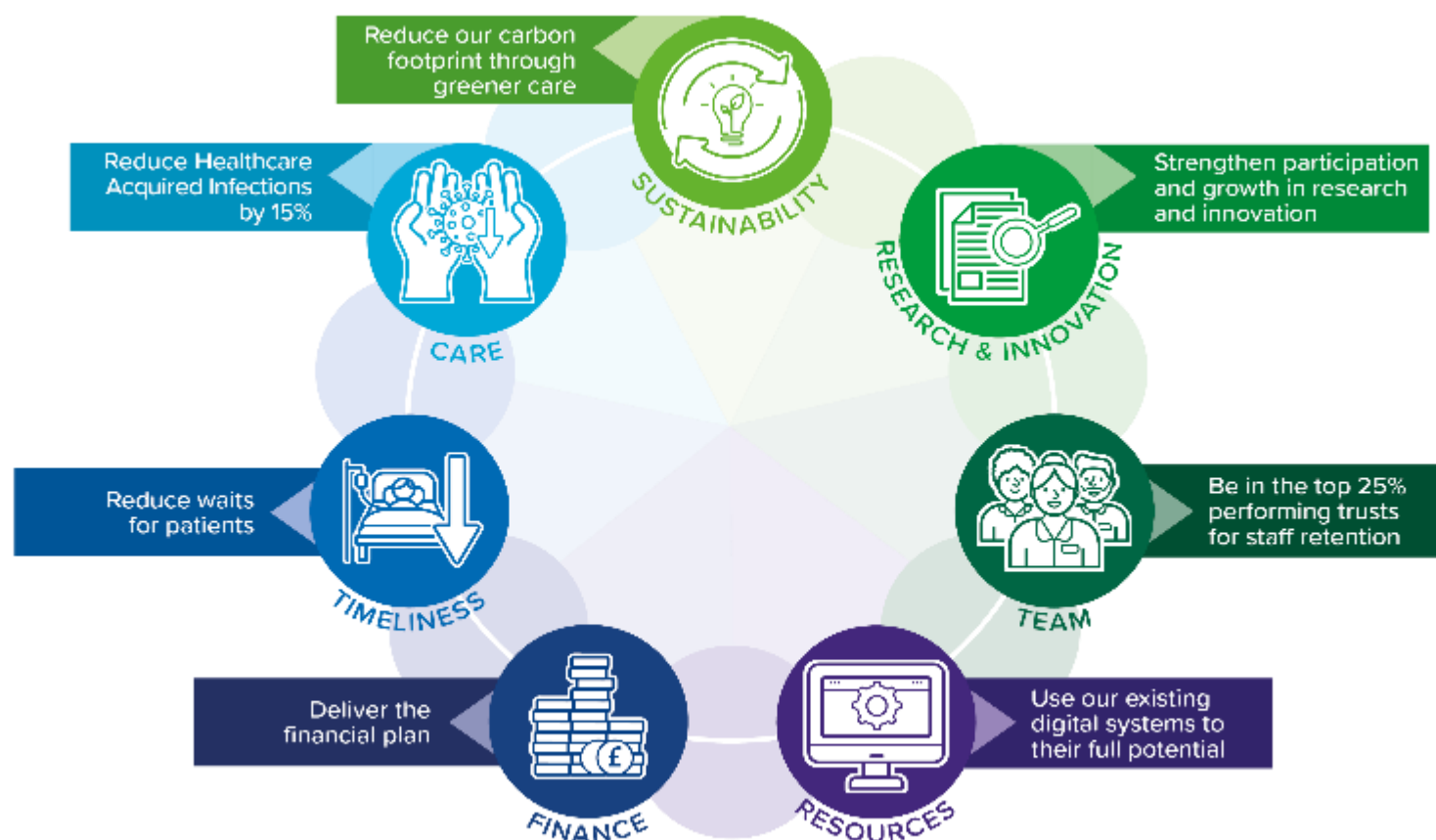


Integrated Quality & Performance Report

January 2025

C7 Commitments



Summary - Performance

Performance

KPI	Latest month	Performance	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
AE Attendances per day	Dec 24	997.8	-			937.2	805.6	1068.8
Ambulance Handovers <15mins LGI	Dec 24	00:16:56	00:15:00			00:14:21	00:12:20	00:16:22
Ambulance Handovers <15mins SJUH	Dec 24	00:24:52	00:15:00			00:19:02	00:15:54	00:22:11
Last Minute Cancelled Ops	Dec 24	134	-			63	29	97
Cancelled Ops 28days	Dec 24	29	-			16	2	30
Cancer 28day FSD	Nov 24	79.4%	75.0%			73.3%	66.7%	79.9%
Cancer 31day	Nov 24	85.9%	96.0%			87.2%	80.5%	93.9%
Cancer 62 day	Nov 24	61.2%	85.0%			55.9%	43.7%	68.1%
Diagnostics	Dec 24	85.0%	95.0%			93.8%	90.8%	96.8%
DNA Rate	Dec 24	7.20%	-			6.92%	4.23%	9.62%
Outpatient DNA Volumes	Dec 24	7485	-			8653	6528	10778
ECS Monthly	Dec 24	73.2%	78.0%			74.5%	69.8%	79.2%
Elective LoS	Dec 24	4.7	-			4.1	3.1	5.1
Elective Readmissions	Dec 24	2.70%	-			3.65%	2.50%	4.80%
Non- Elective LoS	Dec 24	7.4	-			7.4	6.6	8.2
Non- Elective Readmissions	Dec 24	8.90%	-			10.88%	9.13%	12.64%
OPFU3months	Dec 24	34964	-			35894	33762	38025
RTT Performance	Dec 24	64.8%	92.0%			63.3%	61.4%	65.3%
RTT Total Waiting list	Dec 24	86043	-			90981	88239	93724
RTT 65 Week Breach Backlog	Dec 24	132	0			781	475	1087
RTT 78Week Breach Backlog	Dec 24	2	0			68	-9	146



Quality Metrics

KPI	Latest month	Performance	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
VTE	Nov 24	97.1%	95.0%			94.8%	92.5%	97.2%
CDI	Dec 24	16	-			14	7	22
MRSA	Dec 24	1	-			1	2	3
E. Coli	Dec 24	22	-			25	9	41
Pseudomonas	Dec 24	2	-			4	-2	9
Klebsiella spp	Dec 24	11	-			12	2	21
Patient Level Metrics Score	Dec 24	96.6%	90.0%			94.6%	92.7%	96.6%
Environment Level Metrics Score	Dec 24	95.1%	90.0%			93.8%	91.7%	95.8%
Falls	Dec 24	188	-			195	162	228
Falls Rate per 1000 Bed Days	Dec 24	3.33	-			3.46	2.99	3.93
Developed Pressure Ulcers	Dec 24	63	-			55	39	71
Developed Pressure Ulcer Rate	Dec 24	1.12	-			0.99	0.77	1.21
Admitted with Pressure Ulcers	Dec 24	339	-			306	253	359
Admitted with Pressure Ulcers Rate	Dec 24	6.01	-			5.50	4.42	6.57
2222 Calls	Dec 24	63	-			58	35	81
Cardiac Arrest Calls	Dec 24	17	-			16	6	27
SHMI	Jan 25	112.5	100.0			112.1	110.7	113.5
Still Births	Dec 24	3.93	5.20			4.32	3.68	4.97
Rolling Extended Perinatal mortality rate (all NND)	Dec 24	9.03	-			9.63	8.94	10.32
Number of MNSI Referrals	Dec 24	3	-			1	-1	4
% Complaint Responses Sent Within Target Times (LR1 let	Dec 24	45.3%	80.0%			32.3%	12.9%	51.7%
% CSU Draft Comments Received Within Target Times (LR	Dec 24	50.8%	80.0%			44.9%	26.3%	63.5%
Median Response Lead Time (Days)	Dec 24	45	-			53	36	71
Defect Rate	Oct 24	2.65%	15.00%			9.55%	#N/A	#N/A
PALS Concerns - % Patients contacted in 2 w/days	Dec 24	84.6%	80.0%			79.7%	73.7%	85.8%



Core Metrics

Measure	Commitment	Reporting Period	Performance	Target	Variance	Assurance
Rolling Overall Sickness Rate	Deliver the Financial Plan	Nov-24	5.09%	4.90%		
Rolling Voluntary Turnover Rate	Retention	Nov-24	6.02%	5.77%		
In-Month Agency Spend (as % of total pay bill)	Deliver the Financial Plan	Nov-24	0.56%	3.70%		
In-Month Vacancy Percentage	Retention	Nov-24	3.10%	N/A		
In-Month Mandatory Training Compliance Rate	Retention	Nov-24	88.60%	80.00%		
Quarterly Pulse Survey Engagement Score	Retention	Jul-24	6.5	7		
Annual Staff Survey						
Annual Staff Survey Engagement Score	Retention	24/25		7.2		
Annual Staff Survey Response Rate	Retention	24/25		65%		
Annual Response - Unlikely to look for a new job in the next 12 months	Retention	24/25		Statistically Significant Improvement		
Annual Response - Satisfied with opportunities for flexible working patterns	Retention	24/25		Statistically Significant Improvement		



