



The Leeds
Teaching Hospitals
NHS Trust

Integrated Quality & Performance Report

September 2026

Summary - Performance

Performance

KPI	Latest month	Performance	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
AE Attendances per day	Aug 26	897.5	-			977.0	863.5	1090.6
Ambulance Handovers <15mins LGI	Aug 26	00:14:47	00:15:00			00:14:44	00:13:21	00:16:07
Ambulance Handovers <15mins SJUH	Aug 26	00:17:25	00:15:00			00:17:06	00:14:25	00:19:47
Last Minute Cancelled Ops	Aug 26	118	-			133	57	209
Cancelled Ops 28days	Aug 26	46	-			32	3	60
Cancer 28day FSD	Jul 26	83.9%	75.0%			76.1%	68.3%	84.0%
Cancer 31day	Jul 26	96.6%	96.0%			95.1%	92.9%	97.2%
Cancer 62 day	Jul 26	70.5%	85.0%			60.2%	49.9%	70.6%
Diagnostics	Aug 26	86.8%	95.0%			91.2%	87.4%	94.9%
DNA Rate	Aug 26	6.32%	-			6.85%	6.14%	7.56%
Outpatient DNA Volumes	Aug 26	7135	-			8181	6136	10226
ECS Monthly	Aug 26	76.8%	78.0%			75.4%	71.1%	79.7%
Elective LoS	Aug 26	4.2	-			4.1	3.2	4.9
Elective Readmissions	Aug 26	2.80%	-			3.24%	2.89%	3.59%
Non- Elective LoS	Aug 26	7.4	-			7.3	6.6	8.1
Non- Elective Readmissions	Aug 26	11.10%	-			11.35%	10.06%	12.65%
OPFU3months	Aug 26	40998	-			37956	35867	40044
RTT Performance	Aug 26	68.5%	92.0%			64.9%	63.3%	66.5%
RTT Total Waiting list	Aug 26	89575	-			89243	86755	91732
RTT 52 Week Breach Backlog	Aug 26	1486	0			2012	1617	2407
RTT 78Week Breach Backlog	Jul 26	29	0			35	0	70



Summary

Quality Metrics

KPI	Latest month	Performance	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
VTE	Aug 26	96.6%	95.0%			96.6%	95.3%	97.8%
CDI	Aug 26	21	-			14	4	24
MRSA	Aug 26	0	-			1	-2	3
E. Coli	Aug 26	16	-			24	8	40
Pseudomonas	Aug 26	6	-			4	-2	9
Klebsiella spp	Aug 26	13	-			11	-1	23
Falls	Aug 26	179	-			204	148	259
Falls Rate per 1000 Bed Days	Aug 26	3.34	-			3.49	2.92	4.05
Developed Pressure Ulcers	Aug 26	58	-			46	25	67
Developed Pressure Ulcer Rate	Aug 26	1.08	-			0.73	0.26	1.20
Admitted with Pressure Ulcers	Aug 26	299	-			307	251	364
Admitted with Pressure Ulcers Rate	Aug 26	5.57	-			5.45	4.36	6.54
2222 Calls	Aug 26	84	-			64	36	92
Cardiac Arrest Calls	Aug 26	17	-			17	5	29
SHMI	Sep 26	114.2	100.0			112.4	110.8	114.0
Still Births	Jul 26	4.70	5.20			4.03	3.32	4.74
Rolling Extended Perinatal mortality rate (all NND)	Jul 26	8.60	-			9.32	8.34	10.30
Number of MNSI Referrals	Jul 26	1	-			1	-2	4
% Complaint Responses Sent Within Target Times (LR1 let	Aug 26	23%	80%			35%	13%	56%
% CSU Draft Comments Received Within Target Times (LR	Aug 26	29%	80%			50%	33%	68%
Median Response Lead Time (Days)	Aug 26	67	-			51	40	63
Defect Rate	Aug 26	3%	15%			9%	-5%	23%
PALS Concerns - % Patients contacted in 2 w/days	Aug 26	57%	80%			74%	64%	84%



Core Metrics

Measure	Reporting Period	Performance	Target	Assurance
Colleague Engagement	Sep-25	6.7	6.7	
Local Induction	Aug-26	92.37%	85%	
Afc Appraisal Rate	Aug-26	94.62%	95%	
Mandatory Training Compliance Rate	Aug-26	88.97%	85.00%	
Voluntary Turnover	Aug-26	5.01%	5.45%	
Rolling Sickness Absence Rate	Aug-26	5.32%	4.90%	
In-Month Vacancy Percentage	Aug-26	6.10%	N/A	
Worked FTE as % of Establishment +	Aug-26	97.95%	< 100%	

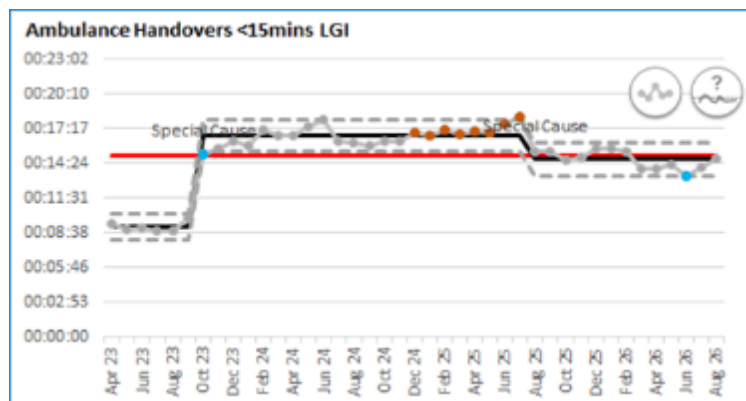
+ Worked FTE as % of Establishment is a new developing metric for 2025/26.

Core Metrics

Ambulance Handover

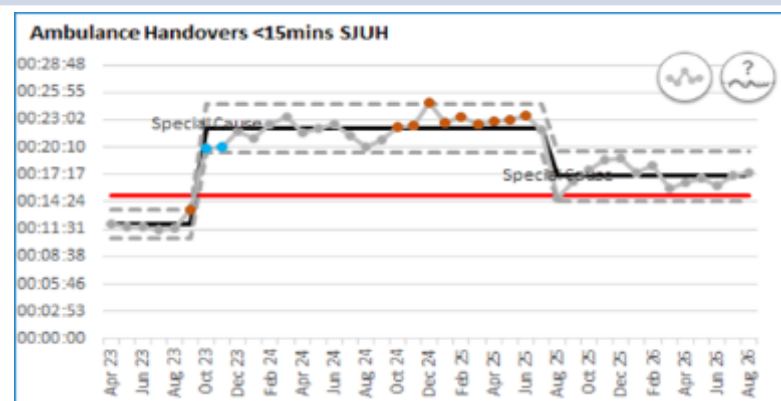
August 2026

Target: <15mins
Performance – LGI : 00:14:47
Performance – SJUH : 00:17:25



Executive Owner: Tim Hiles (Chief Operating Officer)

Variance: LGI -Special cause of improving nature. Hit and miss variation indicated, SJUH Common cause variation. Hit and miss variation indicated



Background	Performance	Key Issues	Current Actions
95% of all handovers should take place within 15 minutes - On average the first 7 minutes of the 15-minute allocation for ambulance handover is taken by the ambulance crew parking the vehicle and "off loading" (YAS term) the patient. This leaves 8 minutes for booking-in and clinical handover to the A&E nurse	- LGI: August 2026 average ambulance handover time was 14:47. - SJUH: August 2026 average handover time was 17:25. - The Trust average handover time for August was 16:17. This compares with 14:52 in June and 15:16 in April, indicating a recent deterioration in performance. - LGI placed 12th and SJUH placed 48th out of 183 hospitals for ambulance handovers for August 2026.	- The ambulance handover clock starts when the ambulance is 25 metres from the A&E front door, rather than at the point of arrival at the ED handover area. - Following LTHT validation of the ambulance handover dataset, YAS has confirmed that they will no longer retrospectively update/amend their dataset following local validation. As a result, the data submitted to NHSE will reflect the YAS dataset and may not fully align with locally validated operational records.	- Continue real-time monitoring of ambulance arrivals and handover performance, with escalation processes activated during periods of increased demand to protect rapid offload capacity and minimise delays. - LTHT will continue to monitor the reported position and identify any material discrepancies between locally validated information and the YAS/NHSE dataset and continue to report this into YAS for their learning and for data accuracy and transparency

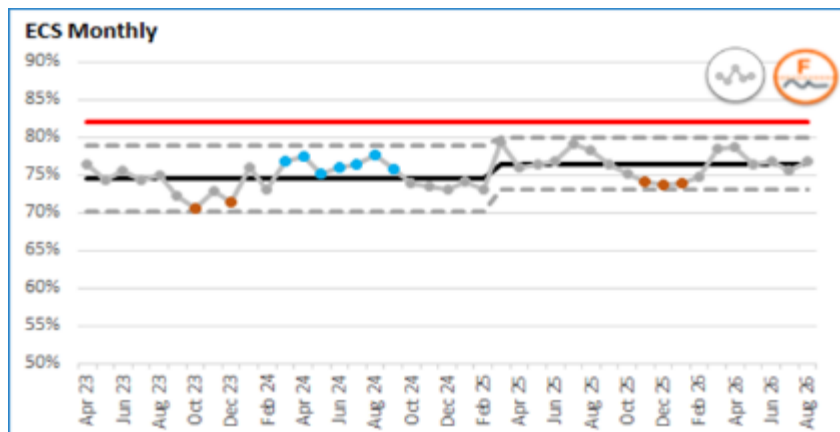
Emergency Care Standard

National Planning Priority Target March 2027: 82%
Performance: 76.8%

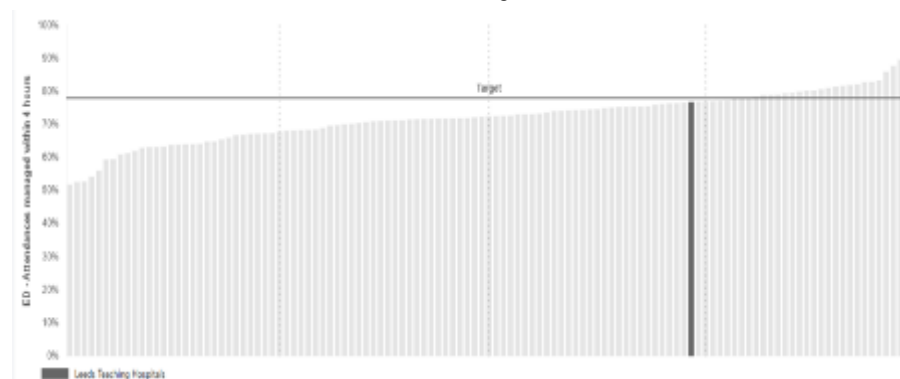
August 2026

Executive Owner: Tim Hiles (Chief Operating Officer)

Variance: Common cause variation. The process will fail to achieve the target.



National Ranking 31/117



Background	Performance	Key Issues	Current Actions
- The constitutional standard is that 95% of attendees to A&E will be admitted, transferred or discharged in 4 hours - The 2026/27 national planning requirement is to deliver 82% in March 2027 - LTHT consistently remains in the top third of Trusts for delivery	- ECS performance for August 2026 was 76.8% which is an improvement from 75.6% in July but remained below 81.5% plan. - National average ECS 72.8% for August 2026 - Ranked 31st out of 117 Trusts for ECS performance in August 2026 and 3rd out of 10 peers 3rd highest volume of attendances amongst peers - In August 2026 ECS for Children was 92.2%	- Reduced UTC/Walk-in Centre activity and increased ED demand remain the largest quantified contributor, with lower activity through these services estimated to account for a 2.0% reduction in ECS performance. - Minor Illness Service instability and delays have contributed to a 1.3% deterioration in ECS performance. - EEMAC implementation pauses have delayed the delivery of planned performance improvement, with an estimated 1.1% of planned improvement not yet realised. - Summer flow constraints has impacted ECS performance through ED congestion and reduced front-door flow.	ECS Recovery Programme: Delivery of an ECS Recovery Programme is underway, focused on the key drivers of performance and supporting achievement of the 2026/27 ECS target of 82% by March 2027 Minor Illness Service: The new provider for this service commenced in August. September focus is to embed extended opening hours, stabilise operational delivery and refine the streaming pathway to maximise appropriate lower-acuity patients being managed outside the ED. EEMAC Optimisation: Implementation of EEMAC is being clinically led. Following the pause at SJUH after the initial test of change and feedback from the clinical team, a wider MDT working group has been established to review the model and develop a revised approach that supports patient care, experience and ECS performance. Implementation continues at LGI, with learning from both sites informing the future model.

