	142,013
In more than five years	204,578	226,395
Total	**572,679**	**558,692**

31.5 Fair values of financial assets and liabilities

Due to the nature of the Trust's financial assets and financial liabilities, book value (carrying value) is considered a reasonable approximation of fair value.

32. Losses and special payments

	2025/26		2024/25	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	9	1	9	2
Bad debts and claims abandoned	175	939	275	814
Total losses	**184**	**940**	**284**	**816**
Special payments				
Ex-gratia payments	132	215	96	126
Special severance payments	-	-	1	8
Total special payments	**132**	**215**	**97**	**134**
Total losses and special payments	**316**	**1,155**	**381**	**950**

33. Gifts

The Trust made no gifts during 2025/26 (2024/25 - None).

34. Related Parties

During the year none of the Department of Health and Social Care Ministers, Trust board members or members of the key management staff, or parties related to any of them, have undertaken any material transactions with the Leeds Teaching Hospitals NHS Trust in either 2025/26 or 2024/25.

The Department for Health and Social Care is the parent department of the Trust and is considered a related party. The Leeds Teaching Hospitals NHS Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These include NHS England, and NHS West Yorkshire ICB. In addition, the Trust has had a number of material transactions with other government-related entities, chiefly HM Revenue and Customs, Leeds City Council and the Department for Work and Pensions.

The Trust's outgoing chair, Dame Linda Pollard, was vice-Chair and Senior Independent Director of NHS Providers, as well as Chair of the NHS Providers RemCo Committee. During 2025/26 the Trust expended £61k with NHS Providers (2024/25 - £51k). The Trust's outgoing Chief Executive, Professor Phil Wood, was a Director of Northern Health Science Alliance. The Trust expended £30k with Northern Health Science Alliance during 2025/26 (2024/25 £30k).

The Trust has received revenue and capital funding from The Leeds Hospitals Charity. Dame Linda Pollard and Chris Schofield, an outgoing Non-Executive Director were trustees of the Charity. The Trust's incumbent Chair, Antony Kildare, is a trustee of the Charity. In 2025/26 Leeds Hospitals Charity have given £1.3m in revenue grants (2024/25 - £1m) and £5m in capital donations (2024/25 - £4.3m) of which £1.8m remained outstanding at 31 March 2026 (£0.5m at 31 March 2025). Leeds Hospitals Charity is independently managed but raises funds for, manages donations received on behalf of, and makes grants to the Trust.

Trust Non-Executive Board positions were held during the year by staff of the University of Leeds. Professor Angela Graves is Head of the School of Healthcare. Professor Jane Nixon is Director of the Institute of Health Science. During the year the Trust's income from the University of Leeds was £14.2m (2024/25 - £10.4m) of which £3.7m remained outstanding at 31 March 2026 (£0.5m at 31 March 2025). Expenditure with the University of Leeds was £17.6m (2024/25 - £17m) of which £0.5m remained outstanding at 31 March 2026 (£0.3m at 31 March 2025).

Philomena Corrigan, an outgoing Non-Executive Director, was the Chair of Trustees of St. Gemma's Hospice. During the year the Trust received income of £130k (2024/25 - £127k) from St Gemma's Hospice. Mike Baker, Non-Executive Director is a Senior Advisor at University of York. During the year the Trust expended £540k (2024/25 - £250k) with the University and received £110k (2024/25 - £0) in income. Andrew Greenwood, Non-Executive Director is a member of the Regional Skills Board at Leeds Beckett University. During the year the Trust expended £380k (2024/25 - £67k) with the University and received £180k (2024/25 - £105k) in income. Chief Medical Officer, Magnus Harrison's spouse is employed at the Virginia Mason Institute. During the year the Trust expended £31k with the Institute (2024/25 - £41k). A family member of Gillian Taylor, Deputy Trust Chair, is employed by Thompson's Solicitors. During the year the Trust expended £33k with Thompson's Solicitors (2024/25 - £0). Professor Laura Stroud is Pro Vice Chancellor of the Faculty of Health Sciences & Wellbeing at the University of Sunderland. During the year, the Trust expended £10k with the University (2024/25 - £12k).

35. Prior period adjustments

Following a review of assets which are fully depreciated, the Trust has identified items which have not been in use for more than two years. The opening cost, and opening accumulated depreciation, of Property, plant and equipment have been restated to reflect this. There is no impact on the net book value of Property, plant and equipment, nor any other aspect of the accounts.

36. Events after the Reporting Date

There are no events that have occurred after the reporting period which have a material impact on these financial statements.

37. Better Payment Practice Code

	2025/26 Number	2025/26 £000	2024/25 Number	2024/25 £000
Non-NHS payables				
Total non-NHS trade invoices paid in the year	262,748	940,473	260,060	792,026
Total non-NHS trade invoices paid within target	246,716	841,131	246,895	738,157
Percentage of non-NHS trade invoices paid within target	**93.9%**	**89.4%**	**94.9%**	**93.2%**
NHS payables				
Total NHS trade invoices paid in the year	27,166	109,340	26,155	180,041
Total NHS trade invoices paid within target	24,996	103,726	24,123	148,155
Percentage of NHS trade invoices paid within target	**92.0%**	**94.9%**	**92.2%**	**82.3%**

The Better Payment Practice code requires the NHS body to aim to pay all valid invoices by the due date or within 30 calendar days of receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed.