Core Metrics

Ambulance Handover

Reduce waits
for patients



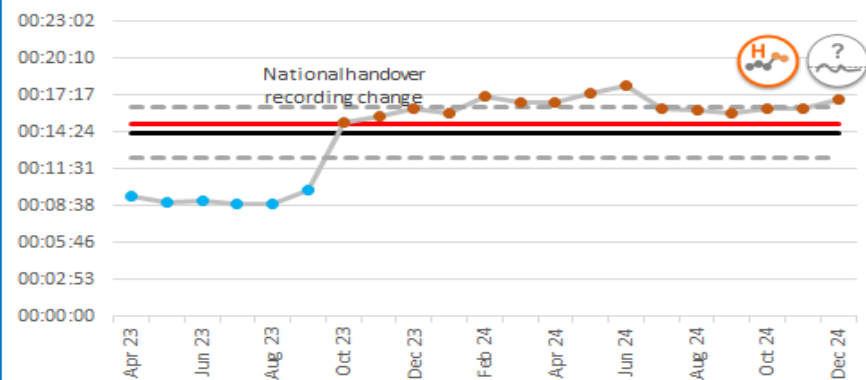
December 2024

Target: <15mins

Performance – LGI : 00:16:16

Performance – SJUH : 00:24:52

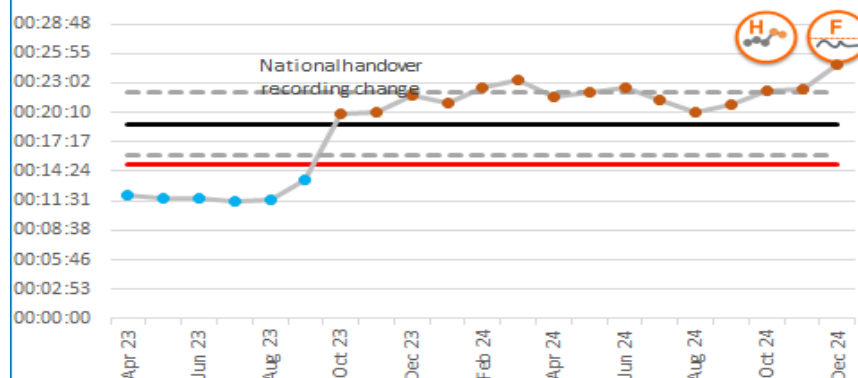
Ambulance Handovers <15mins LGI



Executive Owner: Clare Smith (Chief Operating Officer)

Variance: Special cause variation.

Ambulance Handovers <15mins SJUH



Background	Context	Action
<p>Background / target description:</p> <ul style="list-style-type: none"> 95% of all handovers should take place within 15 minutes Planning guidance target to improve CAT 2 response times to an average of 30 minutes 	<ul style="list-style-type: none"> Increase in recorded ambulance handover times due to reporting changes made in October 2023. This has added 5-8 minutes onto LHTT handover times Handover data is managed by YAS and submitted directly to NHSE. There is no in flow data accuracy corrections made by YAS LGI – In December 2024 there were 1613 handovers under 15 minutes (56.1%). Average handover time at LGI was 16:56 minutes SJUH - In December 2024 there were 992 handovers under 15 minutes (25.7%). Average handover time at SJUH was 24:52 minutes Out of 183 hospitals LGI placed 14th in the country and SJUH placed 62nd for ambulance handover times 	<ul style="list-style-type: none"> Data quality concerns raised with YAS at the WYAAT UEC group along with sharing of best practice Working with YAS to introduce breach validation and accurate recording of handovers recorded as over 1 hour HALO reintroduced until end of March 2025. Will focus on 'fit to sit', self-handover, alternative pathways to avoid A&E attendance and in flow validation of handovers over 45 minutes SJUH PDSA of cubicle management to support flow for timely handovers YAS right site pathway work to ensure patients from a care home setting are brought to the correct department Plan to implement a YAS WiFi to resolve signal issues at St James's to improve timeliness of recording of handover times Working as a West Yorkshire UEC director group to deliver a standard approach to ambulance handover actions, escalations and requests for diverts through the West Yorkshire UEC network

Emergency Care Standard

Reduce waits
for patients



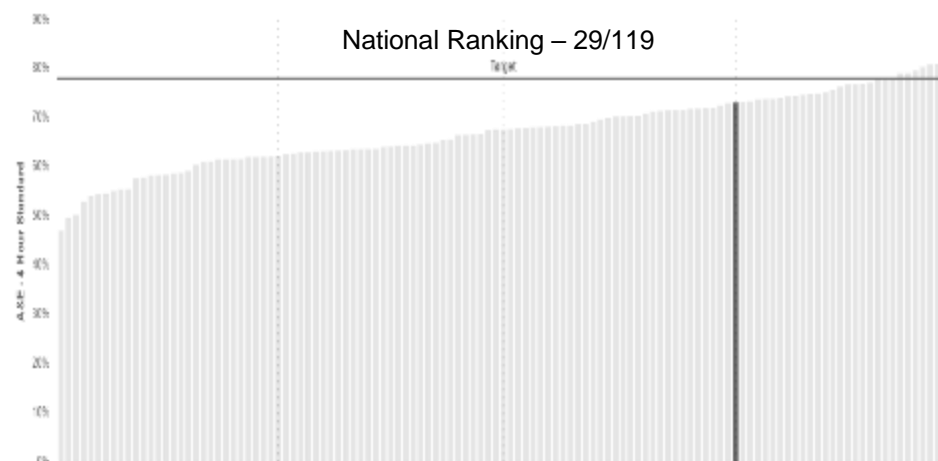
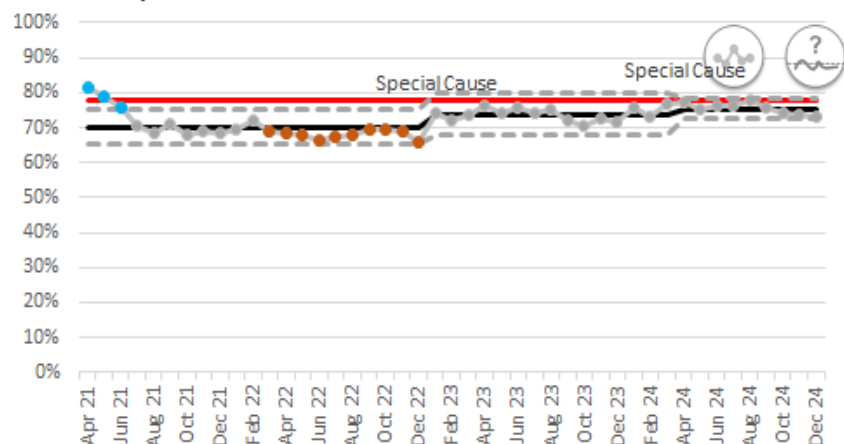
December 2024

National Planning Priority Target 2024/25: 78%
Performance: 73.2%

Executive Owner: Clare Smith (Chief Operating Officer)

Variance: Common cause variation. Hit and Miss variation indicated

ECS Monthly

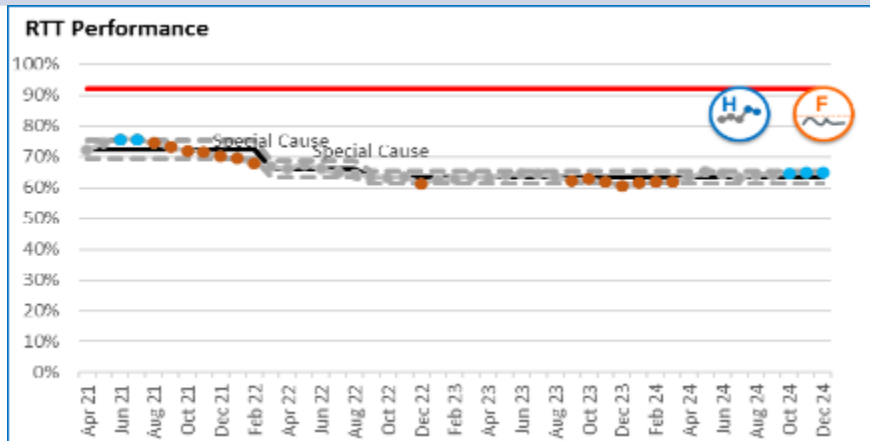


Background	Context	Action
<ul style="list-style-type: none"> The constitutional standard is for 95% of attendees to A&E being admitted, transferred or discharged in 4 hours The 2024/25 national planning recovery requirement is to deliver 78% by March 2025 For July, August, September, October and December LTHT has delivered the national planning submitted trajectory. 	<ul style="list-style-type: none"> ECS delivery for December 2024 was 73.2% against the plan to deliver 73% National average ECS was 68.2% for December 2024 LTHT ranked 29th out of 119 Trusts for ECS performance in December 2024 Out of 10 peers, LTHT had the second highest volume of attendances and was second for ECS delivery for December 2024 Attendances across all sites in December 2024 increased by 7.2% compared to December 2023 	<ul style="list-style-type: none"> Extended observation unit at SJUH A&E will be permanently open from February 2024. This enables patients to leave A&E within the 4-hour timeframe Pathways are being developed for MSAA and LGI SDEC to build on test of change run in 2024. This has enabled increased numbers of patients being treated through this service Embedding benefits of 'Making Every Day Count' across inpatient bed base Golden patient discharges by 10am support increased focus on discharge by 12pm to decongest A&E Continuation 'Outcome Orange' campaign to review patients entering third hour in A&E to support timeliness of care and deliver ECS Month on month improvement plan for minor illness primary care stream at both sites. December 2023 average was 35 patients daily with December 2024 having an average of 42 patients daily