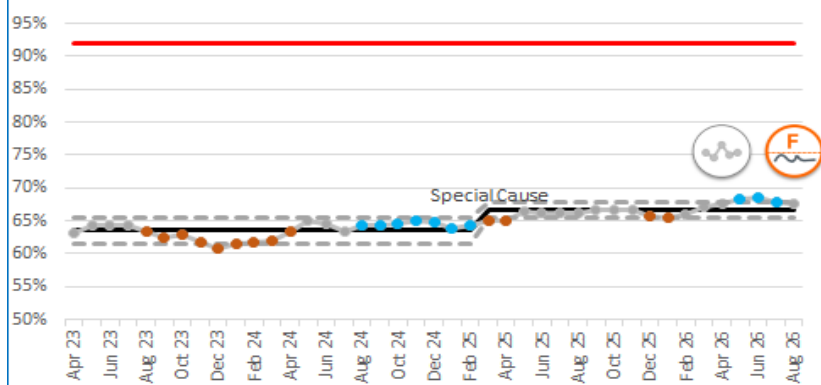
August 2026

Executive Owner: Tim Hiles (Chief Operating Officer)

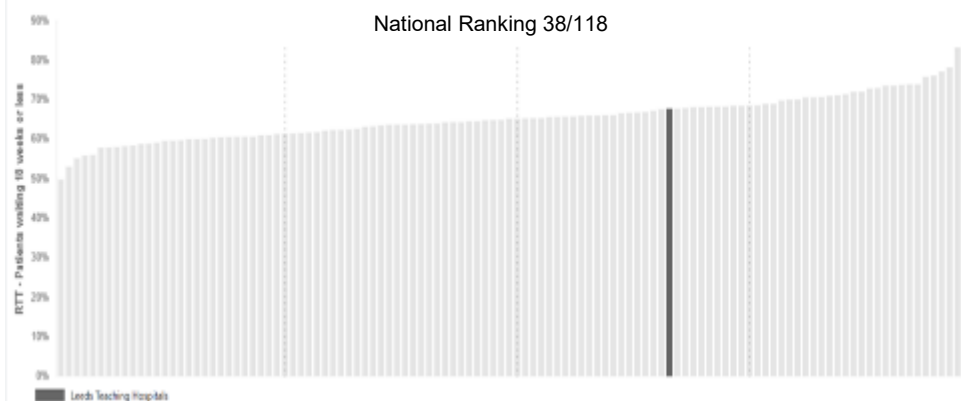
National Planning Priority Target March 2027: 73.35%
National Planning Priority Target August 2026: 68.46%
August Performance: 67.54%

Variance: Special cause improving variation. The process will fail to achieve the target

RTT Performance



National Ranking 38/118



Background	Performance	Key Issues	Current Actions
- The constitutional standard is 92% of patients are treated within 18 weeks of referral - The 2026/27 national planning guidance required an improvement of 7% by March 2027 with the Trust agreed target set at 73.35%	18-week RTT performance was 67.54% in August 2026 a 0.27% reduction from 67.81% in July 2026 . 0.92% below the August plan of 68.46% - TWL increased by 973 patients, from 88,602 in July 2026 to 89,575 in August - Patients waiting over 18 weeks increased by 554 patients from 28,523 in July 2026 to 29,077 in August 1st OPA under 18 weeks reduced slightly (0.36%) from 73.85% in July to 73.49% in August	- Summer annual leave reduces capacity - Theatre staffing as a result of industrial action and workforce gaps - Consultant vacancies and sickness	- Monitoring theatre utilisation and average cases per session through Strategic Theatres Utilisation Group (STUG), has supported improvement in both areas. Utilisation is up by 3% and average cases per session is up by 0.03 when compared to last year - Validation and timely clinic cash up through the use of FDP and E-Outcomes - Director tier monitoring of activity delivered against plan in CSU accountability meetings - Focus shift to RTT and long waits during second half of 2026 - Outpatient transformation plans submitted to increase volume of first outpatient activity

RTT 52 Weeks

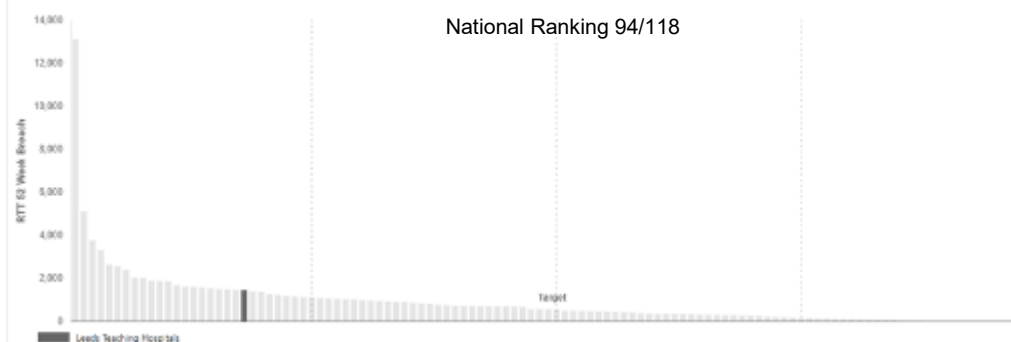
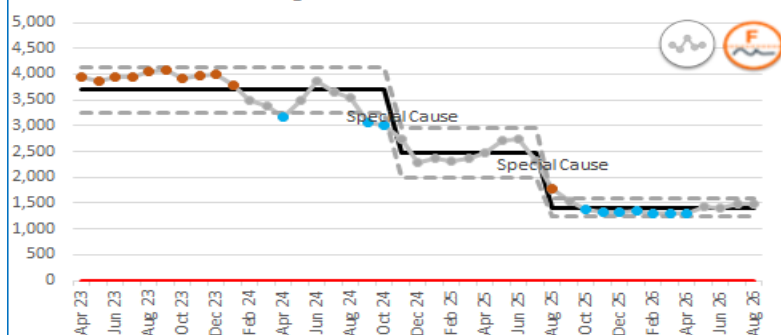
August 2026

Executive Owner: Tim Hiles (Chief Operating Officer)

National Planning Priority Target March 2027: 1% (c750)
National Planning Priority Target August 2026: 1% (c848)
August Performance: 1.66% (1486)

Variance: Common cause variation. The process will fail to achieve the target

RTT 52 Week Breach Backlog

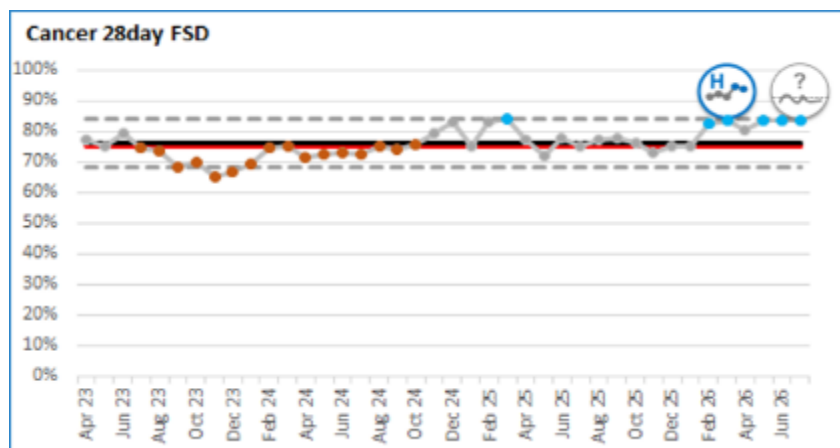


Background	Performance	Key Issues	Current Actions
Planning guidance for 2026/27 requires Trusts to ensure that fewer than 1% of patients on an RTT clock have waited over 52 weeks	- LTHT had 1,486 patients who waited over 52-weeks by the end of August 2026, up from 1,476 in July 52-week waits accounted for 1.66% of total waiting list in August 2026. 0.66% above plan 7 of 13 CSUs met their 52-week trajectory in August	- ICB have reduced IS capacity in key specialities including plastics and Paediatric ENT. - Consultant sickness in Plastics, adult allergy and Children's - Previous workforce gaps in Vascular Surgery	- Funding for outsourcing options to deliver additional capacity for some of the longest waiting patients discussed with ICB including for PENT and Plastics - Mutual aid requested from WYAAT through the ECG presented by Deputy COO and DOP. Evaluation of potential support and impact on local plans underway. - Consultant appointments in Orthopaedics, Vascular & Neurology will allow additional theatre and clinic capacity to support long waiting patients. - Workforce business case for ENT/PENT and GSOT is being considered which would result in expanded capacity 52-week progress is monitored through IAMs and focus will shift to focus on RTT and long waits in second half of the year. - Gynaecology – insourcing capacity and recovery trajectory to be finalised 18/09/26 - Children's – 52 week recovery plan in place – to be at 0 by 30/03/27 - CNS – new scheduling tool developed, 'one more patient' initiative trialled in theatres from 21/09/26 – recovery trajectory to be finalised 18/09/26

Cancer 28 Day Faster Diagnostic

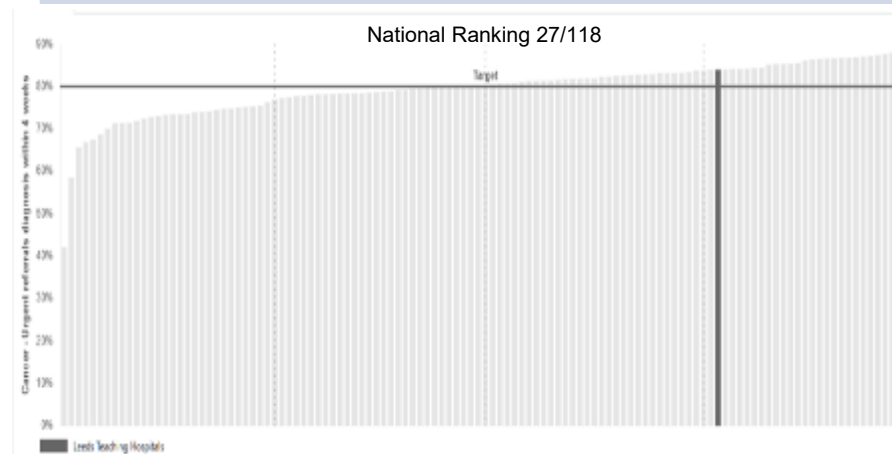
July 2026

Target: 80%
Performance: 83.9%



Executive Owner: Tim Hiles (Chief Operating Officer)

Variance: Special cause of improving nature. Hit and Miss variation indicated

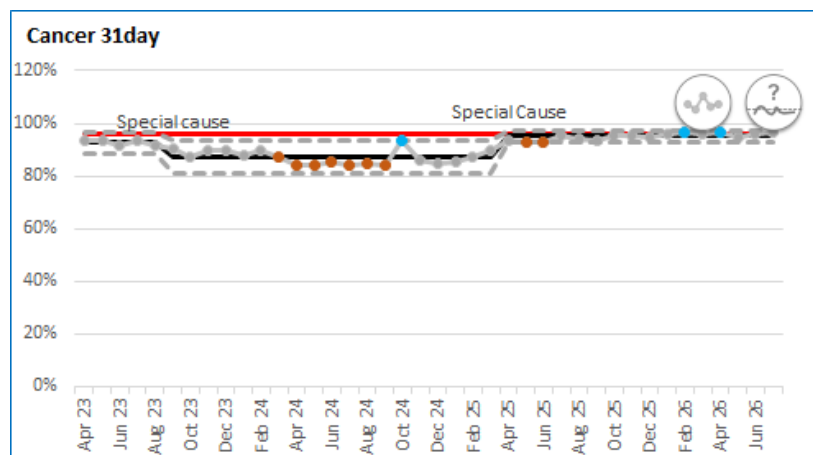


Background	Performance	Key Issues	Current Actions
- Patients should not wait more than 28 days from referral to finding out if they have cancer - The NHSE expectation is that by March 2027(cumulative target), 80% of patients will be notified of their cancer status by day 28	28-day FDS performance 83.6% in June 26 - Ranked 27th of 118 Trusts for July 2026 - Delivering against trajectory for June (80.6%)	Significant workforce challenges in Breast pathway.	- Symptomatic Breast: 2ww capacity continues to be reduced and likely to impact September 28 day performance. Expectation is to deliver over trajectory. Only slight decline in performance for July (76%), not significant enough to impact Trust performance. - Breast 2ww backlog increased but still within expected breach date. Recovery expected from mid September. VO in place to support locum bank radiologists and consultant radiologist from around region to provide additional capacity

Cancer 31 day

July 2026

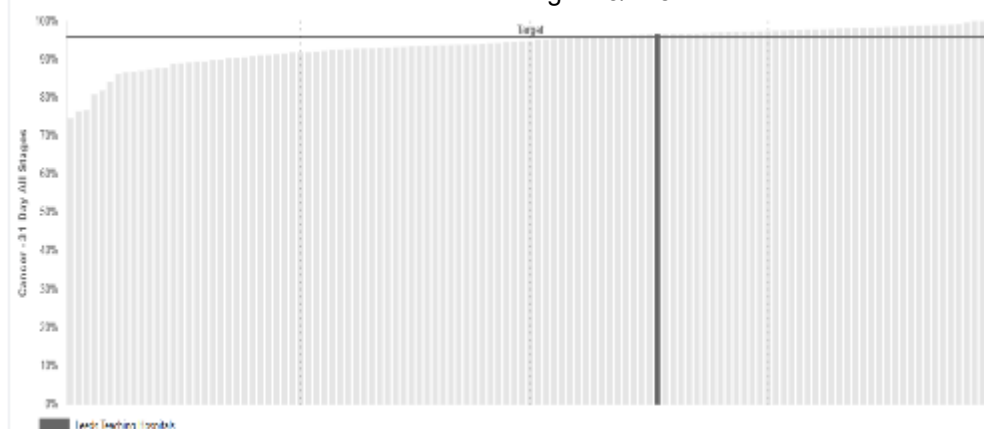
Target: 96%
Performance: 96.6%



Executive Owner: Tim Hiles (Chief Operating Officer)

Variance: Special cause of improving nature.