38. Capital Resource Limit

	2025/26 £000	2024/25 £000
Gross capital expenditure	104,859	76,500
Less: Disposals	(30)	(422)
Less: Donated and granted capital additions	(6,982)	(7,257)
Charge against Capital Resource Limit	**97,847**	**68,821**
Capital Resource Limit (CRL)	97,847	68,821
Under / (over) spend against CRL	-	-

39. Breakeven duty financial performance

	2025/26 £000	2024/25 £000
Adjusted financial performance surplus / (deficit)	**39**	**19,859**
IFRIC 12 breakeven adjustment	9,866	10,937
Breakeven duty financial performance surplus / (deficit)	**9,905**	**30,796**

	2025/26 £000	2024/25 £000
Surplus / (deficit) for the period per SOCI	(46,457)	(17,351)
Remove net impairments not scoring to the departmental expenditure limit	59,271	50,360
Remove I&E impact of capital grants and donations	(2,920)	(3,396)
Remove I&E impact of IFRIC 12 schemes on an IFRS 16 basis	36,063	33,488
Add back I&E impact of IFRIC 12 schemes on former UK GAAP basis	(45,929)	(44,425)
Remove net impact of DHSC centrally procured inventories	11	56
Other performance adjustments	-	1,127
Adjusted financial performance surplus / (deficit)	**39**	**19,859**

40. Breakeven duty rolling assessment

	1997/98 to 2008/09 £000	2009/10 £000	2010/11 £000	2011/12 £000	2012/13 £000	2013/14 £000
Breakeven duty in-year financial performance		963	2,051	4,207	3,089	1,615
Breakeven duty cumulative position	3,868	4,831	6,882	11,089	14,178	15,793
Operating income		910,556	934,527	970,709	1,002,444	1,044,916
Cumulative breakeven position as a percentage of operating income		**0.5%**	**0.7%**	**1.1%**	**1.4%**	**1.5%**

	2014/15 £000	2015/16 £000	2016/17 £000	2017/18 £000	2018/19 £000	2019/20 £000
Breakeven duty in-year financial performance	(24,386)	(30,194)	(1,901)	18,880	52,925	13,956
Breakeven duty cumulative position	(8,593)	(38,787)	(40,688)	(21,808)	31,117	45,073
Operating income	1,086,638	1,115,720	1,172,927	1,238,267	1,335,847	1,414,740
Cumulative breakeven position as a percentage of operating income	**(0.8%)**	**(3.5%)**	**(3.5%)**	**(1.8%)**	**2.3%**	**3.2%**

	2020/21 £000	2021/22 £000	2022/23 £000	2023/24 £000	2024/25 £000	2025/26 £000
Breakeven duty in-year financial performance	8,107	5,917	7,655	5,392	30,796	9,905
Breakeven duty cumulative position	53,180	59,097	66,752	72,144	102,941	112,846
Operating income	1,596,795	1,727,945	1,843,988	1,900,516	2,124,726	2,268,275
Cumulative breakeven position as a percentage of operating income	**3.3%**	**3.4%**	**3.6%**	**3.8%**	**4.8%**	**5.0%**

Appendix 1: Health inequalities data

The NHS England **Statement on Information on Health Inequalities**, published under section 13SA of the NHS Act 2006, provides a framework for Trusts to fulfil their legal duties in tackling healthcare disparities. This includes how trusts collect, analyse and publish health inequalities data to identify and address differences (inequalities).

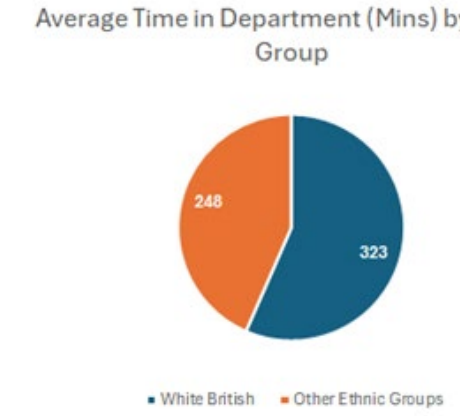
The information published in this appendix provides robust data to help identify groups at risk of poor health outcomes and enables the tailoring of services to meet specific needs. The data presented is a retrospective look at 2025/26 activity and is the first time we have reported on these 'core measures' (as set out by NHS England). Each core measure is broken down by deprivation (Index of multiple deprivation, IMD 2019), ethnicity, age and sex.

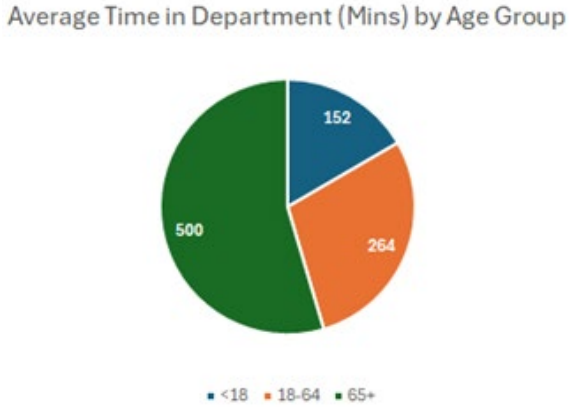
Alongside the suite of health inequalities initiatives and programmes, captured in the Health Inequalities & Public Health Update Report (February 2026), the Trust is transitioning to a more systematic and data-driven performance monitoring of health equity improvements. To ensure sustained progress and transparency, The Trust has formalised a new quarterly Health Equity Integrated Quality and Performance Report (IQPR), which will be a standing item on the Weekly Executive Board from Quarter 1 in 2026/27 providing cyclical assurance and helping to drive continuous improvements.