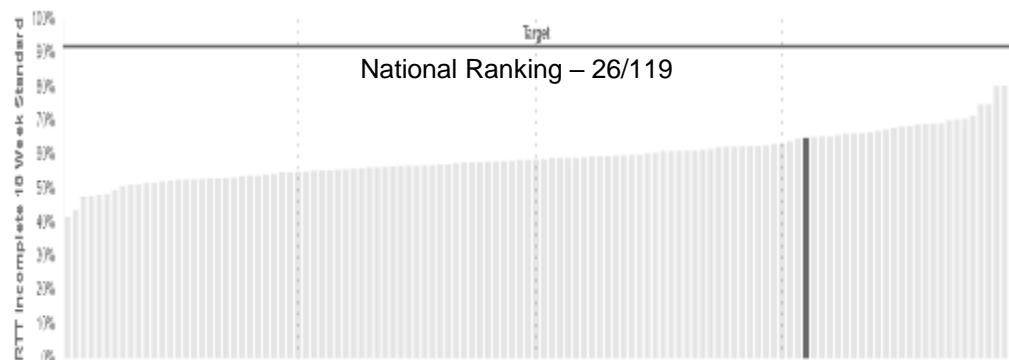
December 2024

Target: 92%
Performance: 64.8%



Executive Owner: Clare Smith (Chief Operating Officer)

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



Background	Context	Action
<ul style="list-style-type: none"> The constitutional standard is to ensure 92% of patients are treated within 18 weeks of referral 2024/25 national planning guidance requires Trusts to reduce maximum waiting times to below 65 weeks by end of September 2024 	<ul style="list-style-type: none"> The December 2024 total waiting list was reported as 86,041, a reduction of 168 from the November 2024 position of 86,209 and a reduction of 5,898 from the April 2024 position The waiting list has reduced in size for 7 consecutive months The number of patients waiting over 78 weeks decreased by 4 in December 2024 to 2 The number of patients waiting over 18 weeks was 30,311 for December 2024. National ranking is 26 out of 119 putting LTHT in top quartile of acute and combined trusts (November 2024) 	<ul style="list-style-type: none"> Outpatient transformation/GIRFT Further Faster programme continues to identify opportunities for improved clinic utilisation, follow-up and DNA reductions to maximise non-admitted capacity Theatre productivity work is delivering improvements in utilisation and cases per list with improved productivity. Development of high volume low complexity lists for elective orthopaedic lists at Chapel Allerton, Urology and Vascular Surgery at Wharfedale Reduction in non-admitted waits will need to be matched with elective inpatient activity growth to reduce overall waiting times for those requiring treatment Activity to further recover will be included in annual planning for 2025/26

Reduce waits
for patients

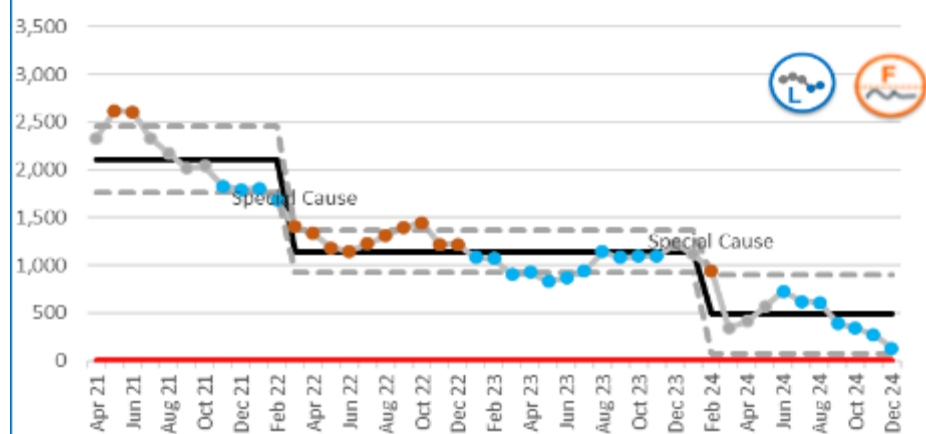


RTT 65 Weeks

December 2024

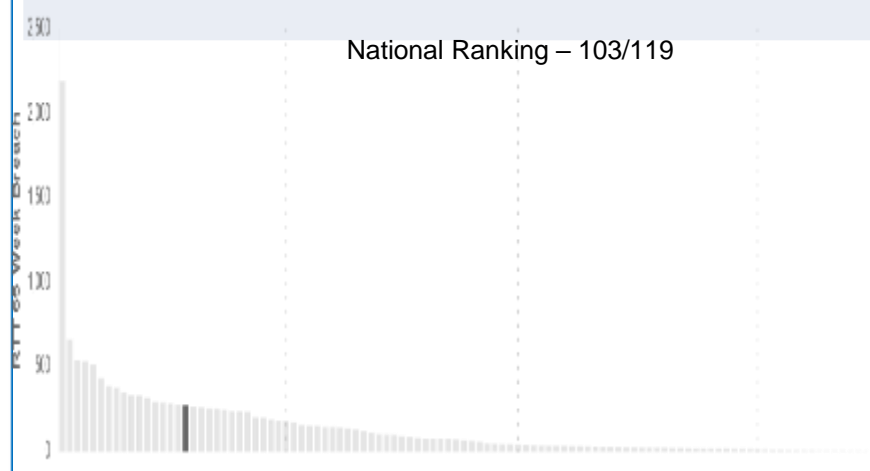
National Planning Priority Target 2024/25: 0
Performance: 132

RTT 65 Week Breach Backlog



Executive Owner: Clare Smith (Chief Operating Officer)

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



Background	Context	Action
<ul style="list-style-type: none"> Planning guidance for 2024/25 has set a target for Trusts to eliminate any remaining waits above 65 weeks by September 2024 	<ul style="list-style-type: none"> December 2024 saw the number of patients waiting 65 weeks reduce from 274 in November 2024, to 132 for December 2024 65 weeks highest point was in May 2021 when there were 2,618 patients Our national ranking is 103rd out of 119 Trusts Trust placed into NHSE's Tier 1 of escalation based on absolute numbers of patients over 65-weeks (not % of waiting list) Some elective cancellations to support unplanned care flows 	<ul style="list-style-type: none"> Mutual aid discussions take place across WYAAT every 2 weeks delivering some support Fortnightly Tier 1 meetings with ICB and NHS E and progress on clearance of 65 week waiting patients against CSU trajectories reviewed by Directors of Operations with CSUs each week IS capacity that can be delivered at tariff to support specialties with long waits Reallocation of theatre capacity and outpatient clinic capacity in key specialties Continued focus on CSU validation of RTT pathways to identify missed clock stops and highlight next steps in patient pathways Trajectory agreed with NHSE as follows: <ul style="list-style-type: none"> - Jan 91, Feb 36, Mar 0 Challenge in some CSUs to date all long-waits in January due to the high rate of deferral for treatment over Christmas period

Cancer 28 Day Faster Diagnostic

Reduce waits
for patients



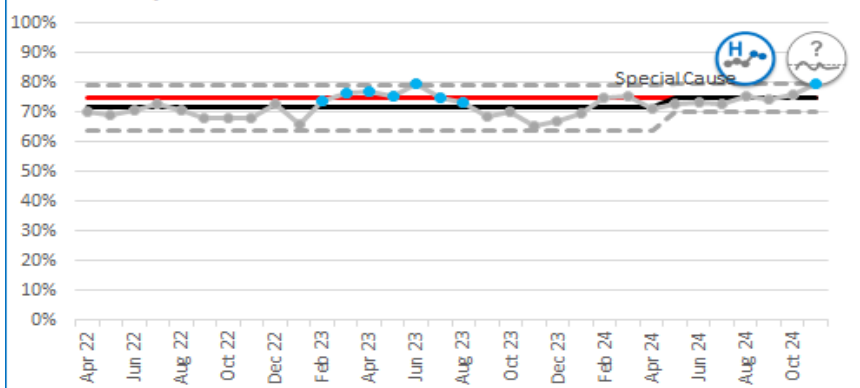
November 2024

Target: 75%
Performance: 79.4%

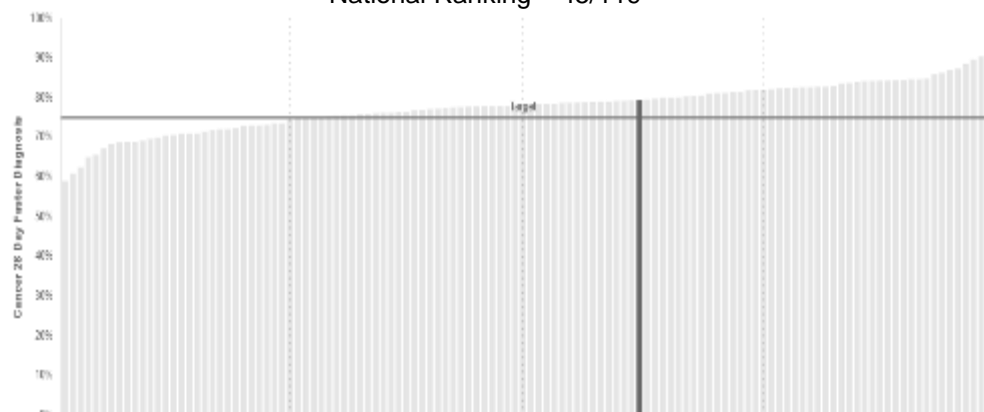
Executive Owner: Clare Smith (Chief Operating Officer)

Variance: Special Cause improving variation. Hit and Miss variation indicated

Cancer 28day FSD



National Ranking – 45/119



Background	Context	Action
<ul style="list-style-type: none"> Patients should not wait more than 28 days from referral to finding out whether they have cancer The current target is that by March 2025, the % of patients being notified of their cancer status by day 28 is 77% In April 2024 deliver was 71.4% 	<ul style="list-style-type: none"> Significant improvement in the delivery of the 28-day FDS in November 2024 (outside control limits) to 79.4%, compared with September, 75.7% Head and Neck improved from 41.87% in October to 70.8% in November with further improvement expected in December Pathways with biggest challenges in delivery of the 28 Day FDS standard are Gynae (64.2%), Prostate (64.2%), and NSS (58%) 3389 out of 4275 patients were informed of their diagnosis within 28 days 	<ul style="list-style-type: none"> Plans to improve the timeliness of prostate biopsies in Radiology outlined in the Radiology Improvement Plan are reviewed at the diagnostics and cancer escalation meetings The newly implemented triage system in Gynae is working well and is showing further improvements in December The non-specific symptoms pathway is a complex one for patients requiring a broad spectrum of assessment and diagnostics before they are either discharged or moved to the relevant cancer pathway with a diagnosis. Mapping this pathway has been completed and support with improvement and escalation processes has commenced with the CCT NHSE are providing support to review breast pathway from Feb 2024

