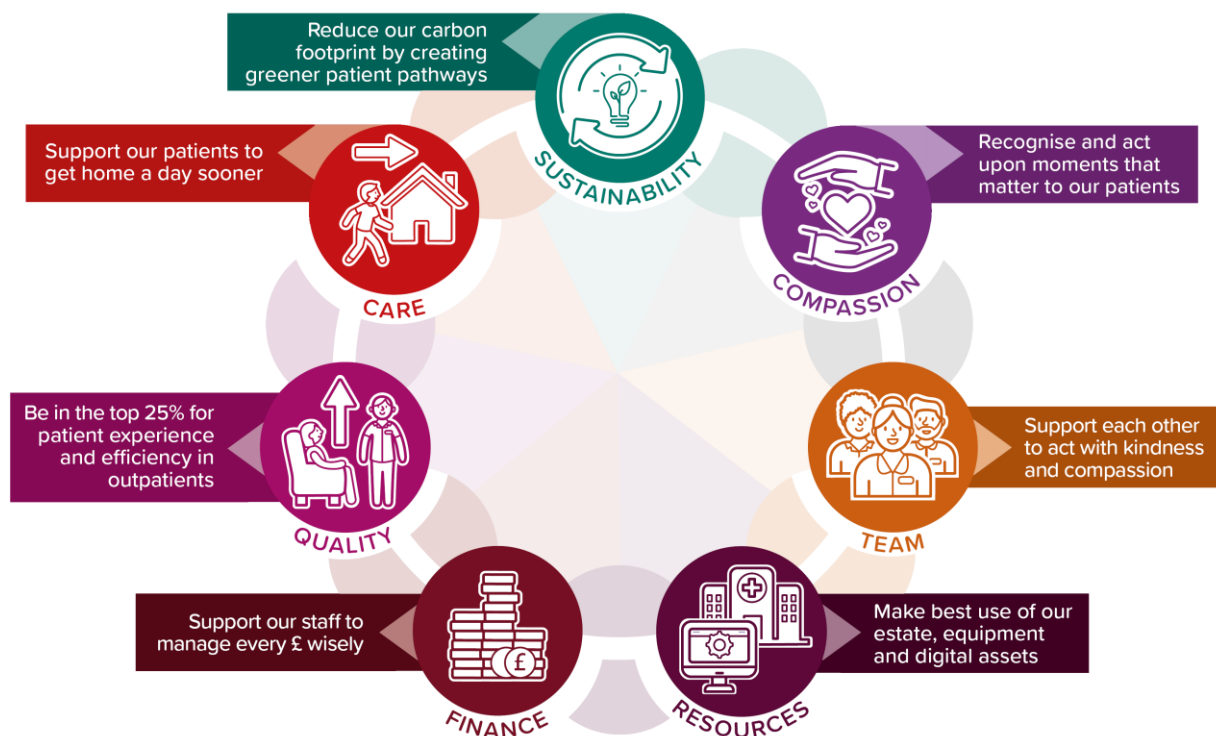


Integrated Quality & Performance Report

July 2025

7 Commitments



Summary - Performance

Performance

KPI	Latest month	Performance	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
AE Attendances per day	Jun 25	1015.0	-			944.3	819.2	1069.5
Ambulance Handovers <15mins LGI	Jun 25	00:17:37	00:15:00			00:17:02	00:16:12	00:17:53
Ambulance Handovers <15mins SJUH	Jun 25	00:23:30	00:15:00			00:23:05	00:20:48	00:25:21
Last Minute Cancelled Ops	Jun 25	129	-			77	39	114
Cancelled Ops 28days	Jun 25	22	-			18	3	32
Cancer 28day FSD	May 25	72.1%	75.0%			74.6%	66.2%	83.0%
Cancer 31day	May 25	93.0%	96.0%			87.7%	81.6%	93.8%
Cancer 62 day	May 25	59.2%	85.0%			57.4%	45.9%	68.9%
Diagnostics	Jun 25	83.8%	95.0%			92.1%	88.8%	95.4%
DNA Rate	Jun 25	6.80%	-			7.08%	6.24%	7.93%
Outpatient DNA Volumes	Jun 25	8235	-			8589	6426	10753
ECS Monthly	Jun 25	76.8%	78.0%			74.8%	69.9%	79.6%
Elective LoS	Jun 25	3.9	-			4.1	3.1	5.1
Elective Readmissions	Jun 25	3.01%	-			3.23%	2.82%	3.64%
Non-Elective LoS	Jun 25	7.3	-			7.3	6.6	7.9
Non- Elective Readmissions	Jun 25	5.55%	-			9.87%	8.10%	11.64%
OPFU3months	Jun 25	37513	-			36108	34067	38149
RTT Performance	Jun 25	66.2%	92.0%			63.6%	61.7%	65.5%
RTT Total Waiting list	Jun 25	88197	-			90289	87719	92860
RTT 52 Week Breach Backlog	Jun 25	2742	0			2689	2205	3174
RTT 78Week Breach Backlog	Jun 25	3	0			55	-7	116