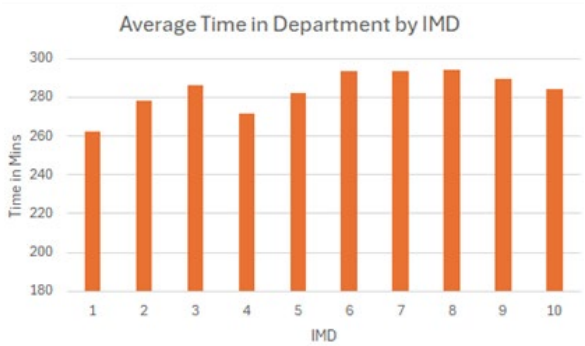
Measure: Urgent and emergency care (UEC)

Source: Symphony data

Time in the emergency department (ED)







Measure: Maternity

Source: K2 data

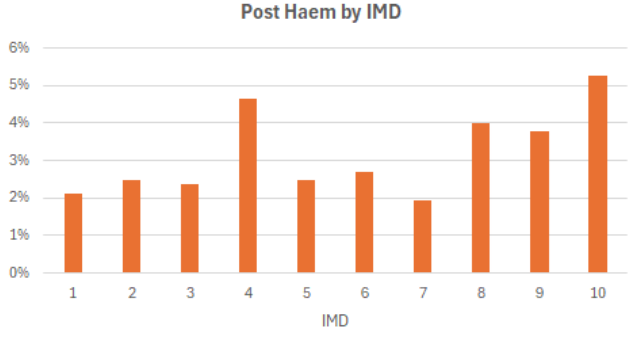
Gestational Age at Booking

		IMD									
		1	2	3	4	5	6	7	8	9	10
	9806	3382	1013	801	409	769	746	871	673	611	531
Age											
12	1	0	0	0	0	0	0	0	1	0	0
14	2	1	1	0	0	0	0	0	0	0	0
15	8	2	2	0	0	1	1	1	1	0	0
16	23	9	1	2	0	1	1	3	3	2	1
17	47	12	7	8	5	1	6	1	4	1	2
18	84	29	11	7	1	9	8	7	4	4	4
19	161	53	14	10	4	21	14	16	12	7	10
20	165	52	11	17	8	15	11	20	11	11	9
21	191	69	15	13	8	15	13	19	14	8	17
22	216	74	28	13	12	21	21	16	11	10	10
23	246	79	33	21	9	16	21	15	18	18	16
24	314	122	34	27	9	11	23	29	19	21	19
25	387	147	42	31	21	19	30	31	21	31	14
26	436	167	50	25	13	34	29	37	41	18	22
27	473	153	63	47	28	34	32	31	33	21	31
28	546	208	60	41	19	51	32	39	33	30	33
29	649	231	63	55	30	58	39	47	57	41	28
30	680	237	58	51	35	42	53	70	38	59	37
31	720	235	61	60	34	54	52	73	57	51	43
32	732	230	76	59	29	57	55	75	55	54	42
33	698	258	63	56	29	59	57	64	46	31	35
34	673	233	59	61	19	52	65	59	39	50	36
35	554	187	53	47	18	37	48	59	34	41	30
36	447	156	41	35	20	46	36	39	30	23	21
37	400	141	41	32	14	30	20	31	37	29	25
38	281	90	33	18	14	23	27	28	19	15	14
39	224	70	30	23	12	21	18	18	10	12	10
40	162	47	23	15	6	13	14	13	7	12	12
41	105	25	15	9	6	12	9	13	8	3	5
42	69	29	10	5	2	3	5	6	3	2	4
43	50	17	7	6	3	2	4	6	2	3	0
44	35	11	6	3	0	9	1	1	3	1	0
45	11	5	1	1	0	0	0	2	1	1	0
46	5	1	1	0	0	2	1	0	0	0	0
47	5	0	0	2	1	0	0	1	1	0	0
48	1	0	0	0	0	0	0	0	0	1	0
49	2	1	0	0	0	0	0	0	0	0	1
50	2	1	0	0	0	0	0	1	0	0	0
52	1	0	0	1	0	0	0	0	0	0	0

The majority of Bookings (first appointment with Midwife) were from those living in the most deprived areas (IMD 1) aged 24 to 37.

Postpartum haemorrhage

% of bookings resulting in postpartum haemorrhage		
White British	124	2.4%
Other Ethnic Groups	144	2.9%



Measure: Smoking

Source: DCRS (Stop Smoking Service system), K2

Smoking

Smoking is the leading cause of preventable illness in the UK. Supporting people to stop smoking is one of the most impactful actions that can be taken to tackle health inequalities. The Trust's Stop Smoking Service was established in 2022 and now supports around 85% of inpatients (identified on admission) who smoke and offers support to 100% of pregnant people who smoke (identified at Booking appointment with a midwife). During 2025/26 the Trust's stop smoking advisers provided support to 6,500 patients in the Trust's care and helped over 600 patients to quit smoking.

Supported quit attempts

The data below provides a breakdown of patients who received support from the stop smoking team to make a quit attempt whilst in the Trust's care.

Supported Quit Attempts	
0-18yrs	11%
18-65yrs	30%
>65Yrs	24%

NB: During 2025/26, 12 patients aged under-18 were offered support in total.