National Ranking – 43/118

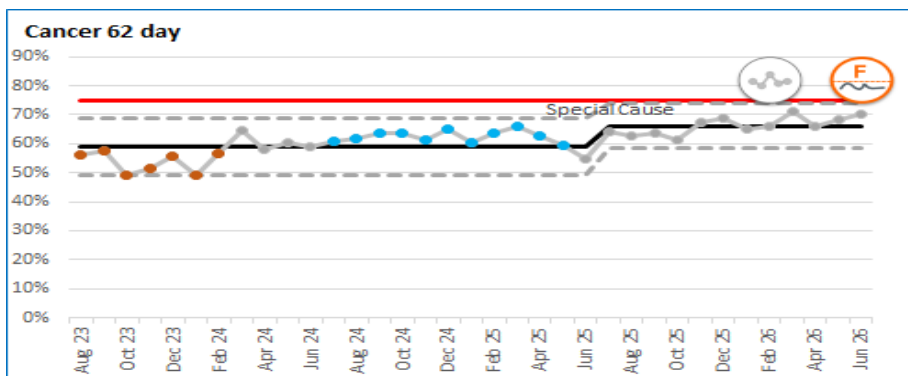


Background	Performance	Key Issues	Current Actions
96% of patients should receive treatment within 31 days - This includes patients receiving both first and subsequent Cancer treatments	- The reported position for May was 95% - The reported position for June was 96.2% - The reported position for July was 96.6% - August Delivery is currently 96.1% - Ranked 43rd out of 118 Trusts for July 2026	- Surgical capacity is the main constraint when compared to other treatment modalities. However, improved position seen in June - May position impacted by April IA	- Additional theatre capacity allocated to TRS to support skin position. Surgical demand & capacity assessment underway - Access to surgical robot remains a key constraint with services continuing to flex lists to respond to peaks in demand - Weekly monitoring of 31-day backlog with key services to explore opportunities and actions

Cancer 62 Days

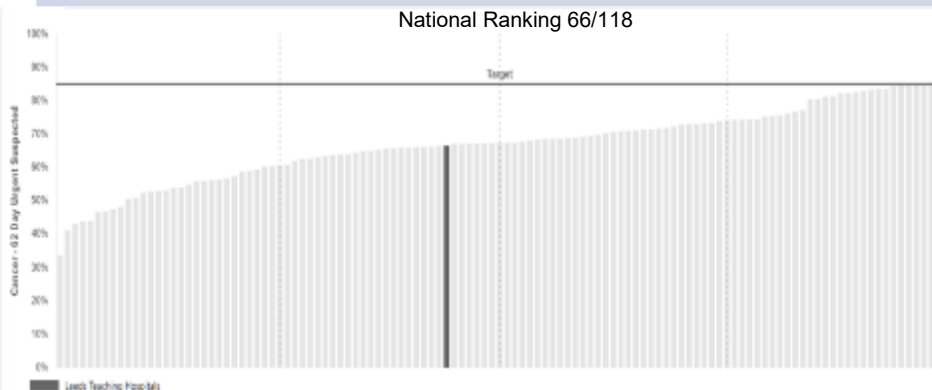
July 2026

Target: 75%
Performance: 70.5%



Executive Owner: Tim Hiles (Chief Operating Officer)

Variance: Common cause variation. The process will fail to achieve the target.



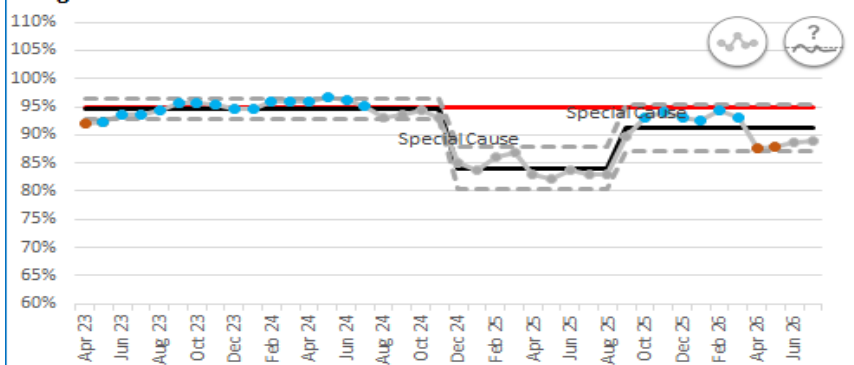
Background	Performance	Key Issues	Current Actions
- The constitutional standard is that 85% of patients receive their first definitive treatment for cancer within 62 days of a referral for suspected cancer - LTHT trajectory to deliver 75% by March 27	62-day performance in June 26 was 70% 0.1 under trajectory for July (70.6%) - Ranked 66th of 118 trusts in July 2026 - Tiering meetings paused until the mid-year review.	62-day backlog has increased over summer (143) - High tip in September/October – impact of summer annual leave and sustained high referrals - Patients waiting over 104-days reduced to 15 from 20.	- Working with Pathology colleagues to ensure all path is reported within reporting month (currently at 6 weeks) - Developing plans to begin pathway workshops with H&N and Gynae for Q3 and Q4 - Outsourcing to respond to seasonal demand in skin whilst converting capacity in-house effectively to maximise capacity - Monthly meeting to progress plans for down-stream impact of lung cancer screening - Surgical capacity assessment to plan reduced waiting for treatment to support delivery of year-end position - Development of one-stop-shop pathway for thyroid and H&N patients - Capacity and demand review complete in oncology with implementation following approval of business case - Scoping of potential use of EPROMs to create NSO clinic capacity for new patients – Trust-wide work aiming to deliver in Q3

Diagnostic Waits

August 2026

National Planning Priority Target March 2027: 94.56%
National Planning Priority Target August 2026: 93.14%
Performance: 86.78%

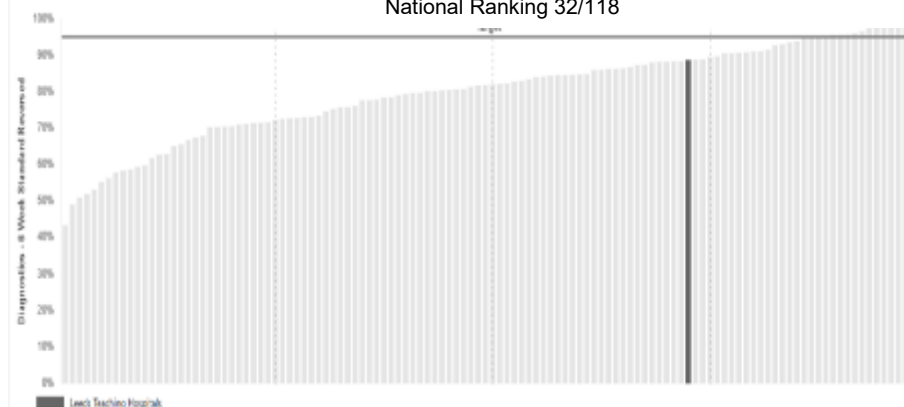
Diagnostics



Executive Owner: Tim Hiles (Chief Operating Officer)

Variance: Common cause variation. Hit and Miss variation indicated

National Ranking 32/118



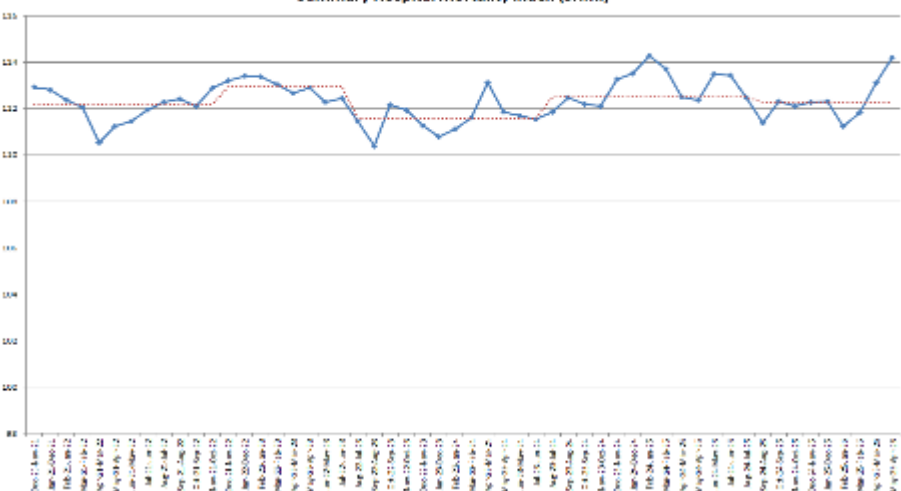
Background	Performance	Key Issues	Current Actions
- Constitutional standard is that 99% of patients wait no more than 6 weeks for a routine diagnostic test - NHS Medium term planning - Improve performance in 2026/27 to deliver a minimum 3% improvement or performance of 80% or better	- Ranked 32 of 118 Trusts (acute and combined) for July 2026 - Diagnostic waiting list was 17,989 a reduction from 20,264 in July. 2378 patients breached 6 weeks at August month end 6.36% below August plan	- Ultrasound have had significant staffing capacity challenges since March 2026 - MRI delays for Paediatric GA due to anaesthetist & theatre capacity - CT capacity shortfalls with increased demand - Audiology overdue waits for paediatric follow-up reviews included as 6ww from April onwards. - Paediatric endoscopy capacity shortfalls	- Ultrasound: 1200 patients outsourced each month. Ongoing recruitment challenges. 3 agency sonographers to support from mid September if successful at assessment - MRI liaising with T&A re opportunities to increase GA capacity with SBAR resubmitted after queries - CT – capacity and demand being reviewed along with any demand optimisation opportunities. - Audiology – additional sessions continue to support recovery of the overdue follow-up waits recently moved to a 6ww clock. - Capsular endoscopy now being used in Paediatrics, however only a small number of patients suitable. The use of capsular endoscopy reduced the requirement for patients to have endoscopy under GA.

Mortality

May 2025 – April 2026

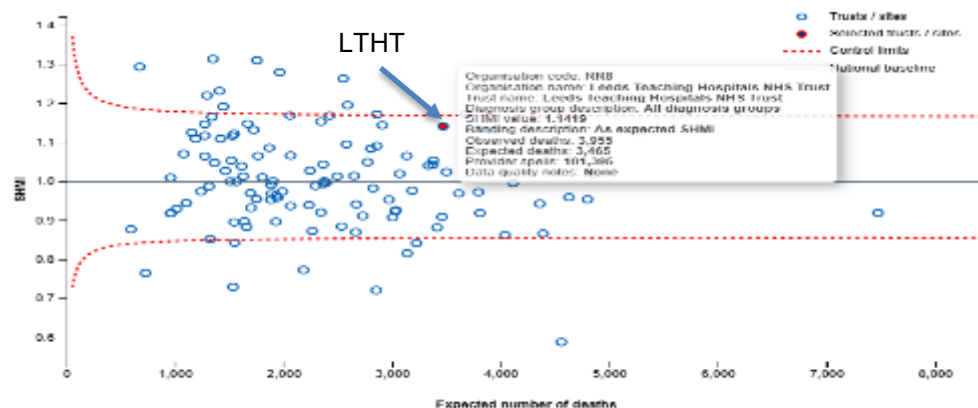
Target: 100
Performance – SHMI: 114.2 “As Expected”

Summary Hospital Mortality Index (SHMI)



Executive Owner: Dr Elizabeth Garthwaite(Chief Medical Officer)

Variance: Common cause variation.



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Background	Context	Action
There are two national Trust-level risk adjusted measures of mortality; the Summary Hospital Mortality Indicator (SHMI) and the Hospital Standard Mortality Rate (HSMR). These are used by NHSi and the CQC to inform the mortality alert process, and are calculated using a twelve month rolling average.	- The Trust SHMI for May 2025 – April 2026 was 114.2 and “As Expected”. - The Upper Control Limit was 117.0	- The Mortality Improvement Group will continue to monitor SHMI in terms of both absolute value, comparison with peer organisations and changes in the diagnostic group breakdown. - We continue to seek assurance through statistical analysis, coding reviews, and case note analysis. The Trust have strengthened the learning from deaths framework and have a robust screening process in place, the Structured Judgement Review (SJR) methodology is used to identify learning and provide assurance on quality of care.

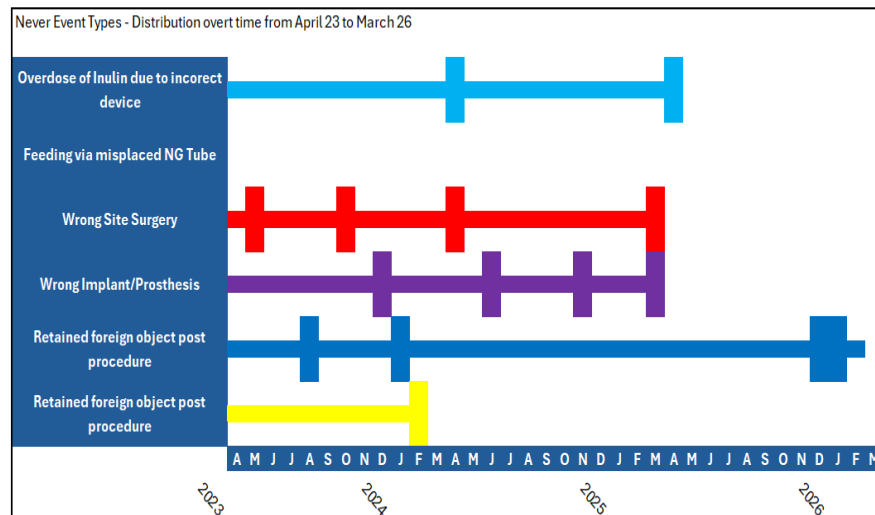
Never Events

Q4 (2025/26)

Target: 0
Performance : 4 (YTD)

Executive Owner: Dr Elizabeth Garthwaite (Chief Medical Officer)

Variance: Common cause variation.



Never Events 2024/25 - 2025/26	Q1 24/25	Q2 24/25	Q3 24/25	Q4 24/25	Q1 25/26	Q2 25/26	Q3 25/26	Q4 25/26	Total
Wrong Site Surgery	1	0	0	1	0	0	0	0	2
Wrong Implant/Prosthesis	0	2	1	1	0	0	0	0	4
Retained Foreign Object post-procedure	0	0	0	0	1	0	1	1	3
Insulin overdose due to abbreviation or incorrect device	1	0	0	0	1	0	0	0	2
Total	2	2	1	2	2	0	1	1	11

Background	Context	Action
Never Events are defined as patient safety incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers The most commonly occurring Never Events are related to failures in established checking procedures. This reflects the national profile in line with the report published by NHSE.	The number of Never Event incidents are reported to our commissioners each quarter via the national Strategic Information System (StEIS). There have been 7 Never Events reported in 2024/25. 4 Never Events have been reported in 25/26: - Overdose of Insulin due to wrong device (ACC). - Retained surgical item (ENT Theatres WGH). - Retained Surgical item (Interventional Radiology/ENT) - Retained Surgical item (gynaecology theatres CHU).	Never Events are a national PSIRP priority. Previously these were always investigated as a PSII. In late 2025, NHS England advised alternative review methodologies could be used where appropriate. Following this advice, the retained item incident reported in December 2025 was reviewed using the after action review methodology, as it was determined that the learning was already identified, and established practice from Theatres and Anaesthesia CSU could be implemented rapidly, reducing risk of further incidents and harm. Learning and actions from Never Events are subject to review at the WYAAT shared learning group chaired by LTIT.