Quality Metrics

KPI	Latest month	Performance	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
VTE	Jun 25	96.6%	95.0%			96.7%	95.3%	98.0%
CDI	Jun 25	11	-			14	6	22
MRSA	Jun 25	0	-			1	-2	3
E. Coli	Jun 25	27	-			25	9	41
Pseudomonas	Jun 25	3	-			4	-2	10
Klebsiella spp	Jun 25	9	-			11	2	21
Patient Level Metrics Score	Jun 25	94.7%	90.0%			95.1%	92.5%	97.7%
Environment Level Metrics Score	Jun 25	95.2%	90.0%			93.6%	91.0%	96.1%
Falls	Jun 25	191	-			196	165	227
Falls Rate per 1000 Bed Days	Jun 25	3.42	-			3.47	3.00	3.94
Developed Pressure Ulcers	Jun 25	26	-			49	32	66
Developed Pressure Ulcer Rate	Jun 25	0.47	-			0.90	0.60	1.19
Admitted with Pressure Ulcers	Jun 25	314	-			308	253	362
Admitted with Pressure Ulcers Rate	Jun 25	5.65	-			5.50	4.41	6.58
2222 Calls	Jun 25	74	-			59	38	81
Cardiac Arrest Calls	Jun 25	23	-			17	6	29
SHMI	Jun 25	113.7	100.0			112.3	110.8	113.7
Still Births	Jun 25	3.56	5.20			3.75	2.99	4.51
Rolling Extended Perinatal mortality rate (all NND)	Jun 25	8.85	-			9.38	8.61	10.16
Number of MNSI Referrals	Jun 25	1	-			1	-1	4
% Complaint Responses Sent Within Target Times (LR1 let	Jun 25	30.0%	80.0%			34.9%	15.5%	54.4%
% CSU Draft Comments Received Within Target Times (LR	Jun 25	52.0%	80.0%			49.0%	31.9%	66.1%
Median Response Lead Time (Days)	Jun 25	48	-			45	36	54
Defect Rate	Apr 25	0.55%	15.00%			9.68%	#N/A	#N/A
PALS Concerns - % Patients contacted in 2 w/days	Jun 25	80.0%	80.0%			79.7%	74.1%	85.2%



Core Metrics

Measure	Commitment	Reporting Period	Performance	Target	Variance	Assurance
Rolling Overall Sickness Rate	Team	Jun-25	5.19%	4.90%		
Rolling Voluntary Turnover Rate	Team	Jun-25	5.87%	5.93%		
In-Month Agency Spend (as % of total pay bill)	Finance	Jun-25	0.66%	0.53%		
In-Month Bank Spend (as % of total pay bill)	Finance	Jun-25	4.61%	2.83%		
In-Month Vacancy Percentage	Finance	Jun-25	7.35%	N/A		
In-Month Mandatory Training Compliance Rate	Team	Jun-25	90.81%	85.00%		
YTD Number of concerns raised to FTSU Guardian	Team	Jun-25	53	N/A		
<i>Quarterly Pulse Survey</i>						
PS Engagement Score	Team	Apr-25	6.4	6.5		
PS Team Working Score	Team	N/A		TBC		
PS Line Management Score	Team	N/A		TBC		
<i>Annual Staff Survey</i>						
SS Engagement Score	Team	25/26		6.9		
SS Response Rate	Team	25/26		47.6%		
SS Team Working Score	Team	25/26		>6.8		
SS Line Management Score	Team	25/26		>6.9		