Supported Quit Attempts	
Male	27%
Female	31%

Supported Quit Attempts	
White British	28%
Other Ethnic Groups	29%

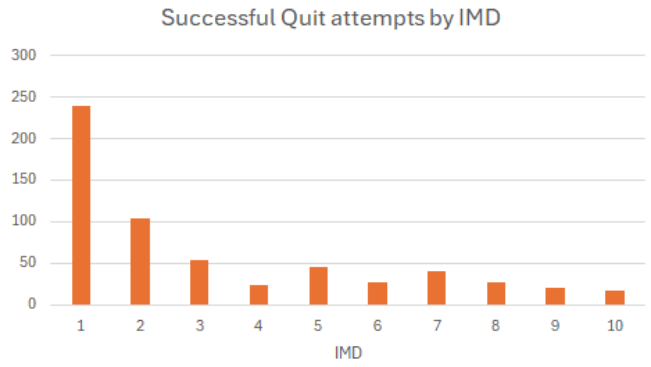
Successful quits at 28 days

The Trust's Stop Smoking Service is required to follow-up patients once they are discharged or after 28 days from first contact for support to quit. The data below provides a breakdown of smoking status at 28-day follow-up. In 2025/26, a total of 608 inpatients reported they remained quit, and these patients were mainly those living in the most deprived areas (IMD 1).

Succesful Quit Attempts	
0-18yrs	16.7%
18-65yrs	9.1%
>65Yrs	10.2%

Succesful Quit Attempts	
Male	9.4%
Female	9.4%

Succesful Quit Attempts	
White British	8.6%
Other Ethnic Group:	11.4%



Learning disability and autism

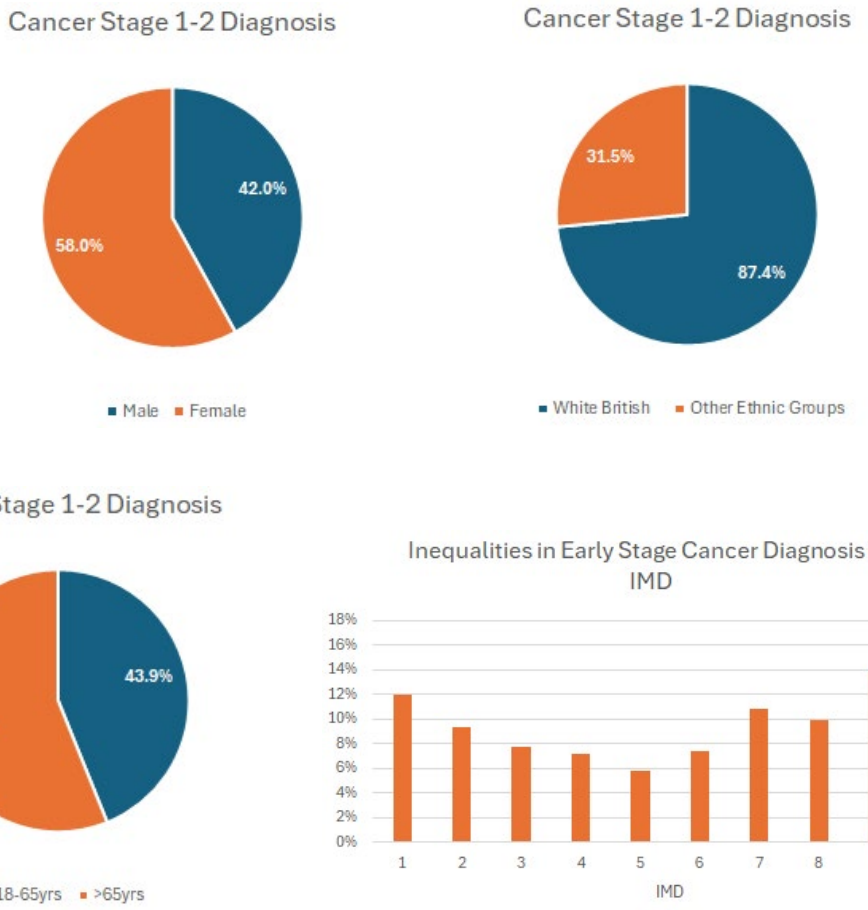
The Leeds Teaching Hospitals' Learning Disability and Autism Service utilises the Learning Disability Improvement Standards to map internal service improvement initiatives against the standards set by NHS England. Each project the service undertakes links directly to one of the standards or sub standards. Additionally, each standard links to relevant NICE guidance to ensure that projects are undertaken with clear improvement strategies that contribute to health equity improvements for patients with a learning disability and autism.

Health inequalities faced by people with a learning disability and autistic people are identified through the learning from lives and death reviews (LeDeR). The Trust utilises LeDeR findings each year to target service improvement initiatives. The Learning Disability and Autism Team also undertakes real time reviews of deaths to ensure that any learning can be embedded as it is identified. The Learning Disability and Autism Team are core members of the mortality improvement group and Child Death Review Meetings. Additionally, the team support the local reviewers from LeDeR with access to patient records and regularly attend the regional review panel where learning from other organisations can be brought into the Trust.

Measure: Cancer

Source: PPM+

Stage 1–2 cancer diagnosis



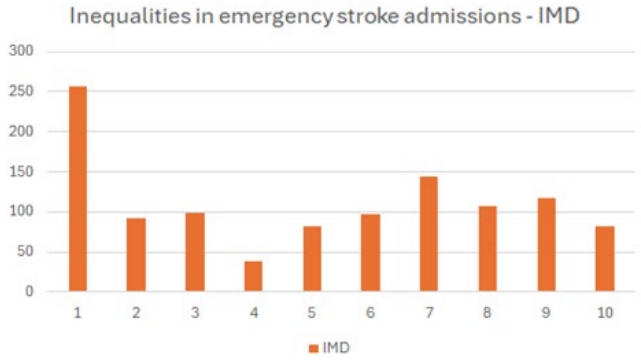
Higher rates of early (stage 1 & 2) cancer diagnosis were amongst those living in the least deprived areas (IMD 9 & IMD 10). However, in the most deprived areas, early death rates are significantly higher than in the least deprived areas and cancer remains one of the main causes of premature death (under 75) in the city.