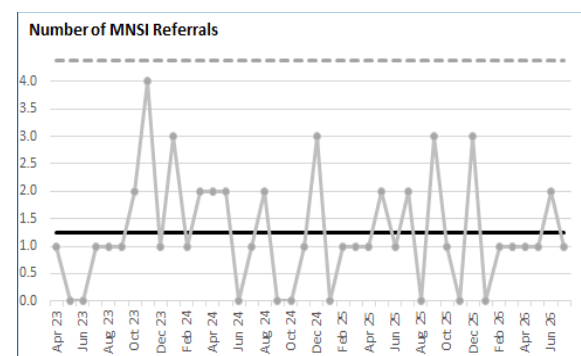
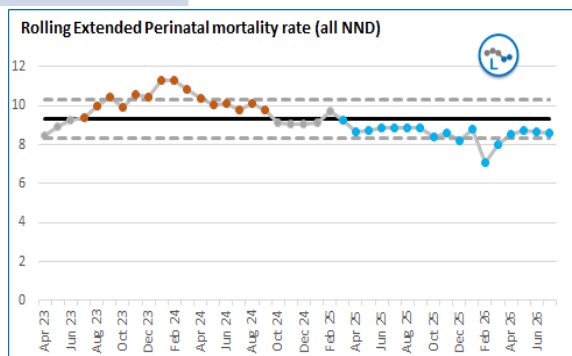
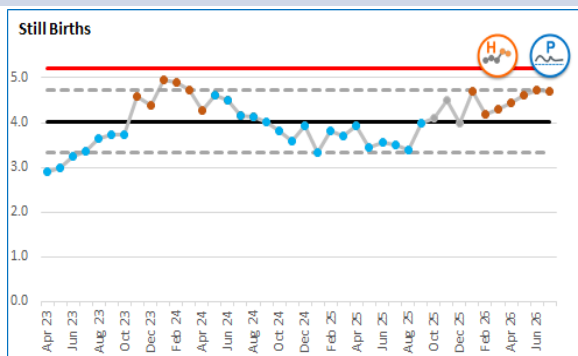
Maternity

July 2026

Still Birth Rate: 4.7
Extended Perinatal Mortality Rate: 8.6
Number of MNSI Referrals: 1

Executive Owner: Beverley Geary (Chief Nurse)

Variance: – Common Cause Variation.



Background	Context	Action
- The MBRRACE definition of a stillbirth is: A baby delivered at or after 24 completed weeks' gestational age showing no signs of life, irrespective of when the death occurred. - The MBRRACE definition of a early neonatal death is: A liveborn baby (born at 20 completed weeks' gestational age or later, or with a birthweight of 400g or more where an accurate estimate of gestation is not available) who died before 7 completed days after birth. - The MBRRACE definition of a neonatal death is: A liveborn baby (born at 20 completed weeks' gestational age or later, or with a birthweight of 400g or more where an accurate estimate of gestation is not available), who died before 28 completed days after birth. - MBRRACE define perinatal death as: A stillbirth or early neonatal death. - MBRRACE define extended perinatal death as: A stillbirth or neonatal death. - LTHT is a tertiary unit and receives referrals for complex congenital abnormalities some of which have an impact on	- There were 3 still births in the reporting period that will be reviewed through the PMRT process. - There was 1 inborn neonatal death associated with extreme prematurity. - There was 1 outborn neonatal death, baby was transferred to Leeds for intensive care facilities, all maternity care provided by another provider - There were 1 new referrals to MNSI in July.	- Continue to review all cases as an MDT using the Perinatal Mortality Review Tool. - Continue to work with other units to support peer review of perinatal mortality. - Continue to meet and engage with MNSI teams to review cases and any trends or concerns. - Review outcomes through a health equity lens to support any learning and service development opportunities.

Sickness Absence Rate



August 2026

Target: 4.9 %

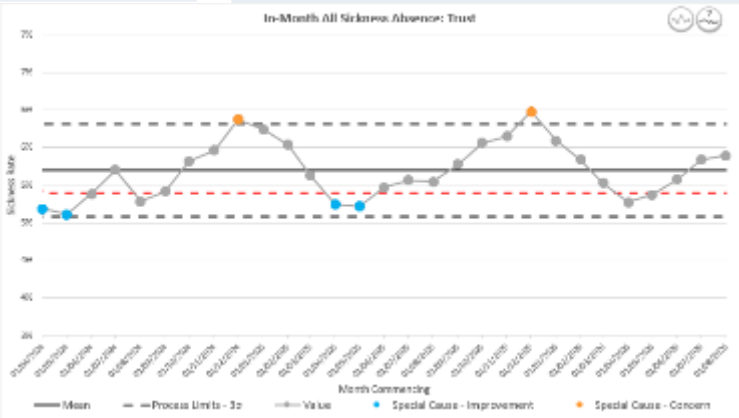
Performance (Rolling Sickness Absence Rate): 5.32% (Avg
Calendar Days Lost Per Person – 18.9)

Variance: Common cause variation in month.

Executive Owner: Suzanne Dunkley, Chief People Officer

Management/Clinical Owner: Jason Eddleston, Deputy
Chief People Officer

Sub-Groups: People Improvement Framework Assurance
Group, People Committee



Context

The trust is seeking to reduce sickness absence levels to reduce costs and improve health and wellbeing in our workforce.

- LTHT is ranked 86th out of 205 trusts nationally for sickness absence (source Model Hospital NOF Score) and 6th out of 33 in North-East and Yorkshire region reflecting a positive position (in the best performing quartile).
- Areas within the trust with the highest sickness absence rates include Outpatients, Chief Nurse, Theatres & Anaesthesia and Women's CSUs.

What the chart tells us

Sickness absence has largely remained within control limits for the last 3 years since they were revised with seasonal highs and lows as expected. However, to achieve the target we will need to see a sustained improvement.

Actions

- The Trust-wide Attendance Improvement Group is progressing a programme of work to improve attendance and workforce availability. Work to date has included: Reviewing national best practice and the Trust's current attendance arrangements; Benchmarking LTHT's sickness absence position; and Reviewing how absence is analysed, managed and assured across the Trust.
- The next phase is focused on developing a consistent Trust-wide approach to strengthening data and monitoring arrangements in absence deep dives (by 31 Oct); reviewing the Trust's attendance assurance process, supported by a PWC audit (dates dependent upon PWC schedule); improving access to attendance guidance and manager support (by 31 Oct); and identifying recommendations to support implementation of the new Supporting Attendance Policy (still under consultation, to be reviewed at TCNC in September).
- Collectively, this work is intended to support sustainable reductions in sickness absence and, in turn, reduce the requirement for bank and other temporary staffing.
- Manager Guidance for OH Referrals is being written, to improve the quality of referrals, and therefore also improve the timeliness, relevance and quality of OH advice to support staff to remain well in the workplace (by 30 Nov).
- The PIF is helping identify the CSUs requiring additional support for sickness absence, e.g.
 - ACC: Focused work has led to improved absence rates in nursing staff (1% improvement since June/July 2025 to June/July 2026). The work included a re-set of the approach to attendance management by detailed 1:1 conversations with matrons with emphasis on decision-making to help progress cases.
 - Similar 1:1 work is taking place in T&A and Women's, especially in hot spot areas and with new Team Leaders.
 - In T&A, Team Leaders now attend assurance meetings (previously just matrons) to support them with ownership and decision-making of cases.
 - Chief Nurse CSU. assurance meetings are being re-established with the DCN, and hot spots being reviewed by Operational

Voluntary Turnover

August 2026

Ceiling: 5.45%

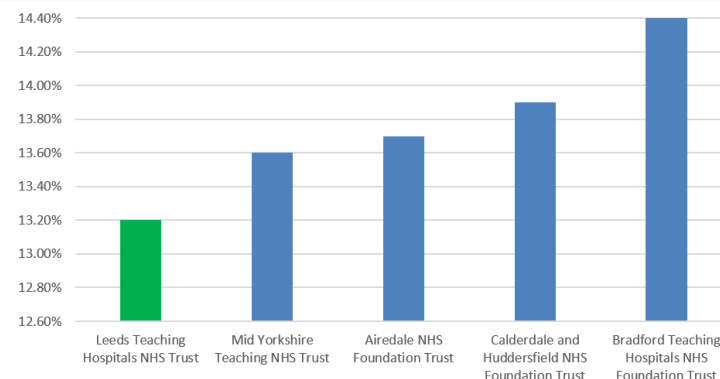
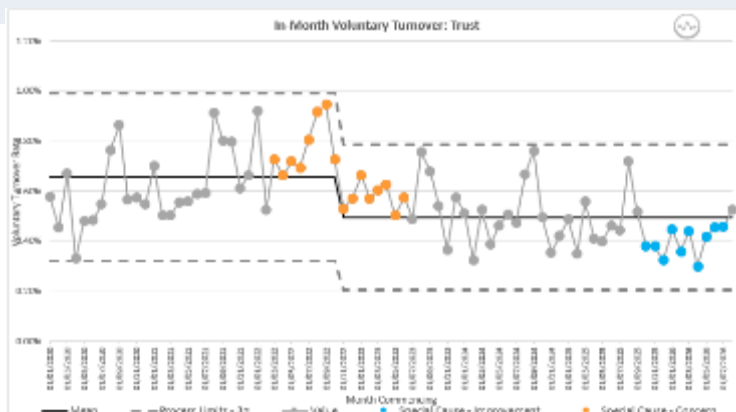
Performance (Rolling Voluntary Turnover Rate): 5.01%

Variance: Common cause variation.

Executive Owner: Suzanne Dunkley, Chief People Officer

Management/Clinical Owner: Chris Jones, Deputy Director of People

Sub-Groups: People Improvement Framework Assurance Group, People Committee



Context	What the chart tells us	Actions
- Voluntary turnover removes fixed term (including rotating resident doctors), contract expiries, dismissals etc. Overall turnover includes all leavers. The data source for the comparison is NHSE Turnover data by trust - Total Trust turnover is 10.5% compared to voluntary turnover being 5.0%. - The Trust has a positive position of being 1st out of 5 trusts in WY ICB for overall turnover (as of June 2026, source NHS Model Health System). The methodology used in the Model Health System (MHS) means that the benchmarking is not 100% comparable to local measures. This is because voluntary turnover is not available in MHS as this is a locally developed turnover ate that strips out fixed term contract expiries, dismissals etc. - The 3 most common reasons for Voluntary Turnover are (in order): Relocation; Promotion; Work/Life Balance. - The CSUs with the highest levels of Voluntary Turnover are Adult Therapies (9.26%) and Neuro (7.21%) and Outpatients (6.91%). The lowest turnover is in Theatres & Anaesthesia (3.3%) and Adult Critical Care (3.36%).	The data from NHSE comparing the overall turnover with other Trusts in the ICB is taken from June 2026 from the NHS Model Health System	- Our People Improvement Framework continues to support deep dives into CSUs with high turnover. - All CSUs have their own on-line Exit Interview Questionnaire that provides them with additional contextual information to understand why colleagues are leaving. The Senior HR Business Partners are supporting their CSUs with understanding this data and providing support and guidance to suggest actions that can be taken. - Voluntary turnover for Adult Therapies remains the highest (9.26%) and we know this is primarily a result of promotions and relocation into Community posts as part of the wider Leeds System. However, Adult Therapies are continuing work on their voluntary turnover and are considering implementing Stay Interviews with colleagues. - Neurosciences has the second highest turnover (7.21%). Their exit interview data shows the top three reasons being due to promotion, flexibility/work-life balance, work environment. The Senior HRBP will work with the CSU to develop an action plan to address these themes. - Outpatients is the CSU with the third highest voluntary turnover (6.91%). A review of their exit interviews show challenges for colleagues based at Seacroft Hospital around communication and volume of workload. An action plan has been developed to address this along with work to try to modernise and improve the service. - Retention plans are incorporated into all CSU Operational Workforce Plans and are part

Agency FTE

August 2026

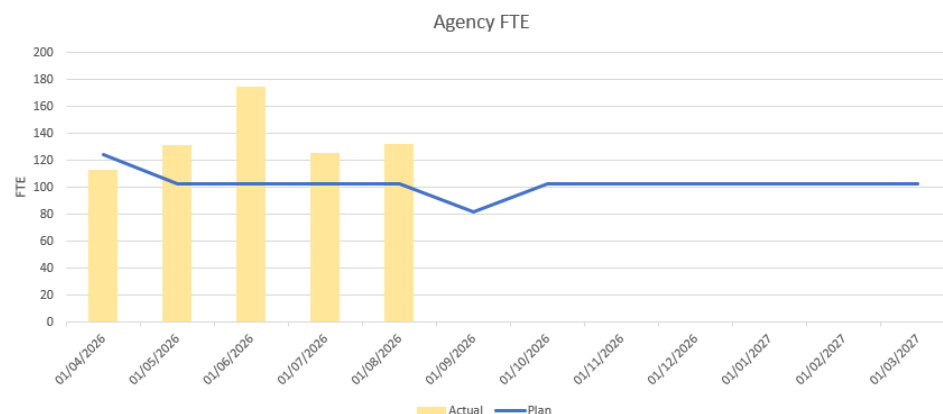
In Month Target: 103 FTE
In Month Performance: 132 FTE

Executive Owner: Suzanne Dunkley, Chief People Officer

Management/Clinical Owner: Jo Buck, Deputy Director of People, Chris Ellison, Deputy Chief Finance Officer