Core Metrics

Reduce waits
for patients



Ambulance Handover

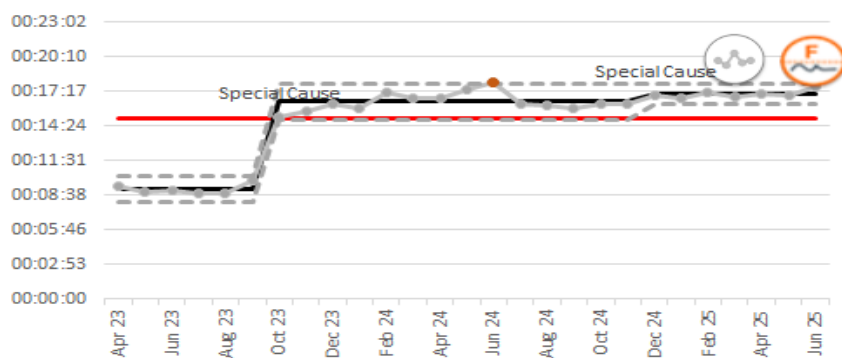
June 2025

Target: <15mins
Performance – LGI : 00:17:37
Performance – SJUH : 00:23:30

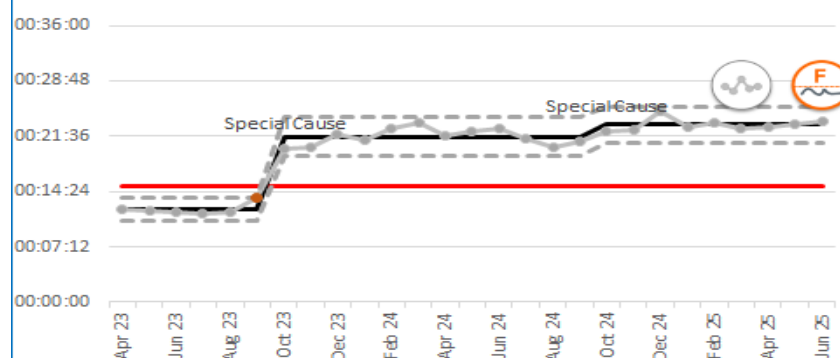
Executive Owner: Clare Smith (Chief Operating Officer)

Variance: Special cause variation.

Ambulance Handovers <15mins LGI



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 added 5-8 minutes onto LTHT times Handover data is managed by YAS and submitted directly to NHSE. No in-flow data accuracy corrections made by YAS LGI – In June 2025 there were 1379 handovers under 15 minutes (51.4%). Average handover time at LGI was 17:37 minutes SJUH - In June 2025 there were 901 handovers under 15 minutes (26.6%). Average handover time at SJUH was 23:30 minutes Out of 183 hospitals LGI placed 36th in the country and SJUH placed 104th for ambulance handovers for June 2025 	<ul style="list-style-type: none"> In June 2025 WYAAT UEC Group trialled breach validation process at SJH. Action plan developed following this trial. West Yorkshire UEC director group working to deliver a standard approach to ambulance handover actions, escalations and requests for diverts through the West Yorkshire UEC network Review of accurate handover recording time stamp has been completed and results have been shared with YAS for improvement SDEC and PCAL pathways have been reshared with YAS to ensure patients are in the right place at the right time YAS have agreed to reduce the 50m radius to a 25m radius when the clock starts for ambulance handover with expected implementation in August

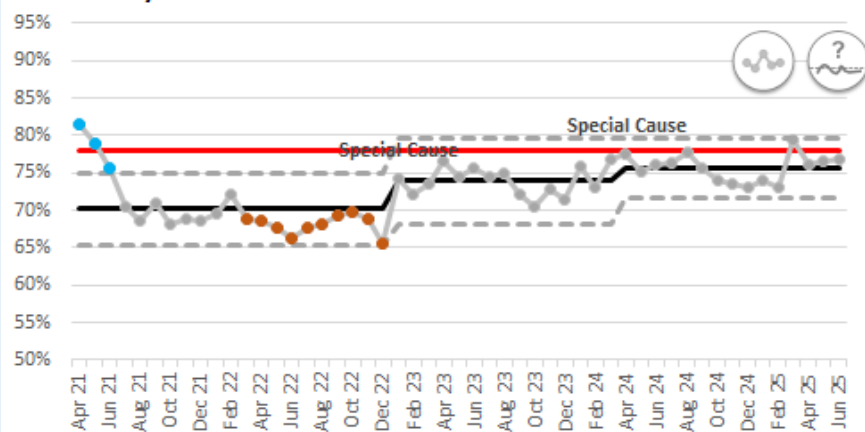


Emergency Care Standard

June 2025

National Planning Priority Target 2025/26: 78% by March 2026
Performance: 76.8% against national trajectory