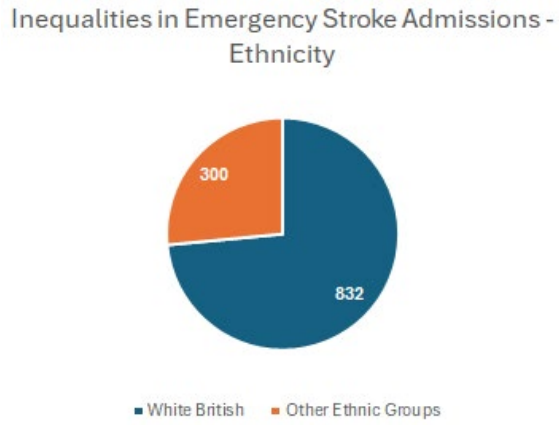
Measure: CVD

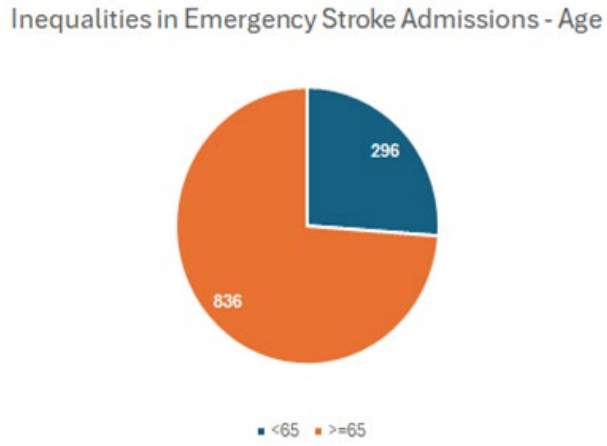
Includes all admissions as defined by diagnosis coding.

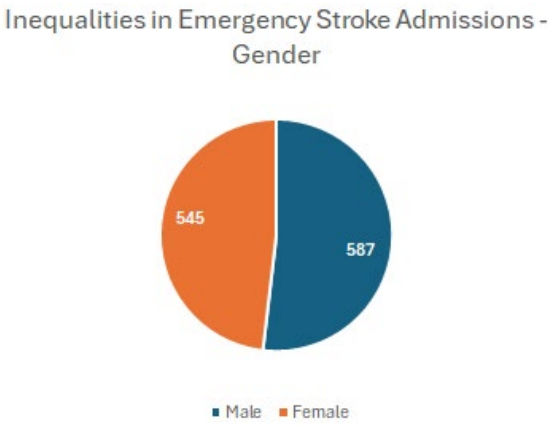
Source: PPM+, SSNAP data.

Emergency stroke admissions





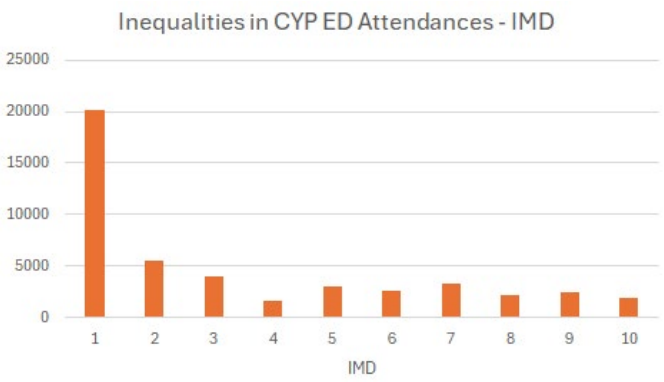


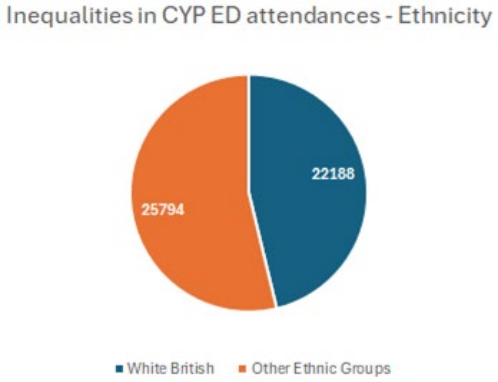


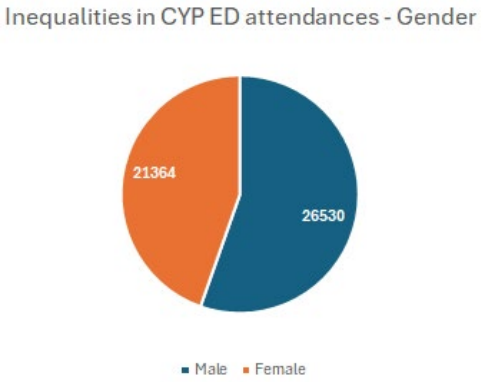
Measure: Children's and young persons (CYP) urgent and emergency care (UEC) - All attendances aged <18