Sub-Groups: People Improvement Framework Assurance Group, People Committee

	01/04/2026	01/05/2026	01/06/2026	01/07/2026	01/08/2026	01/09/2026	01/10/2026	01/11/2026	01/12/2026	01/01/2027	01/02/2027	01/03/2027
Plan	124.00	103.00	103.00	103.00	103.00	82.00	103.00	103.00	103.00	103.00	103.00	103.00
Actual	113.51	131.55	174.78	125.95	132.2							



Context	What the chart tells us	Actions
- The agency WTE worked plan shows the agency expenditure plan required to deliver a positive position against our submitted workforce plan and takes into account historical fluctuations in usage across August and September. - This target is being monitored as we progress through 2026/27. - Over the last 12 months, our highest agency spend/FTE was £1.6m/234.3 FTE however this is always in March and is due to year-end adjustments. Our lowest agency spend in month was £590k in April 26. the lowest FTE usage was April 26 – 113.5 FTE. - LTHT is currently in Model Health System quartile 2 with 0.7% (second lowest quartile) for agency spend as % of total pay bill when compared against other Trusts. - The best performing Trust for agency spend as % of total pay bill is –2.6% currently, the worst is 5.6%. - Note that –2.6% is likely to be an anomaly for the month, the likely normal best performance is 0%. Source = Model Health System. <i>(This has not changed since last IQPR as model health data for this measure has not updated).</i>	- We are currently above target for agency usage. - Agency staff cost continues to include CAMHS agency usage in Children’s CSU, with some reduction in Pathology agency usage in August. - Agency usage was higher in August 2026 (132.2 FTE) compared to August 2025 (77.19 FTE)	- A Trust-wide Attendance Improvement Group is progressing a programme of work to improve attendance and workforce availability (as described on the Sickness Absence slide). - The focus on reducing temporary spend for our Medical and Dental workforce is through the Medical and Dental Optimisation Programme. There are a number of workstreams underway that impact on temporary spend e.g. Job Planning consistency panels are now taking place with CSUs on a rolling basis, a resident doctor medical establishment template has been piloted with CAH CSU and is now being rolled out to other ‘hot spot’ CSUs. - Senior HR Business Partners and Finance Business Partners continue to work with CSUs to develop workforce action plans to address temporary spend e.g. by ensuring controls are in place around the management of sickness absence; support substantive recruitment where possible e.g. Radiology Ultrasound.

Bank FTE

August 2026

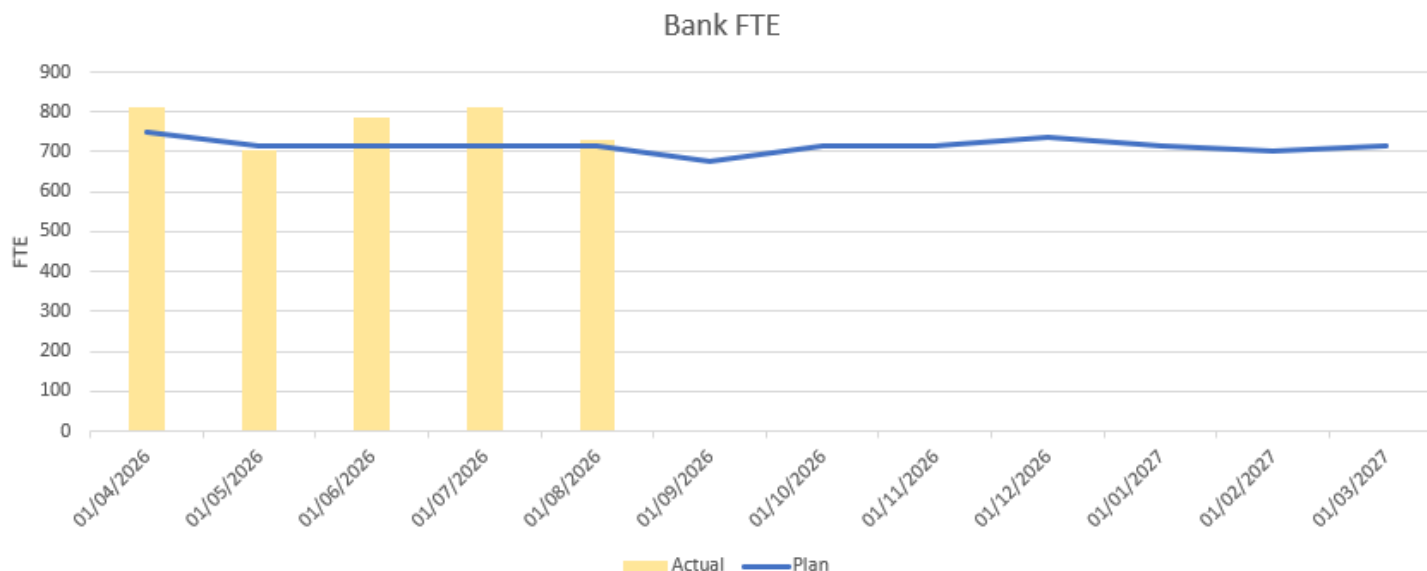
In Month Target: 715 FTE
In Month Performance: 729 FTE

Executive Owner: Suzanne Dunkley, Chief People Officer

Management/Clinical Owner: Jo Buck, Deputy Director of People, Chris Ellison, Deputy Chief Finance Officer

Sub-Groups: People Improvement Framework Assurance Group, People Committee

	01/04/2026	01/05/2026	01/06/2026	01/07/2026	01/08/2026	01/09/2026	01/10/2026	01/11/2026	01/12/2026	01/01/2027	01/02/2027	01/03/2027
Plan	749.50	715.00	715.00	715.00	715.00	674.50	715.00	715.00	738.00	715.00	704.00	715.00
Actual	813.01	705.04	785.39	811.97	729.76							



Narrative on next
slide

Bank FTE

August 2026

In Month Target: 715 FTE
In Month Performance: 785 FTE

Executive Owner: Suzanne Dunkley, Chief People Officer

Management/Clinical Owner: Jo Buck, Deputy Director of People, Chris Ellison, Deputy Chief Finance Officer

Sub-Groups: People Improvement Framework Assurance Group, People Committee

Context	What the chart tells us	Actions
- The bank WTE worked plan shows the bank expenditure plan required to deliver a positive position against our submitted workforce plan . The Plan takes into account historical fluctuations in usage across the year. - LTHT is currently in Model Health System quartile 1 at 4.1% (lowest quartile) for bank spend as % of total pay bill when compared against other Trusts. - The best performing Trust for bank spend as % of total pay bill is 0.3% currently, the worst is 14.2%. - Source = Model Health System (<i>this has not changed since last IQPR as model health data for this measure has not updated</i>).	- We are currently operating above plan for our bank FTE. - Bank usage in August decreased across Medical and Dental and Nursing across multiple CSUs. - The bank usage in August 2026 (729.76FTE) was lower than August 2025 (776.12 FTE).	- The project to centralise all Trust Staff Banks under the People Function is progressing. Phase 1 (September 2026) is on track: consultation with nursing bank team colleagues on the move to the People Function; complete the E&F Bank centralisation and establish a Pathology Bank. Phase 2 will complete by December 2026 centralising less complex AfC bank arrangements. Phase 3 will complete in March 2027 centralising complex or non-standard arrangements. There is an expectation that the centralisation of bank will allow us more grip and control of usage and spend as a result of a unified approach. - A Trust-wide Attendance Improvement Group is progressing a programme of work to improve attendance and workforce availability (as described on the sickness absence slide). - The focus on reducing temporary spend for our Medical and Dental workforce is through the Medical and Dental Optimisation Programme. There are a number of workstreams underway that impact on temporary spend e.g. Job Planning consistency panels are now taking place with CSUs on a rolling basis – this is highlighting inconsistencies in how some job plans are calculated e.g. duplication within job plans where PA time has been given for a lead role but additional PA time has also been given to attend a meeting that should already fall under the lead role PA. Each CSU goes away from the consistency panels with an action plan to address any identified anomalies. - A resident doctor medical establishment template has been piloted with CAH CSU and is now being rolled out to other 'hot spot' CSUs. - The Internal Executive Turnaround Committee is in the process of agreeing what additional actions should be undertaken to address temporary spend. - Overtime is an issue for a limited number of CSUs, and the aim is to have a 'bank first' approach. This creates a risk that bank may increase further away from plan as overtime reduces. - Work is underway by Corporate Nursing to review bank pay arrangements for nursing and midwifery colleagues. A single bank payment rate has been proposed for medical and dental colleagues. - Senior HR and Finance Business Partners continue to work with CSUs to support them with addressing areas of high temporary spend such as highlighting areas of high sickness absence.

Contracted Substantive FTE

August 2026

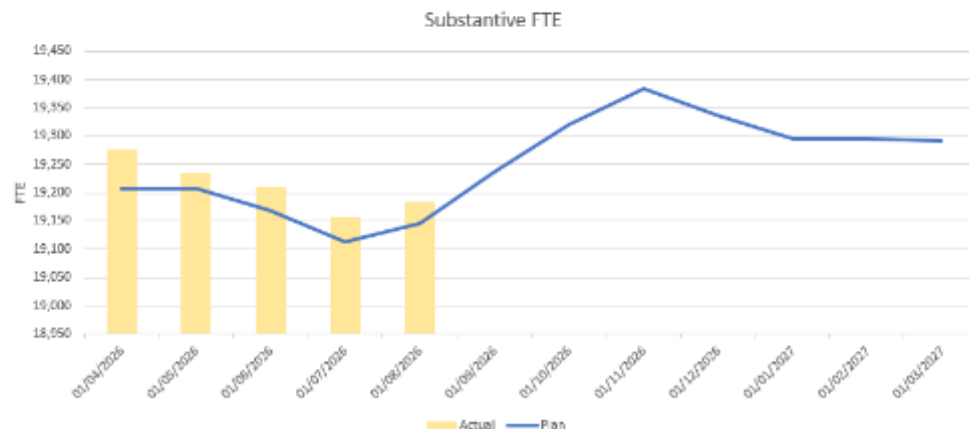
End of Year Target: 19290 FTE
In Month Target: 19167 FTE
In Month Performance: 19183 FTE

Executive Owner: Suzanne Dunkley, Chief People Officer

Management/Clinical Owner: Chris Jones, Deputy Director of People,
Chris Ellison, Deputy Chief Finance Officer

Sub-Groups: People Improvement Framework Assurance Group,
People Committee

	01/04/2026	01/05/2026	01/06/2026	01/07/2026	01/08/2026	01/09/2026	01/10/2026	01/11/2026	01/12/2026	01/01/2027	01/02/2027	01/03/2027
Plan	19207.74	19206.84	19167.50	19112.35	19146.35	19235.68	19320.02	19383.17	19336.24	19295.36	19295.90	19290.40
Actual	19276.09	19234.12	19210.87	19157.96	19183.96							



Context	What the chart tells us	Actions
- Our workforce plan submitted as part of the Medium-Term Planning process for 2026/27 is shown by the blue line. - The Plan takes account of seasonality of our annual recruitment cycles. - A reduction in FTE is required in order to support achievement of the 2026/27 Financial Plan.	<i>To note: Further work is being undertaken to support alignment between workforce and financial reporting.</i> - The chart shows our contracted FTE against plan (blue line). - We are 43.23 FTE above plan for August and we expect to see substantive FTE increase over the coming months as the intake for newly qualified registrants begin working for the Trust.	- Each CSU has been provided with a target by which to reduce WTE (outside of safe staffing areas). To date, 7 CSUs/Corporate areas have met their target, 16 have plans in place and 4 have yet to identify plans. These reductions are being reviewed through the monthly Integrated Accountability Meetings. - Additional rigour has been placed on vacancy control panels at CSU level ensuring they consider alternatives to 'like-for-like' recruitment such as the use of automation or AI where possible. There is also greater oversight by the Executive Team on the number of vacancies being approved at Tier 1 CSU level panels (previously oversight had been focused on Tier 2 vacancy panel decisions). - There is increased focus on reducing absence. - The Internal Executive Turnaround Committee is in the process of agreeing what additional actions should be undertaken to deliver its WRP target.