Cancer 31 day

Reduce waits
for patients



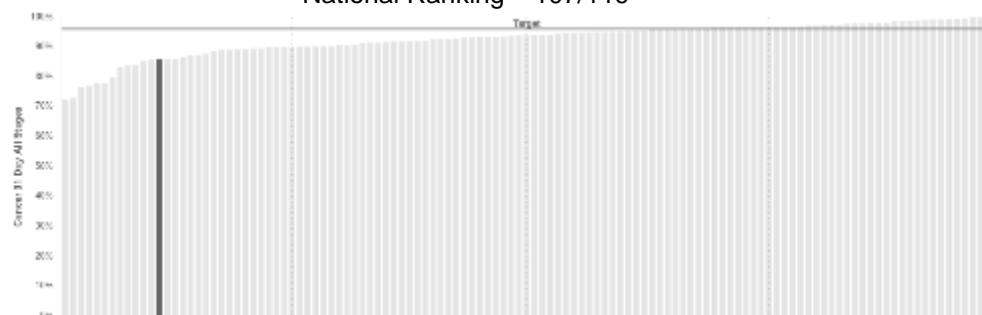
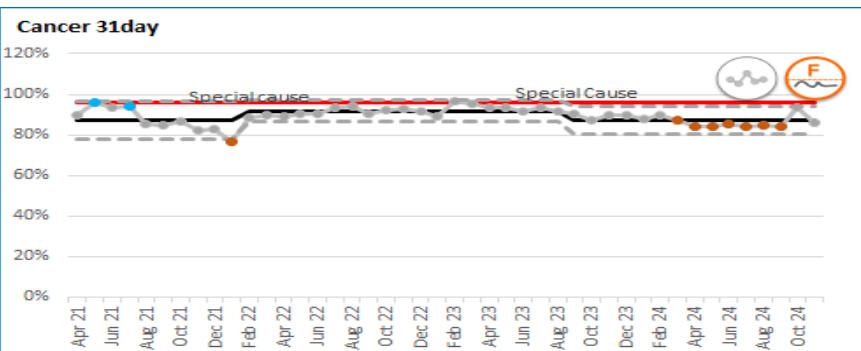
November 2024

Target: 96%
Performance: 85.9%

Executive Owner: Clare Smith (Chief Operating Officer)

Variance: Common cause variation. The process will fail to achieve the target more often than it achieves it.

National Ranking – 107/119



Background	Context	Action
<ul style="list-style-type: none"> 96% of patients should receive their treatment within 31 days This includes patients receiving both first and subsequent Cancer treatments 	<ul style="list-style-type: none"> Overall performance for 31 days is 85.9% 100% of patients receiving chemotherapy are treated within 31 Day from decision to treat Surgical performance in November was: First – 90% Subs – 86.4% Radiotherapy waits First – 83.5% Subs – 74.7% 	<ul style="list-style-type: none"> PTL format amended in the New Year to assess milestone performance with review of all booked surgical breaches in 31 and 62 day standards and appropriate escalation Activity requirements for each pathway to achieve 31-days is being agreed with the CSU's, with a trajectory for improvement to follow Escalation meetings for 2025 to focus on CSU's underachieving individual standards (28, 31 and 62 days), as well as radiotherapy, pathology and radiology separately RT performance significantly improved and delivering against trajectory. Further improvement required for 31 days subs and Cat C and D patients who are awaiting subsequent treatments Pathway Navigator pilot in RT to assess improvements in tracking and booking

Cancer 62 Days

Reduce waits
for patients



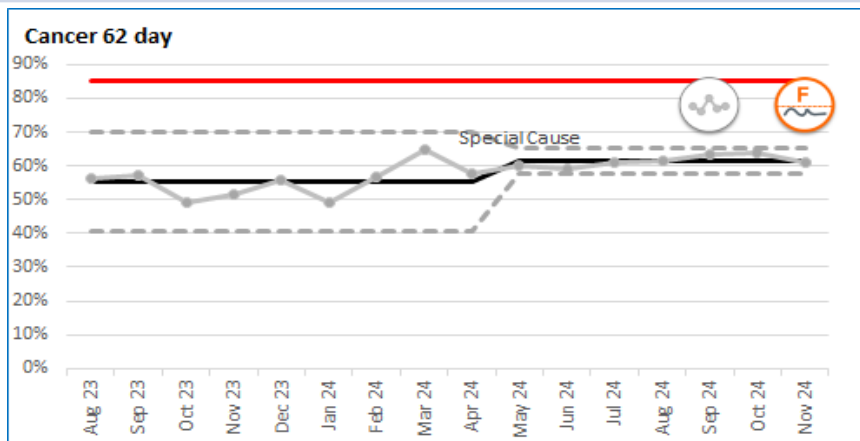
TIMELINESS

November 2024

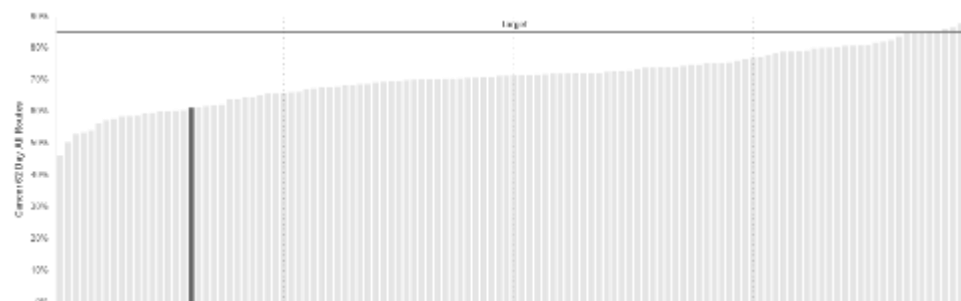
Target: 85%
Performance: 61.2%

Executive Owner: Clare Smith (Chief Operating Officer)

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



National Ranking – 102/119



Background	Context	Action
<ul style="list-style-type: none"> The constitutional standard is that 85% of patients receive their first definitive treatment for cancer within 62 days of a referral for suspected cancer 2024/25 national planning guidance is an expectation from NHSE that all systems will achieve 70% by March 2025 62-day backlog for 2024/5 is planned to achieve 6% or less of the total patient numbers on a CWT pathway 	<ul style="list-style-type: none"> 242.5 of 396, or 61.2% of patients with cancer were treated within 62 days in November 2024 The Trust is delivering against its trajectory for the year, although improvement is required to achieve the year end standards This includes all GP referrals, screening and upgrades The backlog at the end of December was 259, a slight increase in numbers which is normal at this time of year 	<ul style="list-style-type: none"> Cancer Escalation meetings remain in place to support and challenge pathways that are not delivering against their trajectory for the year. In 2025 reviews will take place with CSU's supporting all pathways delivering below 50% The Pathology task and finish group continues to develop improvement plans and will be focussing on patients having resections as well as biopsies to ensure that all cancer treatments are recorded as quickly as possible Pathology production boards and attendance at PTL meetings have supported prioritisation of samples for patients on cancer pathways A pathway navigator is being recruited for the rarer cancer pathway patients so that every patient is being closely tracked. PTL's are now produced for the rare cancers each week Funding for additional support for a radiologist to improve biopsy waiting times has been approved by the cancer alliance Pathology have a new pathologist to help with the head and neck, and gynae TATs The Gynae position may deteriorate slightly while the CSU clears the backlog

Diagnostic Waits

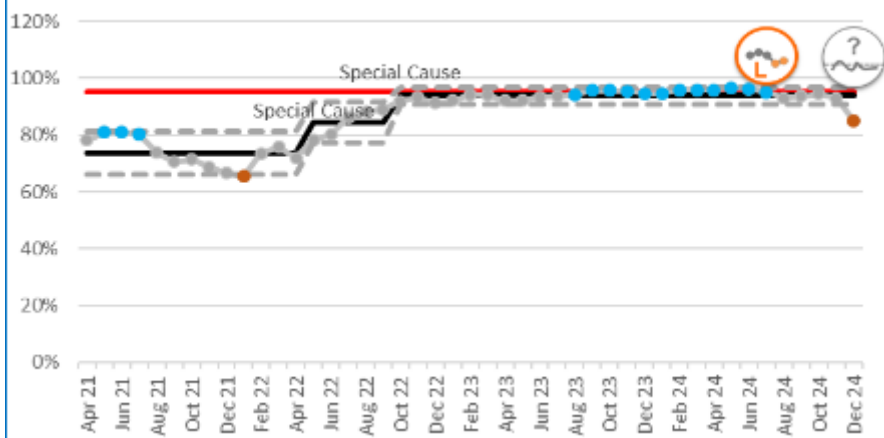
Reduce waits
for patients



December 2024

Target: 95%
Performance: 84.99%

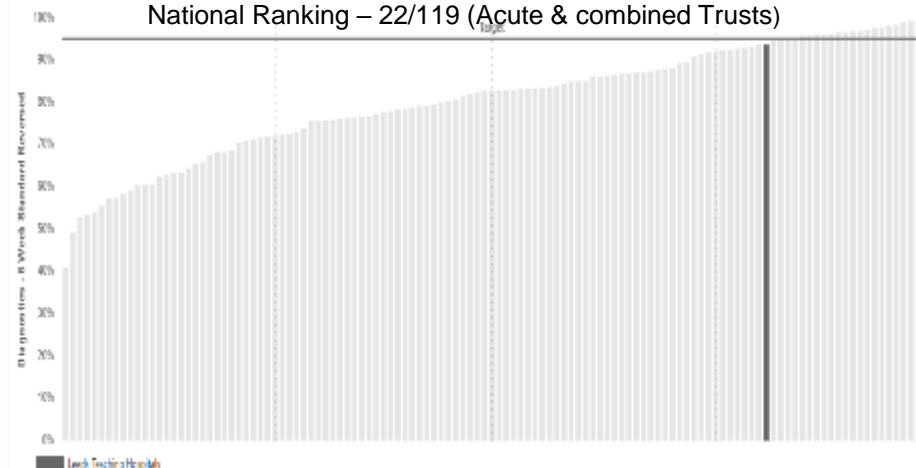
Diagnostics



Executive Owner: Clare Smith (Chief Operating Officer)