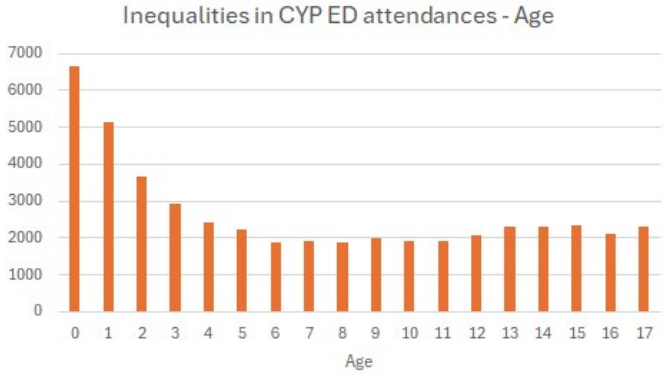
Source: Symphony data

Children and young persons (CYP) emergency department (ED) attendances





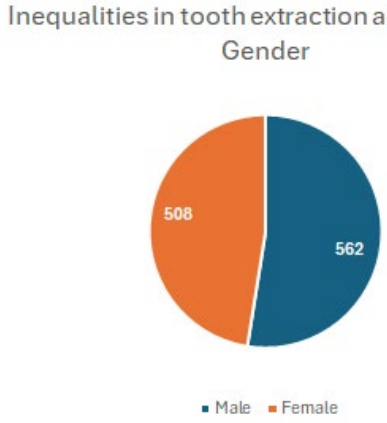


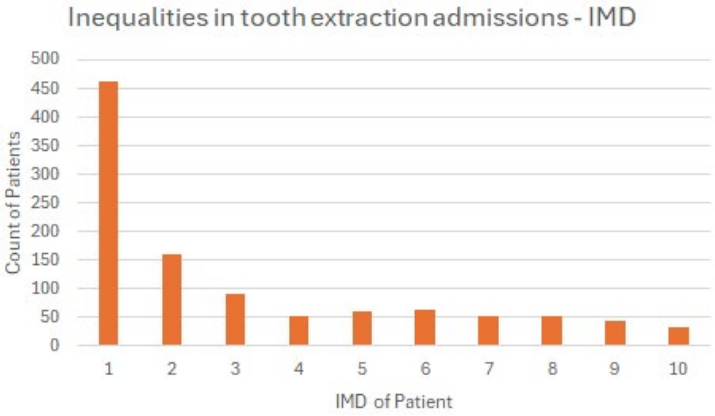


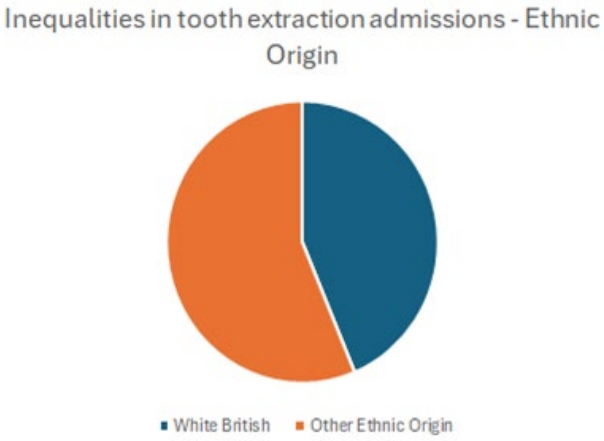
Measure: Children and young persons (CYP) elective admissions; number of patients

Source: PAS data

Tooth extraction admissions

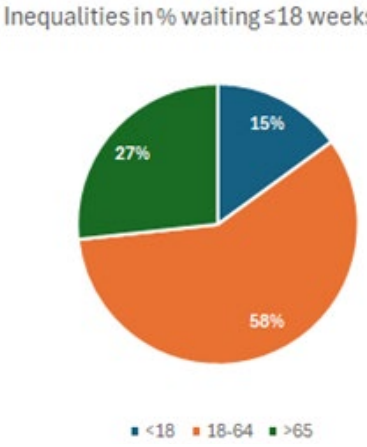


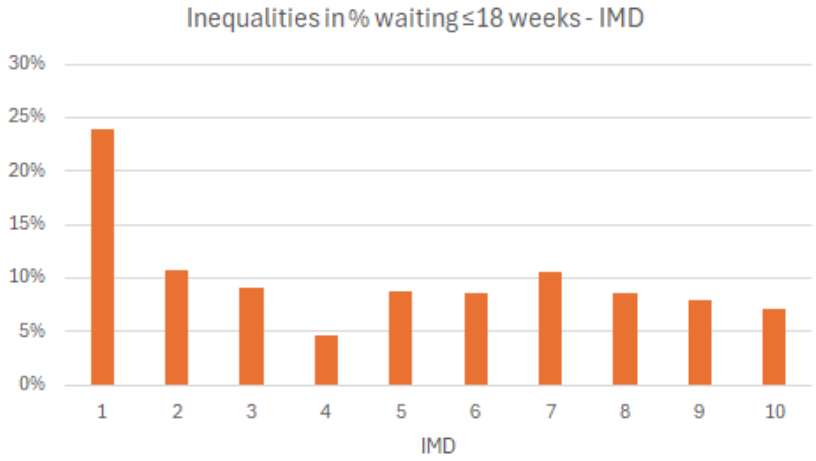




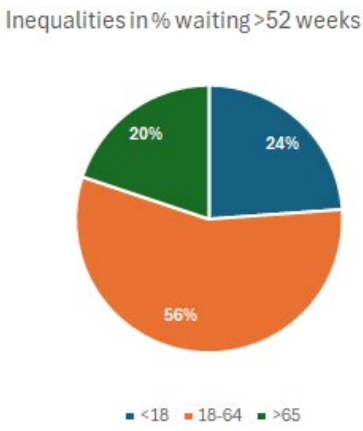
Measure: Elective care – Source: PAS, RTT data

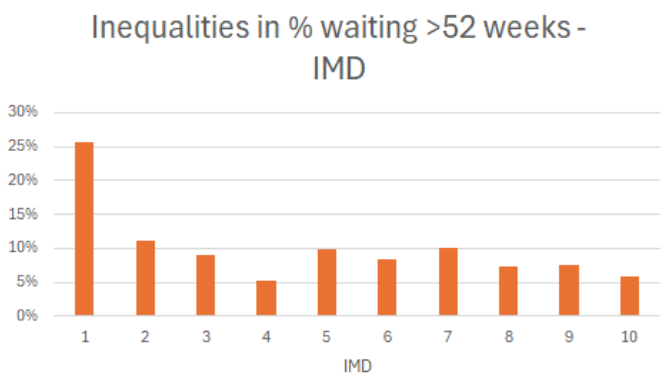
Proportion of patients waiting ≤18 Weeks