Combined Substantive/Bank/Agency FTE

August 2026

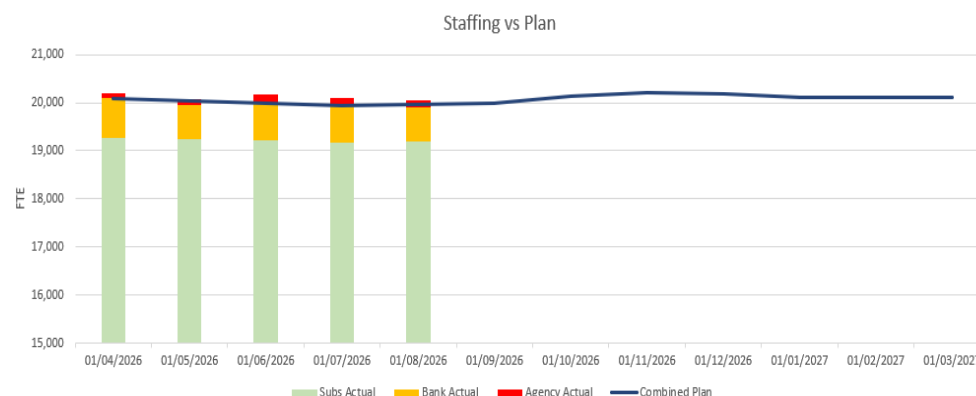
End of Year Target: 20108 FTE
In Month Target: 19985 FTE
In Month Performance: 20045 FTE

Executive Owner: Suzanne Dunkley, Chief People Officer

Management/Clinical Owner: Jo Buck, Deputy Director of People, Chris Jones, Deputy Director of People, Chris Ellison, Deputy Chief Finance Officer

Sub-Groups: People Improvement Framework Assurance Group, People Committee

	01/04/2026	01/05/2026	01/06/2026	01/07/2026	01/08/2026	01/09/2026	01/10/2026	01/11/2026	01/12/2026	01/01/2027	01/02/2027	01/03/2027
Subs Plan	19207.74	19206.84	19167.50	19112.35	19146.35	19235.68	19320.02	19383.17	19336.24	19295.36	19295.90	19290.40
Subs Actual	19276.09	19234.12	19210.87	19157.96	19183.96							
Bank Plan	749.50	715.00	715.00	715.00	715.00	674.50	715.00	715.00	738.00	715.00	704.00	715.00
Bank Actual	813.01	705.04	785.39	811.97	729.76							
Agency Plan	124.00	103.00	103.00	103.00	103.00	82.00	103.00	103.00	103.00	103.00	103.00	103.00
Agency Actual	113.51	131.55	174.78	125.95	132.20							
Combined Plan	20081.24	20024.84	19985.50	19930.35	19964.35	19992.18	20138.02	20201.17	20177.24	20113.36	20102.90	20108.40



Context	What the chart tells us	Actions
- This chart combines the Bank, Agency and Substantive FTE charts from the previous three slides against the workforce plan submitted to NHSE for the 2026/27 Medium-Term Planning Round. - A reduction in FTE is required in order to support achievement of the 2026/27 Financial Plan. - This could still be achieved if substantive FTE increased as long as there was a correlating decrease in bank/agency FTE. - The M4 WYAAT Benchmarking data pack shows LTH is 0.9% above combined plan. LCH is highest above combined plan at 4.4% and YAS lowest below plan at -5.8%.	<i>To note: Further work is being undertaken to support alignment between workforce and financial reporting.</i> - Whilst substantive and agency FTE have increased month on month, bank has reduced by 82.21 FTE. - The combined FTE reduction from M4 to M5 is 44.34 FTE. - However, the combined bank/agency/substantive workforce is 87.19 FTE above plan for M5 and we are above plan for each FTE element. - The data and performance against plan is relatively stable from month	As described in earlier slides: - All CSUs have been provided with a target for reducing WTE. - Vacancy control processes have been tightened. - A Trust-wide absence project group is progressing actions to increase workforce availability to reduce the reliance on temporary workforce. - The focus on Medical and Dental workforce is through the Medical and Dental Optimisation Programme e.g. job planning consistency, resident doctor medical establishment reviews. - Senior HR and Finance Business Partners continue to work with and support their CSUs on workforce plans.

Vacancy Rate

August 2026

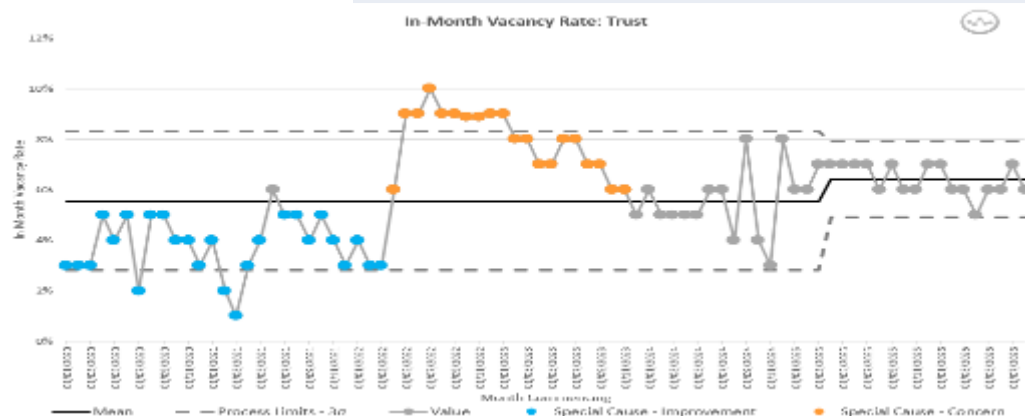
Target: N/A
Performance: 6.10%

Variance: Common cause variation. The process will regularly achieve the target

Executive Owner: Suzanne Dunkley, Chief People Officer

Management/Clinical Owner: Jo Buck, Deputy Director of People

Sub-Groups: People Improvement Framework Assurance Group, People Committee



Context	What the chart tells us	Actions
- Changes in budget are not aligned to recruitment patterns, particularly with relation to the recruitment of newly qualified registered staff. - Vacancy is calculated comparing substantive staffing numbers with funded FTE from the financial ledger which is adjusted for reductions arising from Waste Reduction Programmes and Vacancy Factor targets. - Vacancies can impact the Trust's temporary spend across some staff groups/CSUs	We have re-calculated the control limits as of April 2025 following some large fluctuations. the vacancy rate has remaining consistent since then however there remain seasonal patterns (newly qualified staff recruitment) and one-off establishment adjustments (i.e. Womens CSU in Apr 26) that can impact the vacancy levels.	- A vacancy control process remains in place and involves a 13-week lead in time for adverts for those CSUs who are RED financially. There are however, exceptions to the 13-week lead in time where staffing is classed as 'safer staffing' or where there are other service specific requirements. - The CSUs with the higher vacancies are SIM and Women's. Women's are focusing on midwife recruitment to achieve Birthrate+ numbers. SIM have CSW vacancies and continue to work with Corporate Nursing to appoint New to Care CSWs. - Reducing vacancies in clinical patient facing roles will reduce our bank and agency and help us to achieve our workforce plan. - CSUs continue to identify ways of retaining and developing our workforce through apprenticeships and growing our own into registered and non-registered roles across the Trust i.e. retaining CSW colleagues through development into Trainee Nurse Associates. - CSUs continue to explore and implement alternative options to address vacancy hotspots e.g. alternative roles (ACP, PA, Nursing Associates) along with apprenticeship option.

Colleague Engagement Rate

July 2026

Target: 6.7
Performance: 6.7

Variance: Common cause variation.

Executive Owner: Suzanne Dunkley, Chief People Officer

Management/Clinical Owner: Nikki Hosty, Director of OD & Inclusion

Sub-Groups: Colleague Engagement Forum, People Improvement Framework Assurance Group, People Committee

Context

- Nationally, results declined across a number of People Promise themes, including engagement, advocacy and team working, continuing a downward trend seen since 2023.
- While our results remain broadly aligned with the national picture, our relative position has shifted, and LTHT are no longer performing above the national average across the People Promise themes.
- Against a backdrop of ongoing change and pressure across the NHS, maintaining engagement was a key ambition for 2026. The results highlight areas of focus and provide clear opportunities for LTHT to focus our efforts on improving how people feel safe, supported and valued at work.
- Nationally, results declined across a number of People Promise themes, including engagement, advocacy and team working, continuing a downward trend seen since 2023.
- The Engagement Score has reduced to 6.7 (from 6.9). Consistent with the wider NHS picture, LTHT has seen a decline across all People Promise themes. Whilst this reflects the broader challenges being experienced nationally, our results now sit broadly in line with national averages, rather than above them as in previous years.

What the chart tells us

Score remains within control limits albeit showing a consistent downward trend for the last 3 year



Actions

Progress against NHS Staff Survey High Impact Actions (HIAs) continues, supported by a robust programme of activity and ongoing Trust wide communication and engagement plan.

- People Function delivery plan is either complete or actively progressing, with one action not yet started and one longer-term action planned for 2026 – Review of HIA upon receipt of the results on 22.12.26
- A Champion model, Network governance and listening frameworks are becoming standardised routes for local ownership and speaking up – New champion model in place will monitor engagement each quarter
- Refreshed Trust values and behavioural statements have launched, with communications and leadership guidance moving into delivery – OD team working with tri teams currently
- Induction, mandatory learning, TEL projects and OD interventions demonstrate system improvements colleagues experience day to day – Onboarding review currently happening with the final paper for recommendation taken to People function senior team meeting 21.12.26
- Apprenticeships and employability activity are strengthening future workforce supply, progression and inclusion – Widening participation strategy in train and will be shared with People Function Senior Team 21.12.26

Direct Engagement

- Targeted sessions with Matrons in Women's CSU improved understanding and engagement with survey scores – 1.9.26
- HP and Healthcare Scientist engagement explored barriers, existing actions and where central support can add value – 8.9.26

Hot spot areas

- HRBPs are working with Tri teams to support colleague engagement in these areas

2026 Staff Survey

- Plans are now in place to launch the 2026 staff survey on 5th October 2026
- Communication will be delivered via standard LTHT communication channels via a 'You Said/We Did' theme and there will be enhanced communications directly through CSU own communication channels throughout the course of the season – during staff survey season Oct – Nov 26
- There will be no incentives but there will be encouragement from line managers to respond to the survey and guidance for managers will be shared via the OD team.

I&E Position 2026/27



August 2026

Executive Owner: Jenny Ehrhardt (Chief Finance Officer)

The financial plan submitted for 2026/27 is a breakeven position and includes a waste reduction programme (WRP) of £95m.

In August the Trust is reporting a year-to-date deficit of £18.6m, which is £8.3m adverse to the NHSE plan. The biggest drivers of the year-to-date deficit are costs associated with the resident doctor's industrial action in April, medical pay award funding shortfall, cost pressure from drugs moving from pass through to in tariff, agency costs associated with CAMHS support for An out of area patient and under delivery of the waste reduction programme.

To recover the YTD deficit position and deliver the breakeven plan requires a significant step up in WRP delivery across the whole programme, in line with the approved plan, alongside other mitigations.

The risk range included in the Fundamental Review considered by the Board in June detailed achievement of the breakeven plan in the best case, a deficit of £49m in the mid case and £93.7m deficit in the worst case. As part of the new regional delivery approach framework, the Trust is required to submit a monthly Provider Assurance Model (PAM) which uses a similar risk-adjusted methodology to assess the forecast outturn as the Fundamental Review. Following the Month 5 results, the PAM assessed a mid-case deficit of £41.6m and a worst-case deficit of £78.1m, both improving on the Fundamental Review, while maintaining a breakeven best-case position.

To deliver the best-case position in the latest PAM, mitigations of £22.9m are required. The majority relating to full delivery of existing waste reduction plans, including reducing worked WTE to sustainable levels. The Board will formally consider the updated Fundamental Review of the forecast this month.

The NHS oversight Framework latest published segmentation and league table based on 2026/27 Q1 financial performance gives the Trust a combined finance score of 2. The M5 YTD adverse variance to plan of £8.3m (0.9% of turnover) would be expected to result in a score of 3, with a combined finance score of 2 expected when considered with the other finance scoring metrics.

Capital & Cash Position



August 2026

Executive Owner: Jenny Ehrhardt (Chief Finance Officer)

Capital

2026/27

Whilst the Trust is working towards delivering a capital spend of £119.4m, at the end of August the approved programme is £113.8m. The difference (£5.6m), which appears an over-commitment, will be managed by slippages and potential additional PDC support as the Trust cannot spend beyond its capital allocation, the additional schemes will be ready should capital funding becomes available. In the meantime, the current approved funding allocation is as follows:

Programme	Forecast 2026/27 £'000
Medical Equipment - CDEL	7,432
DIT - CDEL	11,281
Building & Engineering - CDEL	76,177
Building the Leeds Way - CDEL	500
Leases- CDEL	4,000
Donated	9,695
PFI	4,715
Total Capital Programme	113,800

The expenditure to 31 August 2026 was £26.0m. The plan was to achieve a cumulative target of 33% (£37.9m), with a total of 40% to be delivered by September (£45.5m), with 70% being delivered by December (£79.7m). The YTD position is behind plan by £11.9m however, Capital Programme Leads are working towards achieving the 70% target by December 2026.

Capital expenditure forecasts are discussed with Programme Managers monthly together with orders raised and contracts awarded yet to be fulfilled. Progress is formally monitored each month at the Capital Planning Group and reported through the Finance & Performance Committee.

Cash

The August month end cash balance is £103.9m, a decrease of £16.4m which is £25.2m less than the M2 Fundamental Review M2 best case (£129.1m), the adverse variance is due to in year movements in working capital and timing of PDC drawdowns while capital expenditure is materialising.

Total receipts for the month amounted to £182m which included £2.9m PDC income and £4.6m for the June VAT return, which was the final opportunity to reclaim VAT relating to 25/26. The July VAT return was submitted at the end of August, with the cash due in early September (c£2m).

Total payments in month were £194m, comprising £107m for payroll and £87m for accounts payable. The accounts payables spend included £8m of capital invoices.

Bank interest of £0.3m was recognised in the month, with £1.9m for the year to date. A total of £0.019m additional interest income has been received from the investments made with the National Loans Fund to date this year, where marginally higher interest rates were offered.

The risk around availability of cash for the Trust continues to be monitored weekly within the Finance Team, and remains on the Finance team risk register, which is considered at the Risk Management Committee on a six-monthly basis. The Fundamental Review considered by the Board in June detailed year end forecast cash position projections of c£86m on delivery of the best case, reducing to £34m in the mid case (around 6 'operating days' of cash) and only £8m in the worst case. The Board will formally consider the updated Fundamental Review of the forecast this month.