Variance: Special Cause concerning variation. Hit and Miss variation indicated

National Ranking – 22/119 (Acute & combined Trusts)



Background	Context	Action
<ul style="list-style-type: none"> 99% of patients wait no more than 6 weeks for a routine diagnostic test 2024/25 National Planning priority is to deliver 95% by March 2025 	<ul style="list-style-type: none"> MRI have continued to see delays for Paediatric GA MRI due to theatre capacity Ultrasound have the greatest number of breaches due to staffing pressures and capacity shortfalls Growing demand can capacity lost in CT and MRI have resulted in breaches for both modalities In audiology the recovery of paediatric follow up waits has impacted on 6ww LTH national ranking 22 out of 119 Trusts for Diagnostics performance in October 2024 (latest data available) 	<ul style="list-style-type: none"> Radiology CSU has developed a recruitment and retention plan for sonographers and short-term actions taken to mitigate capacity shortfalls Continued use of any available paediatric theatre sessions to deliver extra capacity SBAR developed Gap analysis against GIRFT recommendations will lead to creation of clinical working group with MD leads confirmed MRI mobile scanner procured to deliver increased capacity CT scanner at Seacroft CDC now operational and CT workforce review complete Children's endoscopy proposals to improve productivity through sessions have been developed and implementation being planned Development of a predictive tool for diagnostic demand from clinics is being tested

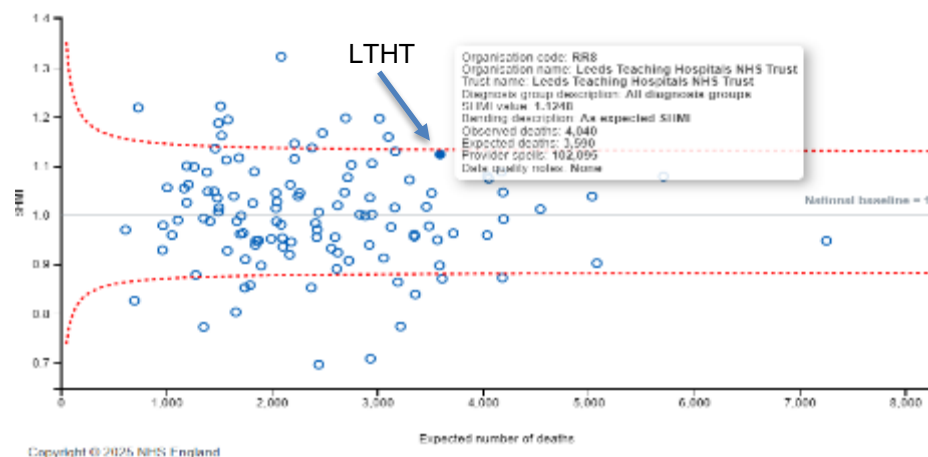
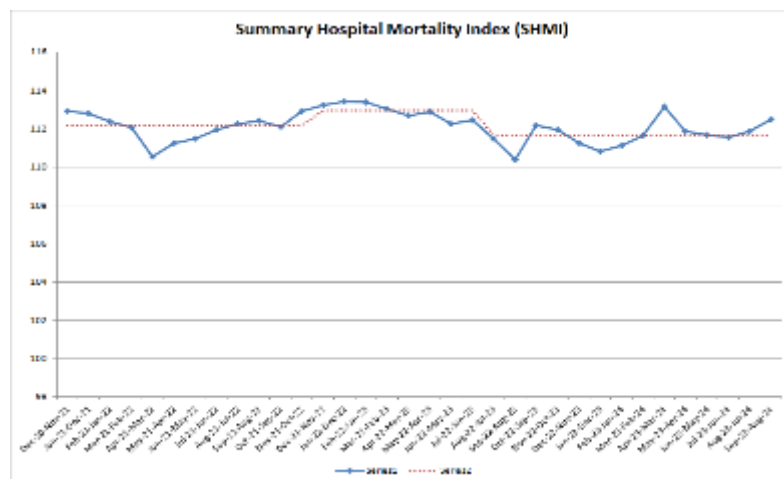
Mortality

September 23 – August 24

Target: 100
Performance – SHMI: 112.48

Executive Owner: Dr Magnus Harrison (Chief Medical Officer)

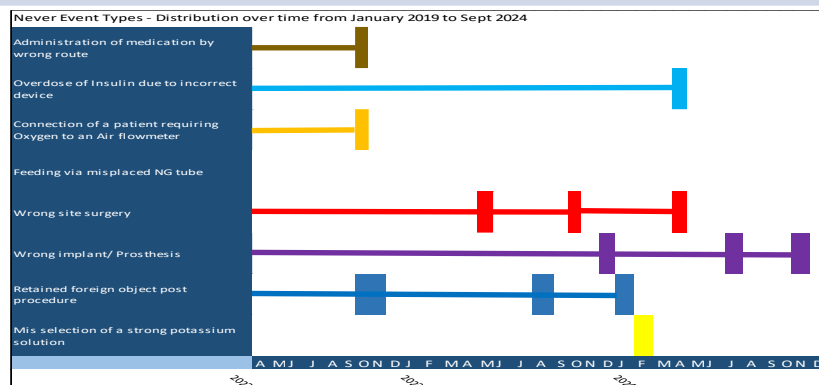
Variance: Common cause variation.



Background	Context	Action
<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> The Trust SHMI for September 2023 – August 2024 was 112.48 and “As Expected”. The Upper Control Limit was 113.44 	<ul style="list-style-type: none"> 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 (SJ) methodology is used to identify learning and provide assurance on quality of care.

Q3 (2024/25)

Target: 0
Performance : 5 (YTD)



Executive Owner: Dr Magnus Harrison (Chief Medical Officer)

Variance: Common cause variation.

Never events by Type April 2023 to present by financial quarter

	Q1 23-24	Q2 23-24	Q3 23-24	Q4 23-24	Q1 24-25	Q2 24-25	Q3 24-25	Total
Administration of medication by the wrong route	0	0	0	0	0	0	0	0
Connection of a patient requiring Oxygen to an Air flowmeter	0	0	0	0	0	0	0	0
Wrong site surgery	1	0	1	0	1	0	0	3
Wrong implant/ Prosthesis	0	0	1	0	0	2	1	4
Retained foreign object post-procedure	0	1	0	1	0	0	0	2
Mis-selection of a strong potassium solution	0	0	0	1	0	0	0	1
Overdose of insulin due to abbreviation or incorrect device	0	0	0	0	1	0	0	1
Total	1	1	2	2	2	2	1	11

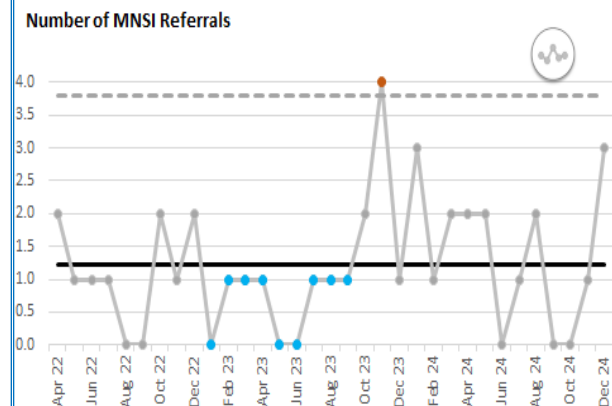
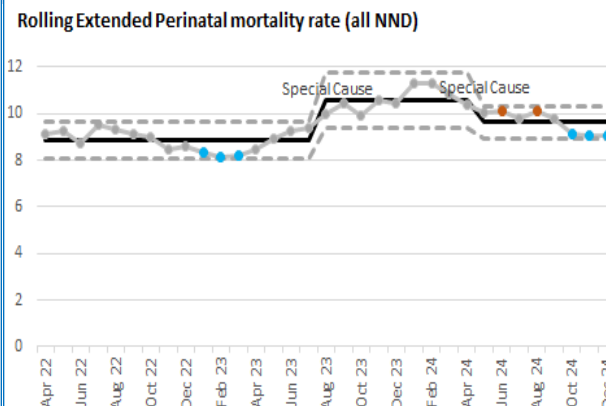
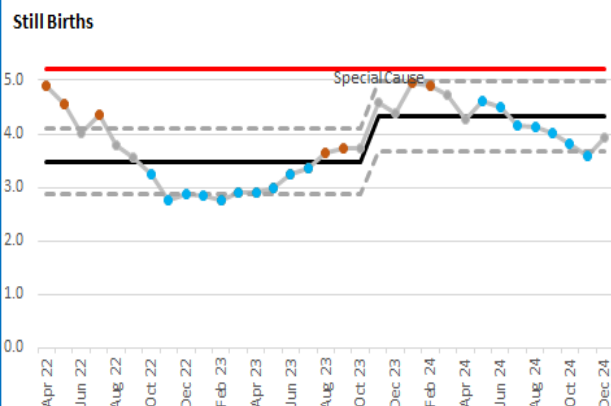
Background	Context	Action
<ul style="list-style-type: none"> Never Events are defined as patient safety Incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers 	<p>The number of Never Event incidents are reported to our commissioners each quarter via the national Strategic Information System (StEIS).</p> <p>The chart shows that there have were 6 Never Events reported in 2023/24.</p> <p>5 have been reported in 24/25 to date. One Never Event has been reported in Q3 2024/25:</p> <ol style="list-style-type: none"> Wrong Implant/ prosthesis (Thumb implant). <p>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.</p>	<p>All Never Event incidents are subject to a Patient Safety Incident Investigation (PSII).</p> <p>Learning from Never Events are subject to review at the WYAAT shared learning group chaired by LTHT.</p>

December 2024

Still Birth Rate: 3.93
Extended Perinatal Mortality Rate: 9.03
Number of MNSI Referrals: 3

Executive Owner: Rabina Tindal (Chief Nurse)

Variance: Still Births - Special cause Improvement.