Proportion of patients waiting >52 Weeks





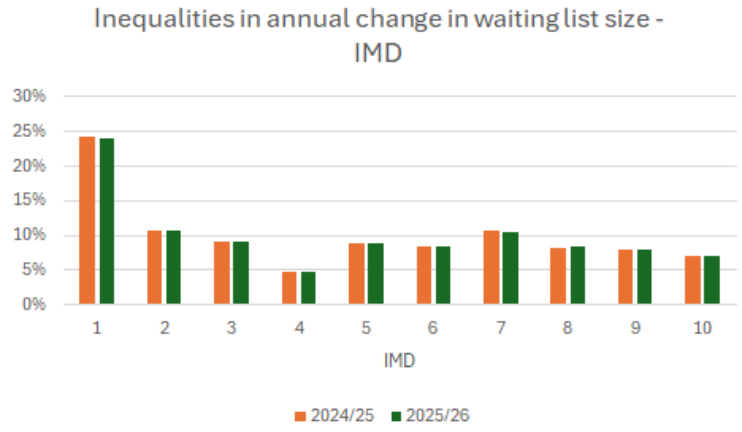
Annual change in waiting list size

	2024/25	2025/26
Male	40.1%	41.1%
Female	59.9%	58.9%

Ethnicity	2024/25	2025/26
White British	48.1%	38.6%
Other Ethnic Group	51.9%	61.4%

Age	2024/25	2025/26
<18	14.1%	15.9%
18-64	60.4%	57.9%
>65	25.5%	24.8%

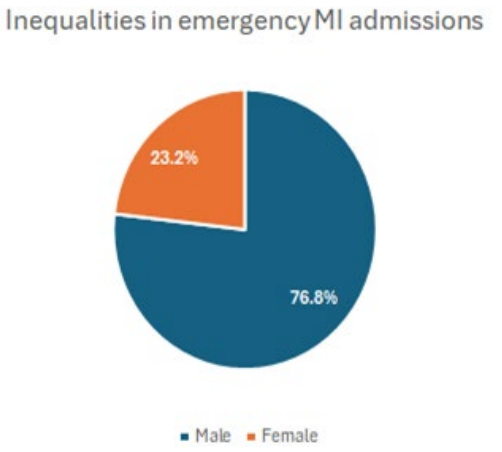
IMD	2024/25	2025/26
1	24.2%	24.1%
2	10.7%	10.8%
3	9.0%	9.1%
4	4.8%	4.7%
5	9.0%	8.8%
6	8.4%	8.5%
7	10.7%	10.5%
8	8.2%	8.5%
9	8.0%	8.0%
10	7.0%	7.1%

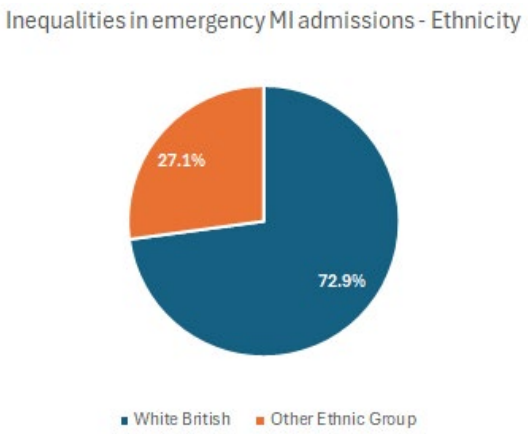


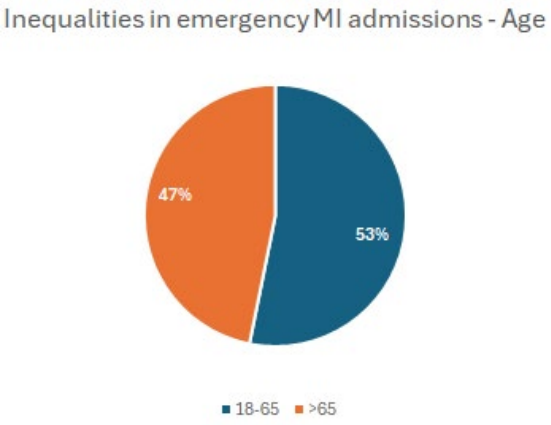
Measure: Cardiovascular disease (CVD)