Statement of Comprehensive Income



August 2026

Executive Owner: Jenny Ehrhardt (Chief Finance Officer)

	Annual Plan £m	In Month			Year to Date		
		Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Commissioner Income (excluding Non-PbR Drugs, Blood and Devices)	1,351.3	112.6	117.2	4.6	563.0	571.0	7.9
Non-PbR Drugs, Blood and Devices	394.8	32.9	31.2	(1.7)	164.5	157.9	(6.6)
Sub-Total Commissioner Income	1,746.1	145.5	148.4	2.9	727.5	728.9	1.4
Other Clinical Income	15.2	1.3	1.0	(0.3)	6.3	4.9	(1.4)
Total Clinical Income	1,761.3	146.8	149.4	2.6	733.9	733.8	(0.0)
Other Income (non Covid)	313.1	26.0	28.6	2.6	128.7	139.3	10.6
Other Income (Covid Top Up; Testing; Vaccination)	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Income	2,074.4	172.8	178.0	5.2	862.6	873.1	10.6
Pay Costs	(1,267.0)	(106.2)	(110.0)	(3.8)	(535.6)	(549.4)	(13.8)
Sub-Total Pay	(1,267.0)	(106.2)	(110.0)	(3.8)	(535.6)	(549.4)	(13.8)
Non Pay Costs (excl Non-PbR Drugs, Blood and Devices)	(418.5)	(33.7)	(39.0)	(5.3)	(175.2)	(189.1)	(13.9)
Non-PbR Drugs, Blood and Devices	(394.0)	(32.8)	(31.2)	1.6	(164.2)	(158.0)	6.2
Sub-Total Non Pay	(812.5)	(66.6)	(70.2)	(3.7)	(339.4)	(347.1)	(7.7)
Total Expenditure	(2,079.5)	(172.8)	(180.2)	(7.5)	(875.0)	(896.5)	(21.5)
EBITDA	(5.1)	0.0	(2.2)	(2.3)	(12.4)	(23.4)	(11.0)
EBITDA %			-1.3%			-2.7%	
Depreciation	(58.2)	(4.9)	(4.7)	0.2	(24.3)	(23.3)	0.9
Amortisation	(4.5)	(0.4)	(0.4)	(0.1)	(1.9)	(2.1)	(0.3)
Impairments	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Investment Revenue	3.9	0.3	0.6	0.3	1.6	2.9	1.3
Other Gains and (Losses)	0.0	0.0	0.0	0.0	0.0	(0.0)	(0.0)
Finance Costs	(24.6)	(2.1)	(1.1)	0.9	(10.3)	(13.8)	(3.5)
Dividends payable on Public Dividend Capital (PDC)	(13.9)	(1.2)	(1.0)	0.2	(5.8)	(5.2)	0.5
Retained Surplus/(Deficit) BEFORE ERF/TIF	(102.4)	(8.1)	(8.9)	(0.8)	(53.0)	(65.0)	(12.0)
Allowed Technical Adjustments							
IFRIC 12 Adjustment	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Donated Asset Adjustment/ Peppercorn Lease	(2.5)	(0.2)	0.2	0.4	(1.1)	(0.1)	0.9
Impairments	0.0	0.0	0.0	0.0	0.0	0.0	0.0
NHP Redundancy Provision	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Impact of consumables donated from other DHSC bodies	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Adjusted Surplus/(Deficit) BEFORE ERF	(104.9)	(8.3)	(8.6)	(0.4)	(54.0)	(65.1)	(11.1)
Elective Recovery Fund (ERF)	115.3	9.6	9.6	(0.0)	48.0	48.0	(0.0)
Adjusted Surplus/(Deficit) INCLUDING ERF	10.3	1.3	1.0	(0.4)	(6.0)	(17.1)	(11.1)
Adjust PFI revenue costs to UK GAAP basis	(10.3)	(0.9)	(1.9)	(1.0)	(4.3)	(1.5)	2.8
Adjusted financial performance surplus/(deficit)	(0.0)	0.5	(1.0)	(1.4)	(10.3)	(18.6)	(8.3)

Statement of Financial Position



August 2026

Executive Owner: Jenny Ehrhardt (Chief Finance Officer)

	Year to date movement			In Month	
	Closing 31st March 2026 £m	As at 31st August 2026 £m	Year to date movement £m	Prior Month £m	In-month movement £m
Non-Current Assets:					
Property, Plant And Equipment	784.0	786.1	2.1	782.7	3.4
Intangible Assets	24.2	22.8	(1.5)	23.1	(0.3)
Trade And Other Receivables	14.5	16.0	1.5	15.8	0.2
Total Non-Current Assets	822.8	824.9	2.1	821.6	3.3
Current Assets:					
Inventories	29.9	29.0	(0.9)	29.8	(0.8)
Trade And Other Receivables	94.0	100.7	6.7	96.1	4.6
Cash and Cash Equivalents	134.0	103.9	(30.1)	120.4	(16.5)
Non-Current Assets Held for Sale	0.0	0.0	0.0	0.0	0.0
Total Current Assets	257.9	233.7	(24.3)	246.3	(12.7)
Total Assets	1,080.7	1,058.6	(22.1)	1,068.0	(9.4)
Current Liabilities:					
NHS Trade Payables	(3.0)	(2.0)	1.0	(2.1)	0.1
Trade and Other Payables	(278.0)	(272.6)	5.5	(283.6)	11.0
Borrowing / DH Loans	(2.1)	(2.2)	(0.1)	(2.2)	(0.0)
Other Financial Liabilities - PFI	(23.4)	(24.2)	(0.8)	(24.0)	(0.2)
Provisions For Liabilities And Charges	(3.3)	(3.1)	0.3	(3.3)	0.3
Total Current Liabilities:	(309.8)	(304.0)	5.8	(315.2)	11.2
Net Current Assets/ (Liabilities)	(51.9)	(70.3)	(18.4)	(68.9)	(1.5)
Total Assets Less Current Liabilities	770.9	754.6	(16.3)	752.8	1.8
Non-Current Liabilities:					
NHS Trade Payables	0.0	0.0	0.0	0.0	0.0
Trade and Other Payables	0.0	0.0	0.0	0.0	0.0
Borrowings / DH Loans	(7.2)	(7.2)	0.0	(7.2)	0.0
Other Financial Liabilities - PFI	(270.3)	(268.2)	2.2	(270.3)	2.1
Provisions For Liabilities And Charges	(8.5)	(8.5)	0.1	(8.4)	(0.0)
Total Non-Current Liabilities	(286.0)	(283.8)	2.2	(285.9)	2.1
Total Assets Employed	484.9	470.8	(14.1)	466.9	3.9
Financed By Taxpayers Equity					
Public Dividend Capital	702.3	702.3	(0.0)	702.3	(0.0)
Retained Earnings	(222.0)	(239.0)	(17.0)	(239.7)	0.7
Revaluation Reserve	4.5	4.5	0.0	4.5	0.0
Total Taxpayers Equity	484.9	467.8	(17.1)	467.1	0.7



Cash Flow Statement

August 2026

Executive Owner: Jenny Ehrhardt (Chief Finance Officer)

Cash Flow	Closing 31st March 2026 £m	As at 31st August 2026 £m	Previous Month £m
<u>Operating Activities</u>			
Operating surplus/(deficit)	(16.8)	(0.8)	(3.1)
Depreciation and amortisation	56.9	25.4	20.3
Impairments and reversals	59.3	0.0	0.0
Donated assets received credited to revenue but non cash	(7.0)	(1.8)	(1.7)
Interest paid	(14.2)	(5.5)	(4.4)
Dividend paid	(9.1)	0.0	0.0
Decrease/(increase) in inventories	(0.5)	0.9	0.1
Decrease/(increase) in trade and other receivables	(22.0)	(7.0)	(2.1)
(Decrease)/Increase in trade and other payables	65.7	(0.7)	11.4
(Decrease)/Increase in provisions	(6.2)	(0.4)	(0.4)
Net cash inflow/(outflow) from Operating Activities	106.0	10.0	20.0
<u>Cash Flows from Investing Activities</u>			
Interest received	5.8	2.9	2.3
(Payments) for property, plant and equipment	(95.1)	(34.7)	(29.3)
Proceeds from disposal of property, plant and equipment	0.2	0.0	0.0
(Payments) for intangible assets	(1.2)	(0.7)	(0.6)
Proceeds from disposal of intangible assets	0.0	0.0	0.0
Receipt of cash donations to purchase capital assets	7.0	1.8	1.7
PFI lifecycle prepayments (cash outflow)	(6.8)	(3.0)	(0.4)
Net cash outflow from Investing Activities	(90.1)	(33.6)	(26.2)
Net cash inflow before Financing	15.9	(23.6)	(6.2)
<u>Cash Flows from Financing Activities</u>			
Public dividend capital received	60.5	3.0	0.0
Public dividend capital repaid	0.0	0.0	0.0
New capital investment loans	0.0	0.0	0.0
New revenue support loans	0.0	0.0	0.0
New finance lease	0.0	0.0	0.0
Other loans	0.0	0.0	0.0
Revenue support loans repaid	0.0	0.0	0.0
Capital investment loans repayment of principal and interest	(2.1)	0.0	0.0
Capital element of leases and PFI	(22.6)	(9.4)	(7.4)
Net cash inflow/(outflow) from Financing Activities	35.9	(6.5)	(7.4)
Increase/(decrease) in cash	51.8	(30.1)	(13.6)
Cash at the beginning of the year	82.2	134.0	134.0
Cash at the end of the financial period	134.0	103.9	120.4

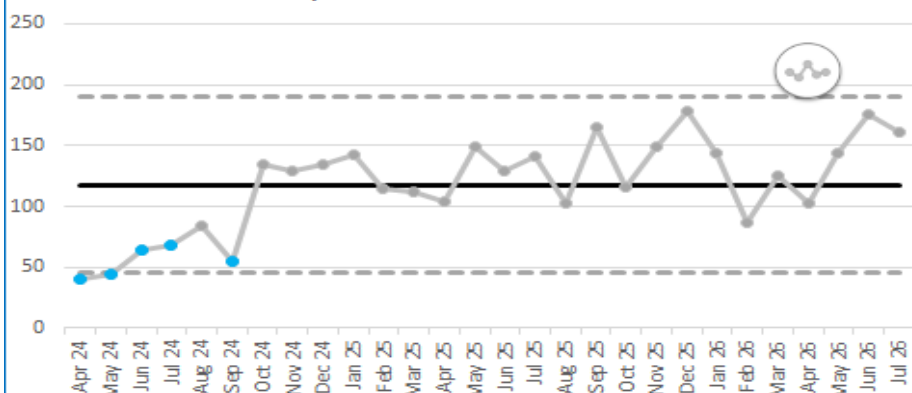
Supplementary Metrics Produced by Exception

Cancelled Ops

August 2026

No Target for LMCO- Performance – LMCO: 118
Target-28-day breaches: 0 Performance – 28-day Standard: 46

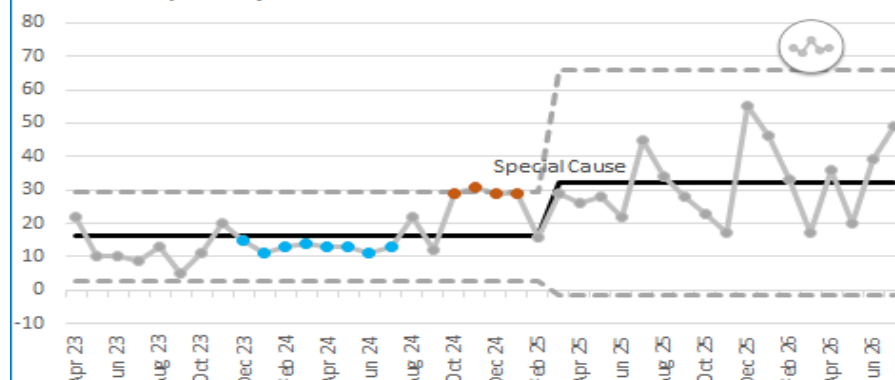
Last Minute Cancelled Ops



Executive Owner: Tim Hiles (Chief Operating Officer)

Variance: LMCO – Common cause variation.
28 day –Common cause variation

Cancelled Ops 28days



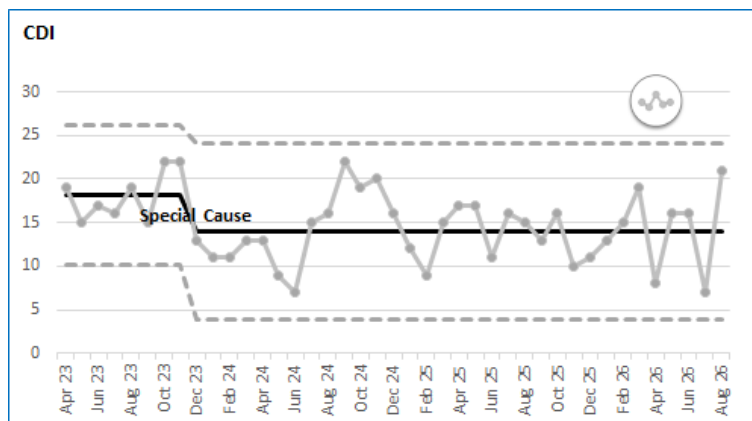
Background	Performance	Key Issues	Current Actions
Ensure all patients who have operations cancelled on the day of surgery, for non-clinical reasons are offered another binding date to be treated within a maximum of 28 days (zero tolerance standard)	Cancelled Operations 118 LMCO in August 2026. - Cancellation reason 'Ran out of theatre time' equated to 41% of the total non-clinical LMCO on-the-day 28 Day Breaches - There were 46 breaches of the 28-day standard in August 2026 which is a decrease from July. This is above the zero tolerance standard - Ranked 78th out of 118 Trusts for Q1	LMCO and 28-day breaches are due to: - Bed pressures - Critical care capacity - Risk that as more patients are added to lists to improve theatre utilisation more on-day cancellations may occur which may be challenging to rebook within 28-days.	- Pre-op questionnaire designed to screen if patients still require surgery and if they are currently fit – planned August launch has been delayed due to PPM+ issues. Pre-assessment outcome form to be available in PPM+ - Increasing telephone pre-assessment capacity at CAH - Process to identify standby patient lists to minimise and replace last minute cancelled ops in urology, ENT, plastics, vascular and Paeds - Reinforcement of 'first-start' principles in adult cardiac surgery, in combination with an improved critical care position, has seen non-clinical cancellation in cardiac surgery drop from 12 in April & May to 2 in July and August - New OSA wearable tech being implemented in H&N to reduce number of patients cancelled for no HOBs/HDU bed - TRS HOBs temporarily expanded from 6 to 8 beds in August and September. There have been no reported cancellations for HOBs capacity reported during this period. - Re-launch of 6-4-2 underway to reduce short notice and on-day cancellations for workforce gaps