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 expected survival rates.

- There were 4 stillbirths during December 2024**
 - 1 known fetal congenital anomalies
 - 1 2nd twin death confirmed at 18 weeks born at 37+3 with live twin
 - 1 24 weeks reduced fetal movements
 - 1 attended another local provider with reduced fetal movements at 36 weeks but wished to birth at LTHT
- There were 3 inborn neonatal deaths in December 2024:**
 - 1 hypoxic ischaemic encephalopathy (MNSI referral) and referred to HM Coroner
 - 1 concealed placental abruption
 - 1 known severe congenital abnormalities
- MNSI Referrals**
 - Neonatal death referred to HM Coroner as above
 - Neonatal cooling, reduced attendance during pregnancy
 - Neonatal cooling, referred to MNSI but parents have declined investigation as happy with the care.

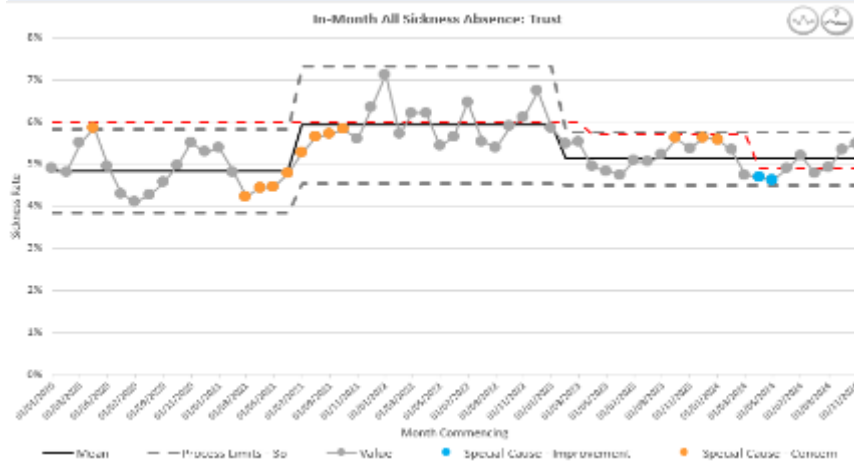
- Continue to review all cases as an MDT using the Perinatal Mortality Review Tool.
- Continue to work with other units to support peer review of perinatal mortality.
- Continue to meet and engage with MNSI teams to review cases and any trends or concerns.
- Use appreciative enquiry to review the findings of the reviews and use outputs to inform service improvements.
- Review outcomes through a health equity lens to support any learning and service development opportunities.

Sickness Absence Rate

Nov 2024

Target: 4.9 %
Performance: 5.09%

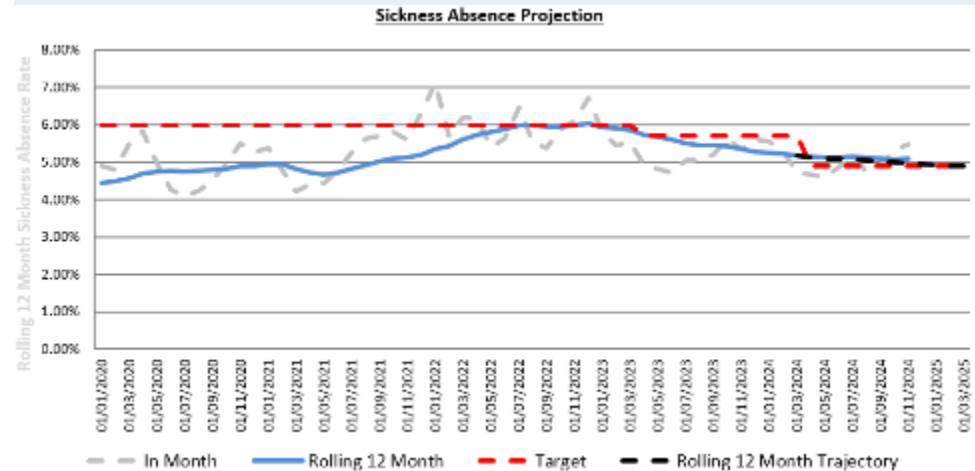
Variance: Common cause variation in month.



Executive Owner: Jenny Lewis (Director of HR & OD)

Management/Clinical Owner: Chris Jones

Sub-Groups: Health and Wellbeing Group and Workforce Management Group



Background	What the chart tells us	Issues	Actions	Context
<ul style="list-style-type: none"> The control limits for In-month Sickness Absence have been recalculated after a sustained improvement in 2023/24. The 2024/25 target for Rolling 12-month Sickness Absence has been reduced to 4.9% which is a stretching end of year target to account for the continued focus, attention and work on managing sickness absence. 	<ul style="list-style-type: none"> In order to achieve the year-end target, we will need to see improvements on last year's performance. 	N/A	<ul style="list-style-type: none"> Additional coaching and bespoke training provided to managers to support them with managing attendance. Strengthened assurance process with CSU ownership supported by Operational HR. Continued focus on improving access and usage of data and information to enable managers to proactively manage sickness and special leave in their teams. Increased focus on supporting attendance for medical and dental staff. Absence management and assurance process for M&D staff now operational in all CSUs except one, where additional support is being provided. New Burnout group established led by Deputy Chief Medical Officer, Dr Liz Garthwaite and Jo Buck, Deputy Director of HR, and reported to Workforce Management Group (WMC) on 27 August 2024 and Workforce Committee (WFC) on 19 September 2024. Supporting Attendance Policy being reviewed. Current practice on greater emphasis on health and wellbeing support throughout, especially at an early stage, is being written into the policy with a revised Target date for completion by 31 March 2025. Review of stress management process also under review, with a scheduled completion by the end of the calendar year. PWC audit action on track. 	N/A

Voluntary Turnover Rate

Nov 2024

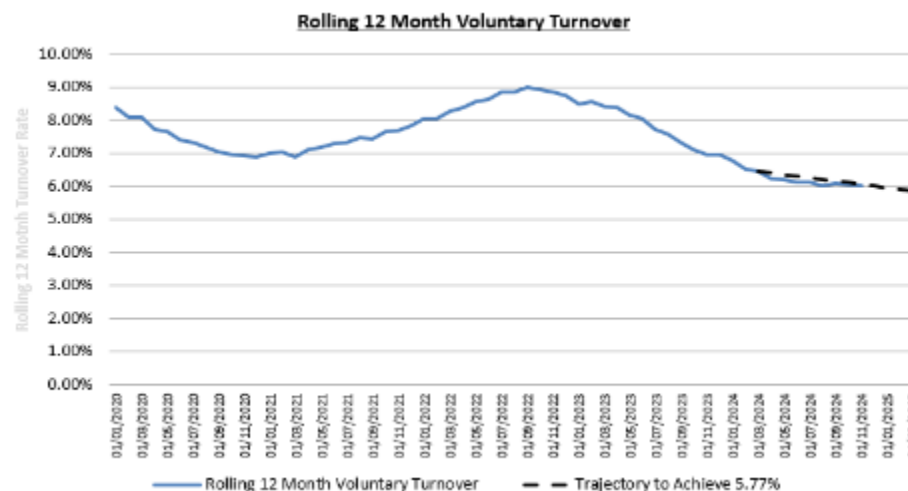
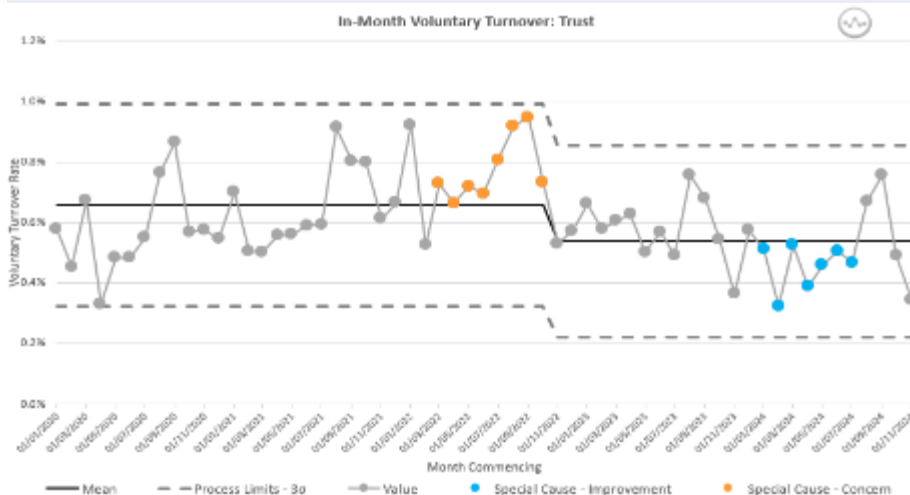
Target: 5.77%
Performance: 6.02%