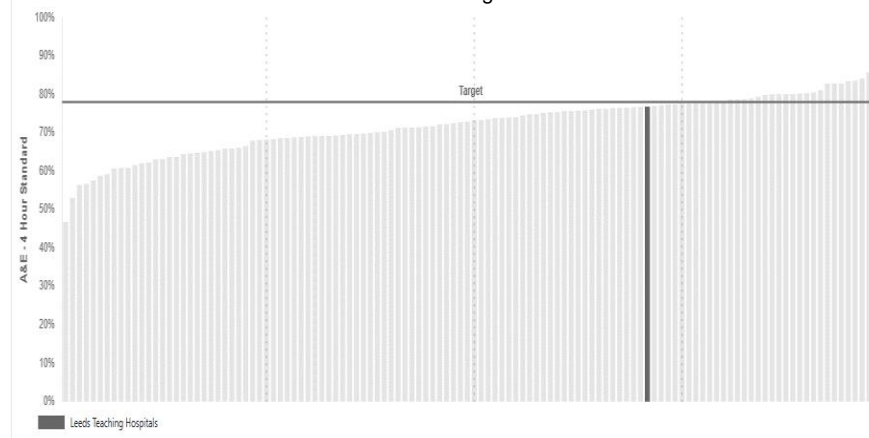
ECS Monthly



Executive Owner: Clare Smith (Chief Operating Officer)

Variance: Common cause variation. Hit and Miss variation indicated

National Ranking 34/118



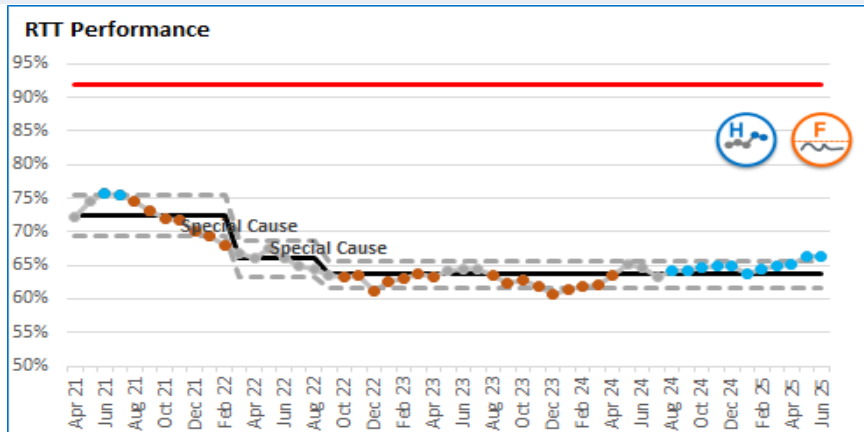
Background	Context	Action
<ul style="list-style-type: none"> The constitutional standard is for 95% of attendees to A&E being admitted, transferred or discharged in 4 hours The 2025/26 national planning recovery requirement is to deliver 78% by March 2026 	<ul style="list-style-type: none"> ECS delivery for June 2025 was 76.8% against the trajectory target of 76.5% National average ECS was 72.9% for June 2025 LTHT ranked 34th out of 118 Trusts for ECS performance in June 2025 Out of 10 peers, LTHT was 5th for ECS delivery for June 2025 LTHT had the second highest volume of attendances amongst peers. Attendances across all sites in June 2025 increased by 2.1% compared to June 2024 Ambulance conveyances in June 2025 (6028) increased by 0.8% compared to June 2024 (6074) 	<ul style="list-style-type: none"> West Yorkshire UEC waterfall action plan delivered for June and is underway to achieve July trajectory in line with plan An internal stretch trajectory is in place to achieve 80% ECS between now and September and paper has been submitted to the Executive Team. Service is reviewing 2019 delivery and looking for ways to improve productivity and efficiency to deliver higher ECS CSU business team is reviewing daily missed opportunities and sharing the outcomes with clinical teams to improve practices Standard work developed regarding 4-hour ECS delivery target and shared with clinical teams ED medical workforce gap analysis completed with paper submitted to utilise escalated rate to maintain service delivery has now been implemented