Supplementary Metrics NHS Oversight Framework

CDI

August 2026

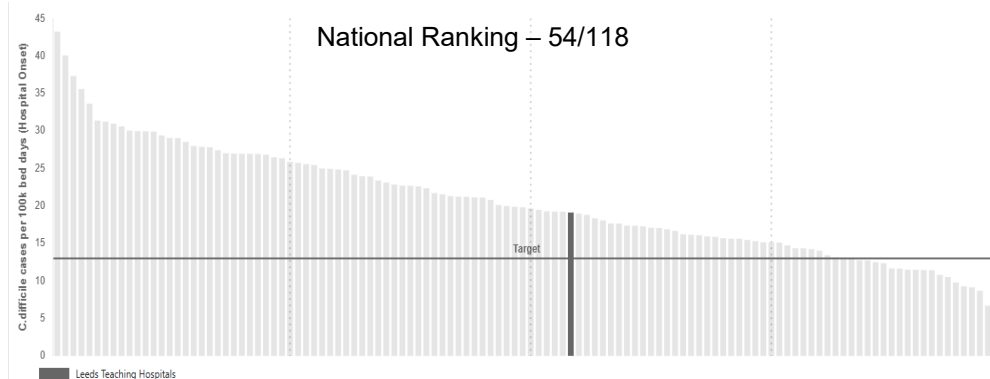
Target:
Performance: 21



Data as at 09/09/26

Executive Owner: Elizabeth Garthwaite , Chief Medical Officer and Director of
Infection Prevention & Control

Variance: Common cause variation. The process will regularly achieve the target



Data Source: Fingertips

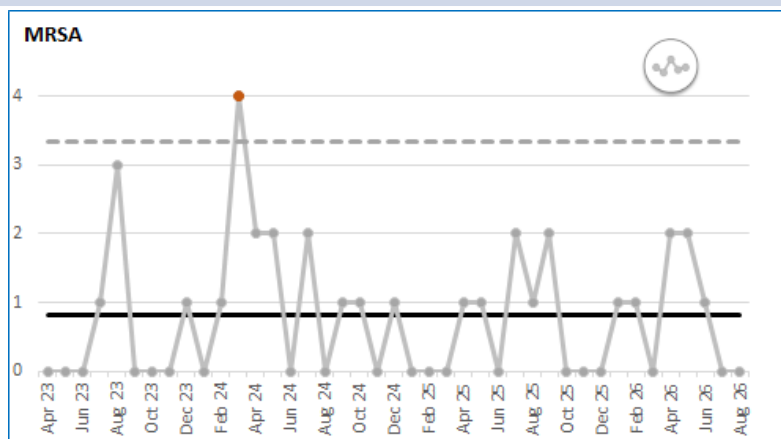
Data Period: June 2026

Background	Context	Action
NHS Standard Contract 2026/27: Minimising Clostridioides difficile and Gram-negative bloodstream infections providing threshold levels set by NHS England was issued 20 July 2026. LTHT is currently working with CSUs to agree individual thresholds.	- The SPC chart demonstrates a drop in the number of cases below the mean. The number of cases for July 2026 is 7. - National comparator Hospital Onset data from May shows LTHT's position remaining in the third quartile ranked 49 out of 118 NHS Trusts, which is a deterioration from our previous position of 45. - This ranking accounts for infection rates based	- The Trust continues to monitor antimicrobial prescribing as a control measure for CDI using #CARES, and adoption of this tool continues to increase slowly across the organisation - Delayed and inappropriate sampling is a theme in PSIRF review meetings in a number of CSUs; educational resources have been shared, and CSUs are leading specific responses to this to improve compliance with LTHT guidance.

MRSA

August 2026

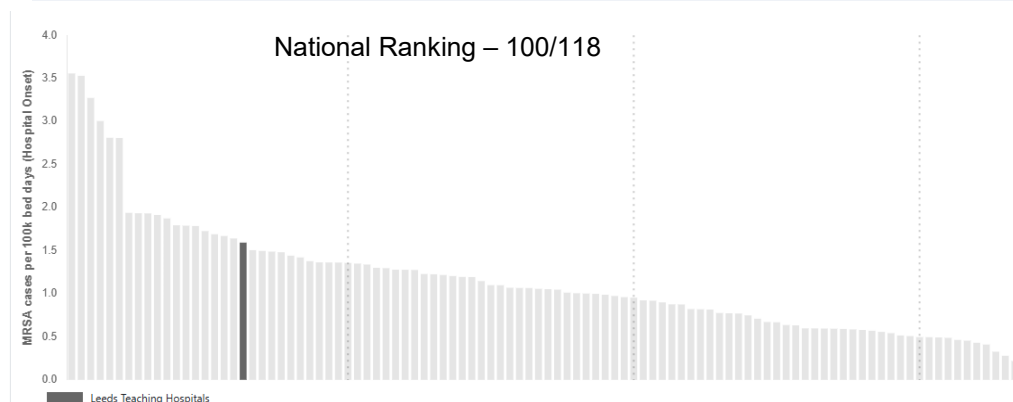
Target:
Performance: 0



Data as at 09/09/26

Executive Owner: Elizabeth Garthwaite, Chief Medical Officer and Director of Infection Prevention & Control

Variance: Common cause variation. The process will regularly achieve the target



Data Source: Fingertips

Data Period: June 2026

Background	Context	Action
- There is a National 'zero tolerance' approach to MRSA bloodstream infections - National MRSA bacteraemia incidence has increased year on year since 2020 (lowest rates were seen during the COVID-19 pandemic); this is accounted for by increases in both healthcare-associated and community cases.	- The SPC chart shows LTHT has recorded 0 cases in July 2026 against a zero-tolerance approach. - National comparator Hospital Onset data from May shows LTHT's position remaining within the first quartile of the table and is ranked 100 out of 118 NHS Trusts with no change to the previously recorded position.	- Weekly monitoring of MRSA positive patients used to support safe patient placement and identify areas that need additional support - Instigation of an MRSA working group led by Medical and Nursing Director to urgently review the Trust-wide MRSA strategic response, including, screening, decolonisation and devices. - Device management and aseptic practice

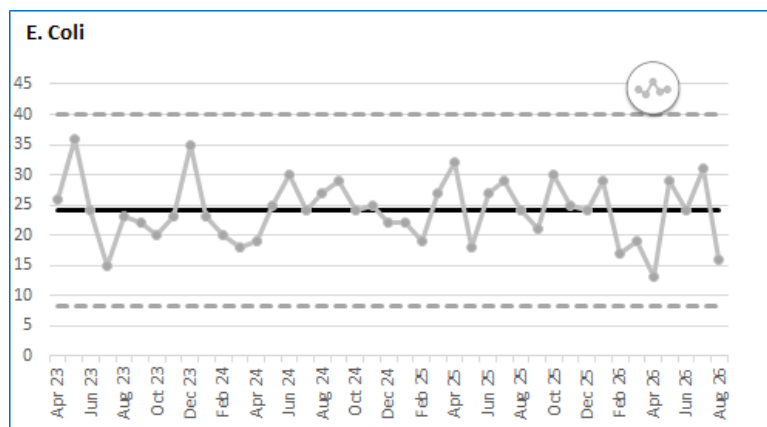
E. Coli

August 2026

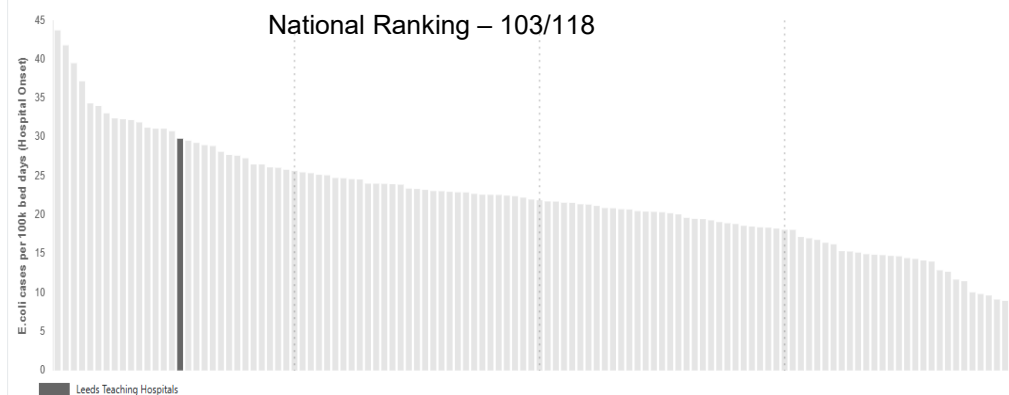
Target:
Performance: 16

Executive Owner: Elizabeth Garthwaite , Chief Medical Officer and Director of Infection Prevention & Control

Variance: Common cause variation. The process will regularly achieve the target



Data as at 09/09/26



Data Source: Fingertips

Data Period: June 2026

Background	Context	Action
NHS Standard Contract 2026/27: Minimising Clostridioides difficile and Gram-negative bloodstream infections providing threshold levels set by NHS England was issued 20 July 2026. LTHT is currently working with CSUs to agree individual thresholds.	- The SPC chart shows an increase in cases above the mean. The number of E. coli cases for July 2026 is 31. - National comparator Hospital onset data from May shows LTHT's position remaining within the first quartile of the table and is ranked 105 out of 118 NHS Trusts, which is a deterioration on the previously recorded position of 102.	- The preventing urinary sepsis group continues to meet monthly using a dyad model. Actions include: - Establish a laboratory group- diagnostics and lab process - Presentation of literature on catheter associated UTI and Gram-negative bacteraemias with completed actions re prescribing - Presentation of trust-wide catheter device

Appendix – A Guide to SPC

Statistical process control (SPC) is an analytical technique that plots data over time. It helps us understand variation and in so doing guides us to take the most appropriate action.

- If the target line is above the upper process limit you cannot expect to hit the target; doing so would represent a highly unusual occurrence as approximately 99% of values fall within the process limits
- Reset triggers (e.g. run of points above/below mean) set at 7 data points for Monthly however you need to first question the system, understand the cause and then only if, working with others, you're sure there's a new system, redraw the mean and limits from the point the new system was introduced.
- Baseline period (for setting mean & control limits) to be set at 12 data points for Monthly
- Baseline reset rules are only applied after the baseline period
- Whenever a data point falls outside a process limit (upper or lower) something unexpected has happened because we know that 99% of data should fall within the process limits.
- A run of values above or below the average (mean) line represents a trend that should not result from natural variation in the system. When more than 7 sequential points fall above or below the mean that is not deemed to be natural variation and may indicate a significant change in process. This process is not in control.
- When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process.

Appendix – A Guide to SPC

Variation			Assurance			
						
Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or higher pressure due to (H)igher or (L)ower values	Common cause - no significant change	'Pass' Variation indicates consistently - (P)assing of the target	'Hit and Miss' Variation indicated inconsistency - passing and failing the target	'Fail' Variation indicates consistently - (F)ailing of the target	Data Currently unavailable or insufficient data points to generate SPC

Special Cause Concern - this indicates that special cause variation is occurring in a metric, with the variation being in an adverse direction. Low(L) special cause concern indicates that variation is downward in a KPI where performance is ideally above a target or threshold e.g. ED or RTT Performance. (H) is where the variance is upwards for a metric that requires performance to be below a target or threshold e.g. Pressure Ulcers or Falls.

Special Cause Concern - this indicates that special cause variation is occurring in a metric, with the variation being in a favourable direction. Low (L) special cause concern indicates that variation is upward in a KPI where performance is ideally above a target or threshold e.g. ED or RTT Performance. (H) is where the variance is downwards for a metric that requires performance to be below a target or threshold e.g. Pressure Ulcers or Falls.

Glossary

Full Name	Abbreviation
Associate Director of Operations	ADOP
Abdominal Medicine & Surgery	AMS
Better Payments Practice Code	BPP
Building the Leeds Way	BtLW
Cancer 2 Week Wait	Cancer 2WW
Clostridioides difficile	CDI
Chief Operating Officer	COO
Care Quality Commission	CQC
Clinical Service Unit	CSU
Cancer Wait Time	CWT
Did Not Attend	DNA
Director of Operations	DOPs
Emergency Care Standard	ECS
Emergency Department	ED
Faster Diagnosis Standard	FDS
First Definitive Treatment	FDT
General Practitioner	GP
Human Resources	HR
Health Safety Investigation Branch	HSIB
Hospital Standard Mortality Rate	HSMR
Integrated Care Board	ICB
International Financial Reporting Standards	IFRS
Key Performance Indicators	KPI
Leeds General Infirmary	LGI
Last Minute Cancelled Operations	LMCO
Length of Stay	LoS
Leeds Teaching Hospitals NHS Trust	LTHT

Full Name	Abbreviation
Multidisciplinary Team	MDT
Motor neurone disease	MND
Maternity & Newborn Safety Investigations	MNSI
Methicillin-resistant Staphylococcus aureus	MRSA
NHS England	NHSE
Plan, Do, Study, Act	PDSA
Patient Initiated Mutale Aid	PIDMAS
Personalised People Management	PPM
Patient Safety Incident Investigation	PSII
Right procedure right place	RPRP
Referral to Treatment	RTT
Service Delivery Accountability Meetings	SDAM
Same Day Emergency Care	SDEC
Summary Hospital Mortality Indicator	SHMI
Specialty & Integrated Medicine	SIM
Structured Judgement Review	SJR
St James University Hospital	SJUH
Statistical Process Control	SPC
National Strategic Information System	StEIS
Trauma Related Services	TRS
Venous thromboembolism	VTE
Waste Reduction Programme	WRP
West Yorkshire Association of Acute Trusts	WYAAT
Yorkshire Ambulance Service	YAS
Year to Date	YTD

Sub Groups	Abbreviation
Finance & Performance	F&P
Quality Assurance Committee	QAC
Quality Safety & Assurance Group	QSAG
Clinical Effectiveness & Outcomes Group	CEOG
Patient Experience Sub-Group	PESG
Mortality Improvement Group	MIG
Quality Improvement Steering Group	QISG