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

Executive Owner: Jenny Lewis (Director of HR & OD)

Management/Clinical Owner: Chris Jones

Sub-Groups: Staff Engagement Group and Workforce Management Group



Background	What the chart tells us	Issues	Actions	Context
<ul style="list-style-type: none"> The control limits have been recalculated following a slight improvement in 2023/24. However, there remains a wide margin between the upper and lower control limits indicating a likelihood of large movements each month for the in-month rate. 	<ul style="list-style-type: none"> Voluntary turnover is on trajectory to achieve target by the end of 24/25 CSU voluntary turnover less varied and improving, with most CSUs now meeting the target. 	N/A	<ul style="list-style-type: none"> Corporate Retention A3 workstreams are progressing CSU Retention A3s established for all CSUs. With one Workforce Plan that remains outstanding but is in the draft stage. KPIs are being considered holistically in reports to WMG and WFC. Annual NHS Staff Survey launched (open until 29 November), with a focus on continuing to increase the participation rate (2022=37%, 2023=55%). LTHT response rate currently in line with national average. Further targeted communications are planned and CSU communication strategies are underway. Following discussion at October's Staff Engagement Group, an extraordinary meeting will be scheduled to discuss the use CSU stay conversations, exit interviews, appraisals, scope for growth, 1-1s etc as part of standard work, to ensure the longevity of progress made post Commitment and Exemplar closure, February 2025. 	<ul style="list-style-type: none"> The national 'NHS People Promise Exemplar Programme' structure underpins the progression against the retention in-year commitment. The Corporate Retention A3 outlines the 2024/25 targets and focus areas. Target for Trust turnover is to be in the top 25% of Acute Teaching and Acute large trusts (ie 18th out of 73 Trusts). Latest data (June 2024) showed the Trust was 28th out of 73. Stretch LTHT Target to improve the LTHT Staff Survey engagement score from 7.0 to 7.2.

Staff Engagement Rate

Jul 2024

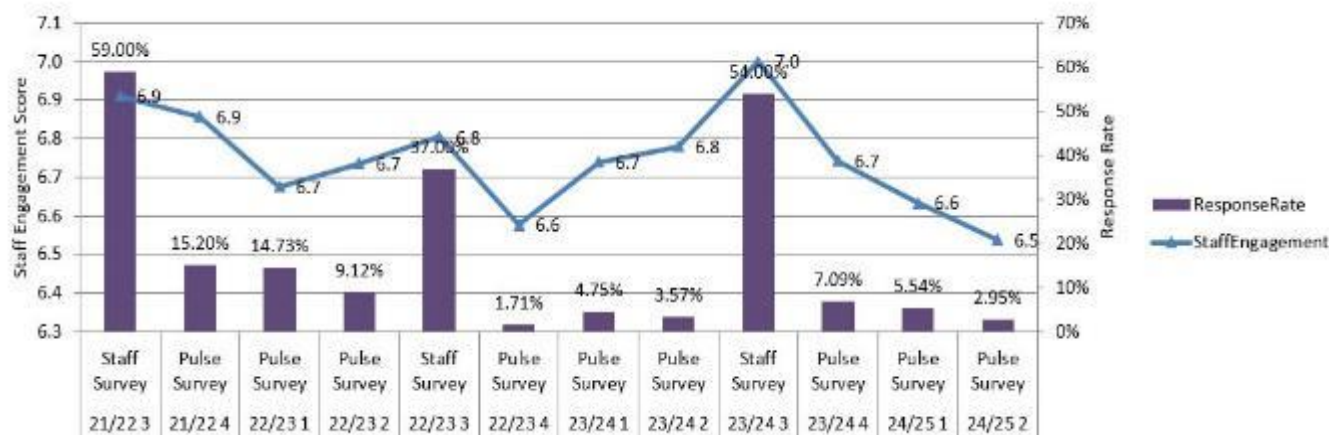
Target: 7
Performance: 6.5

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

Executive Owner: Jenny Lewis (Director of HR & OD)

Management/Clinical Owner: Chris Jones

Sub-Groups: Resource Management Group and Workforce Management Group



Background	What the chart tells us	Issues	Actions	Context
<ul style="list-style-type: none"> Response rates have historically been much lower for NHS Pulse Surveys compared to annual NHS Staff Survey due to the nature of the survey (temperature check), and therefore caution should be placed on direct comparisons between them. The Pulse Survey launched January 2022. <i>Actual</i> trends will therefore be analysed via SPC at the start of 2024/25 when there are sufficient data points in the series. 	<ul style="list-style-type: none"> The Pulse Survey staff engagement score has continued to deteriorate in July 2024, therefore observing a change in trend from previous years since. 	<ul style="list-style-type: none"> This may indicate greater challenge in achieving the annual NHS Staff Survey staff engagement score target (7.2). 	<ul style="list-style-type: none"> A deep dive into the data took place, identifying the following hotspots: line managers (self-reported) and the staff groups of Admin & Clerical, Healthcare Scientists, Medical & Dental. Furthermore, the deep dive identified that we remain above the national average for acute and acute & community trusts, however the average has remained stable rather than deteriorated. Staff Engagement Group and Workforce Management Group discussions took place. Discussions led to recognition of the current Trust and national context, including the new financial context, which is likely impacting certain staff groups greater than others. Activity agreed at local levels to support our people to navigate the challenges of the current reality. 	N/A

Agency Spend

Nov 2024

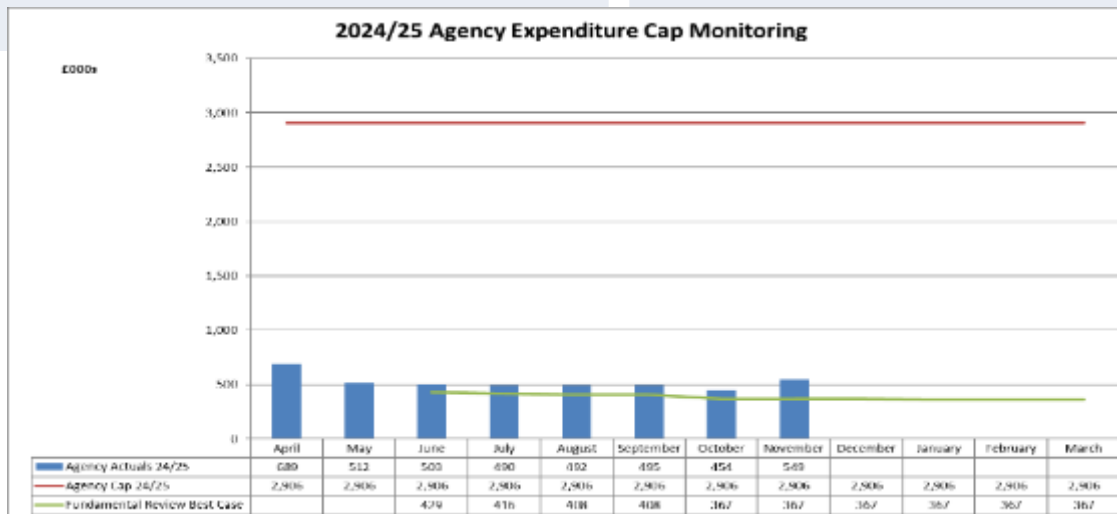
Target: 3.2% Performance: 0.56%

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

Executive Owner: Jenny Lewis (Director of HR & OD)

Management/Clinical Owner: Adele Brear

Sub-Groups: Resource Management Group and Workforce Management Group



Background	What the chart tells us	Issues	Actions	Context
<ul style="list-style-type: none"> The agency cap for 2024/25 has been set by NSHE at 3.2% of the pay bill equating to approximately £2.9m per month. Against the 3.2% target our spend is at 0.56%. This target is being monitored as we progress through 2024/25. An internal LHTT target has been set at 0.4% of the total pay bill based on our financial forecast which has been developed to support the achievement of the Trust's financial plan. 	<ul style="list-style-type: none"> We are well below the NHSE agency target but slightly above the internal target. 	N/A	<ul style="list-style-type: none"> The Trust has worked hard to reduce the reliance on agency staff and this has been achieved by aligning our workforce plans to service delivery along with our success in retaining our workforce. For 2024/25 the Leeds Improvement Method (LIM) principles of daily management are supporting further reductions in the use of agency spend and other variable pay and the work on reducing bank and agency is predominantly being sustained. Actual costs are tracking slightly above the best case. This is due to Pathology implementing the LIMS project and these costs were not included in the target. The target will not be recalibrated as the costs for Pathology will be charged against the capital scheme. The Pathology agency costs are capitalised on a quarterly basis therefore November includes Pathology LIMs agency costs which will be capitalised at the end of the quarter. Actual costs of agency are still tracking above the best case due to use of agency in Estates & Facilities along with additional support for winter covid vaccinations. The Trust is continuing to focus on forecasting FTE and reviewing pay budgets. A working group will be established in January 25 to conduct a deep dive into Bank, Agency and Contractual spend. 	N/A