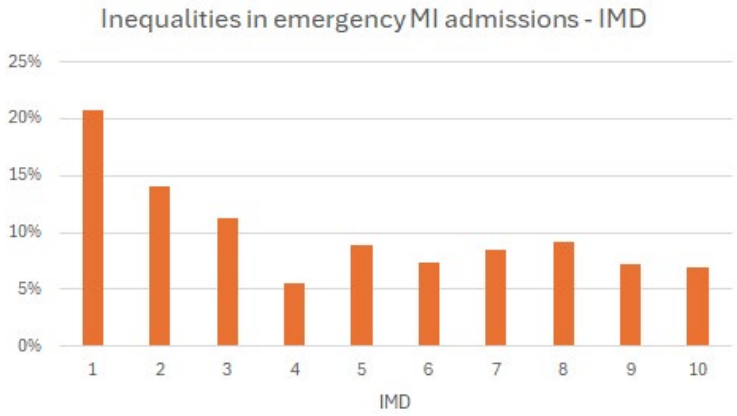
Source: MINAP, NICOR Audit data

Emergency myocardial infarction (MI) admissions





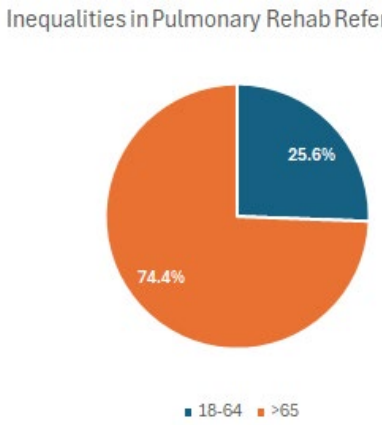


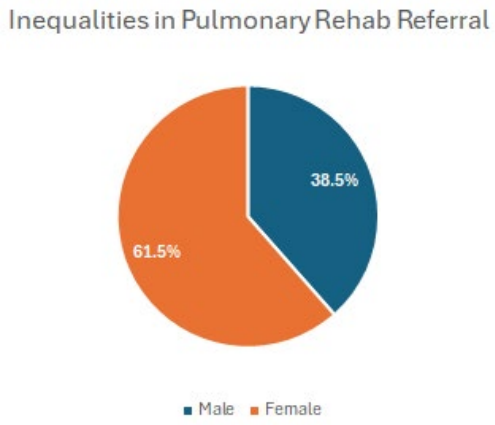


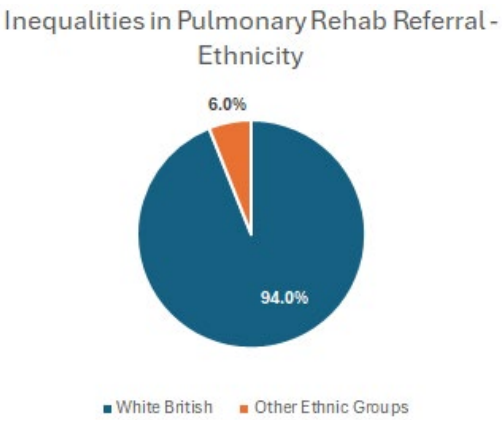
Measure: Respiratory

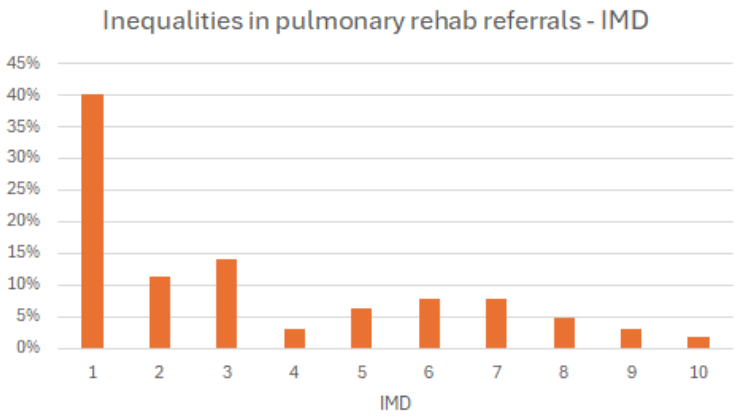
Source: NRAP, COPD Audit data

Pulmonary rehab referral









Measure: Non-elective bed days COPD

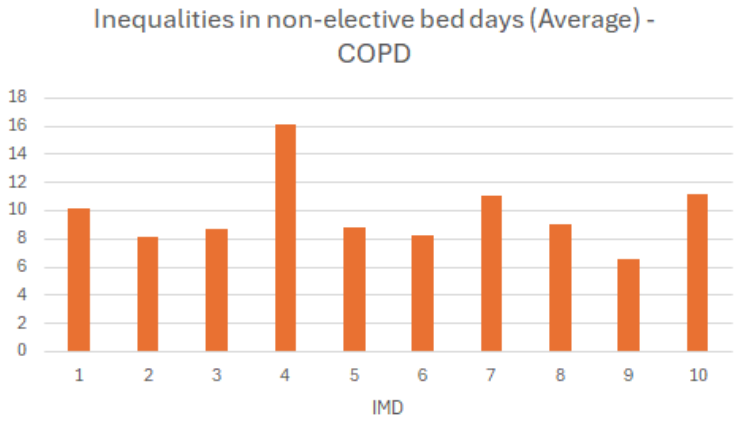
Source: PAS

Length of stay – Chronic obstructive pulmonary disease (COPD)

None-Elective Bed Days (Average)	
White British	9.86
Other Ethnic Groups	9.16

None-Elective Bed Days (Average)	
Male	8.19
Female	10.60

Age	
18-64	21.2%
>65	78.8%



Measure: Data Quality – Ethnicity recording

Source: PAS

Data quality

Leeds Teaching Hospitals is transitioning from high level ambition, as set out in the Health Equity & Public Health Strategy, to transparent and data-led accountability for health inequalities across the Trust. Through developing and publishing a quarterly Health Equity report the Trust will collect and analyse our performance data with an equity lens. Data quality will play an important part in how we can identify inequities and in measuring progress. We recognise the importance of complete and accurate recording practices and improvements in data quality will be factored into our action plans.

% patient records with valid ethnicity documented = **88.2%**

(Based on inpatients in 2025/26 where ethnicity is not stated, none or not known)

% records with blank/null ethnicity = 8.5%.

% records with residual codes not stated/not known = 0.2%.

The Leeds Teaching Hospitals NHS Trust
1st Floor, Trust HQ, St. James's University Hospital

communications.lth@nhs.net

www.leedsth.nhs.uk

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