Vacancy Rate

Nov 2024

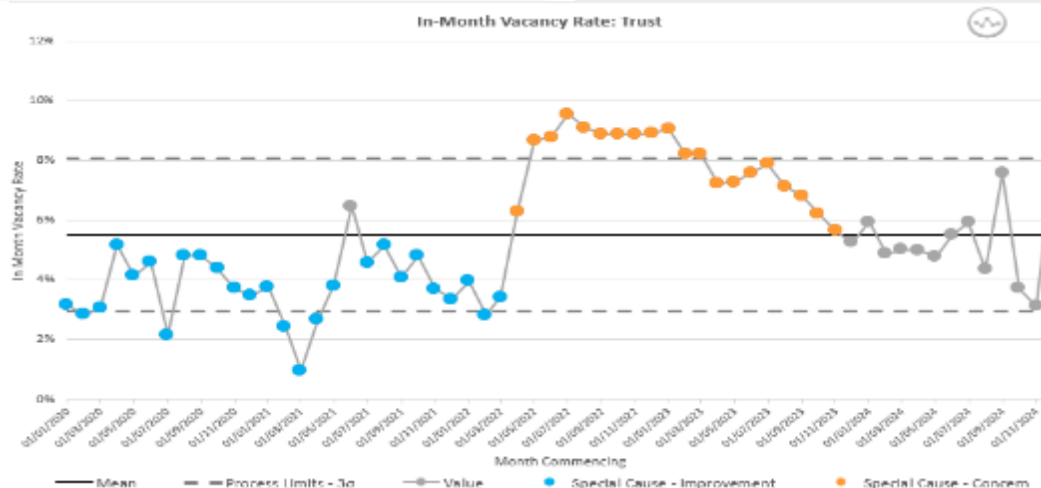
Target: N/A
Performance: 3.1%

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

Executive Owner: Jenny Lewis (Director of HR & OD)

Management/Clinical Owner: Jo Buck

Sub-Groups: Resource Management Group and Workforce Management Group



Background	What the chart tells us	Issues	Actions	Context
<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> The large increase in the vacancy rate for September 2024 and subsequent decrease in October 2024 are due to budget realignments in MMPS, Outpatients and E&F CSUs. Staff in post has increased from August to October. 	N/A	<ul style="list-style-type: none"> Success in retaining our workforce along with successful international, local recruitment and growing our own into registered and non-registered roles has supported our reduction in vacancies across the Trust. SHRBPs continue to work closely with CSUs and corporate teams to ensure operational workforce plans include actions to address vacancy hotspots and exploring alternative options e.g. alternative roles (ACP, PA, Nursing Associates) along with apprenticeship options. As part of our in-year commitment on retention, all CSUs have developed A3s to address retention and actions from this are in their workforce plans. 	N/A

I&E Position 2024/25

November 2024

Executive Owner: Jenny Ehrhardt (Director of Finance)

In December the Trust reported an in month surplus of £1m, which was £1.1m adverse to plan and a year to date deficit of £17m, which is £2.4m adverse to the NHSE plan. Income to date is £1,473.1m which is £40.2m favourable to plan and expenditure to date is £1,490.1m, £42.6m adverse to plan. Year to date income includes £1.7m additional funding which partially offsets costs and loss of income in June and July due to industrial action.

Pay expenditure to date is £866.9m, £18.2m adverse to the NHSE plan and includes expenditure associated with the cost of covering industrial action (c£2m). Non-pay expenditure to date is £623.2m (including depreciation and finance costs), £24.4m adverse to the plan. The Trust has had mitigation plans in place since Month 2, which have significantly reduced the run-rate, and further work is ongoing to reduce variable pay costs, improve productivity and deliver the waste reduction programme.

The Trust continues to forecast a £2.1m surplus for year end, however, there remain a number of significant risks, particularly around risks to delivery of the waste reduction and mitigation plan, winter costs and assumed levels of funding for drugs and devices.

Capital & Cash Position

December 2024

Executive Owner: Jenny Ehrhardt (Director of Finance)

Capital

The Trust's capital expenditure forecast for 2024/25 is £73.3m. The forecast outturn has increased by £4.9m to £73.3m due to an increase of £4.2m to BtLW HOTF to be in line with the current NHP forecast of £9.4m, the disposal of theatres equipment which gives the trust a £0.5m benefit to the capital programme and additional PDC of £0.2m for Diagnostics Endoscopy and Perinatal Pathology Equipment. The programme is broken down as follows:

Programme	Forecast
2024-25	
£000	
Medical Equipment	15,187
Informatics	12,845
Building & Engineering	32,316
Building the Leeds Way	10,918
Leases	1,500
Disposal Benefit	521
Total	73,287

Expenditure to 31 December 2024 is £37.5m, which was ahead of forecast by £0.2m. B&E was £0.2m ahead of forecast due to a combination of minor variances over several schemes. BtLW was £0.1m ahead of forecast due to various minor variances on the HotF Enabling Works. Both M&SE and DIT were £0.1m behind forecast; for M&SE, the theatre lights delivery slipped back into M10 and for DIT, the Digital Pathology staff recharges were less than forecast. Capital expenditure forecasts are discussed with Programme Managers monthly together with orders raised and contracts awarded but yet to be fulfilled. Progress is formally monitored each month at the Capital Planning Group.

Cash

The cash balance at the end of December is £30m, a decrease of £6m during the month. This is £6m ahead of the "best case" fundamental review forecast due to additional receipts in the month.

Receipts in the month totalled £172m and included £2.4m of digital pathology funding and £3.8m of ERF funding. Total payments were £178m comprising £102m for payroll, which included the additional tax, national insurance and pension contributions on the November pay awards and £76m for payments to suppliers.

Payments to our suppliers in December totalled £76m. Better Payments Practice Code ("BPPC") compliance for the month was 96% and the year-to-date compliance is also 96%

The application for capital cash PDC support of £16m to ensure full delivery of the capital programme has been approved by the Department of Health & Social Care and NHS England and will be drawn down in January.

The latest cash forecast shows that the Trust will not require revenue cash support for the remainder of the calendar year. However, there are considerable risks in delivering the I&E position of a £2m surplus. If the position cannot be delivered it is possible that cash support will be required in the final months of this financial year.

Supplementary Metrics Produced by Exception

Cancelled Ops

Reduce waits
for patients



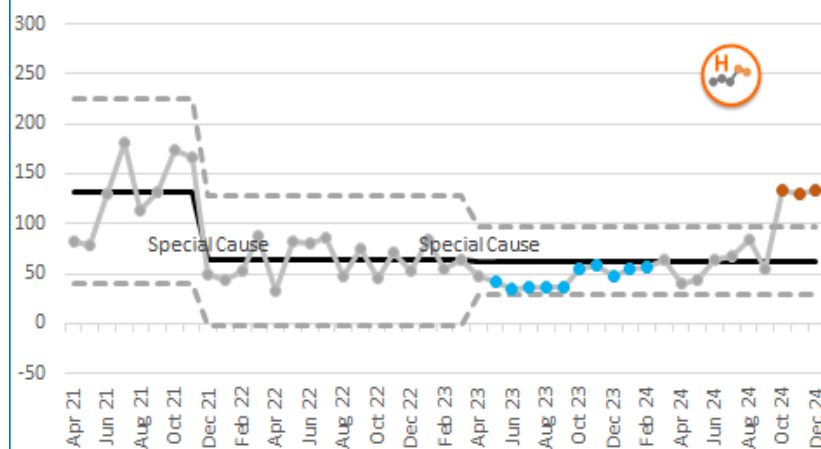
December 2024

Target: 0

Performance – LMCO: 134

Performance – 28 day Standard: 29

Last Minute Cancelled Ops

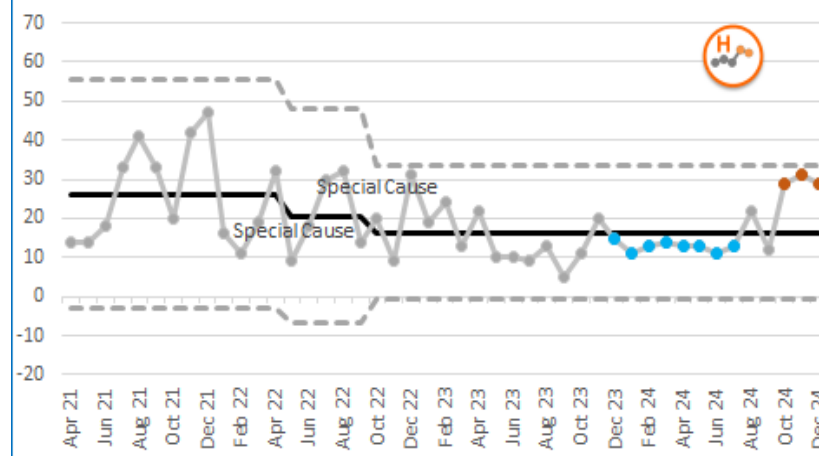


Executive Owner: Clare Smith (Chief Operating Officer)

Variance: LMCO - Special cause concerning variation.

28 day - Special cause concerning variation

Cancelled Ops 28days











Background	Context	Action
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)	<p>Cancelled Operations</p> <ul style="list-style-type: none"> There were 134 LMCO in December 2024. This is a slight increase from the 129 LMCO reported in November. The main reason for LMCO was 'ran out of theatre time' <p>28 Day Breaches</p> <ul style="list-style-type: none"> There were 29 breaches of the 28-day standard in December 2024. This is a reduction to the 31 28-day breaches reported in November 2024 LTHT's cancellation rate of 0.86% in Q2 ranked 63rd of 117 Trusts and is in line with the target of 0.87% set for teaching hospitals 	<ul style="list-style-type: none"> Site pressures continued through December with some cancellations resulting (mainly in paediatrics). Efforts to protect elective patients from cancellation are supported by the DMT and escalation of patients at risk of cancellation Deep dive into BADs procedures to assess specialities with greatest opportunity to convert overnight stays to day case Increase the number of patients treated per session through exploring more HVLC sessions at WGH Improve utilisation for overnight stays at WGH In month monitoring and escalation to CSUs of month-end risks for patients needing to be rebooked in 28-days

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