RTT

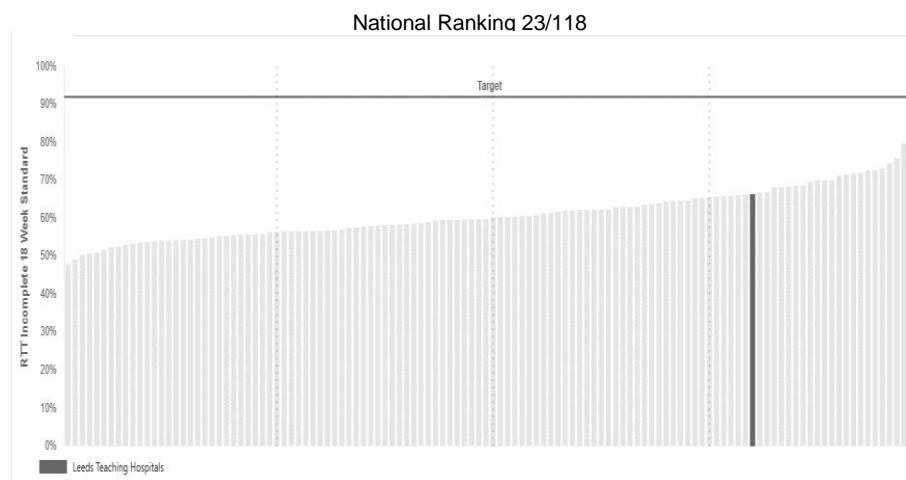
June 2025

Target: 92%
Performance: 66.2%



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 In the 2025/26 national planning guidance there is a requirement for RTT delivery to improve by 5% from Nov 24 65% to 70% by March 2026 	<ul style="list-style-type: none"> RTT fell slightly from 66.4% in May to 66.2% in June The Total Waiting List size in May 2025 was 88,184, stable compared with the June 2025 position (88,197) The number of patients waiting over 18 weeks increased by 133, from 29,646 in May 2025 to 29,779 in June National ranking for RTT is 23 out of 118 Trusts 	<ul style="list-style-type: none"> The Total 'incomplete performance' trajectories will be monitored through the Service Delivery Matrix and CSUs accountability meetings Q1 Validation Sprint April – June finished with funding received for 424 clock stops above our set target from NHSE. Q2 started 7th July 2025 Federated Data Platform went live on Monday 14th July with 4 CSUs. The Federated Data Platform and Performance Team have been supporting and working to engage the next wave of CSUs. The tool will support ongoing validation of waiting lists A working group continues to review Total Waiting List growth, working with the ICB to identify any opportunities to reduce demand The Outpatient Transformation Board and GIRFT Further Faster programme will focus on clinic utilisation, follow-up and DNA reductions throughout 2025/2026



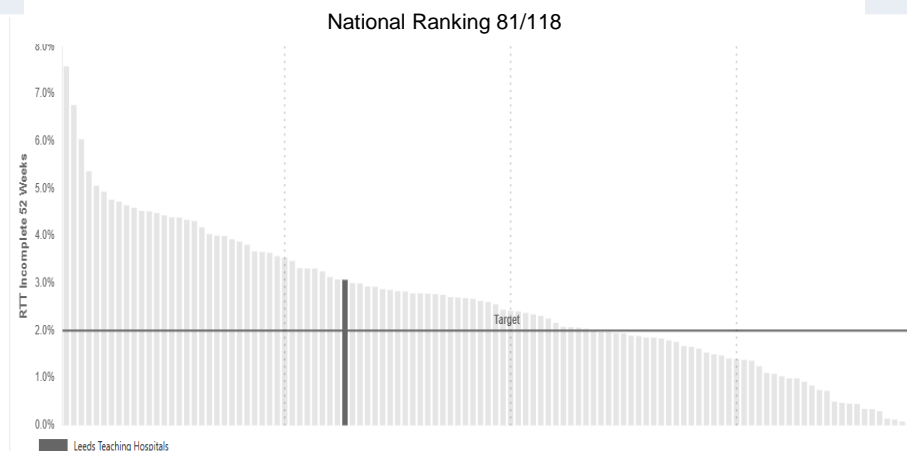
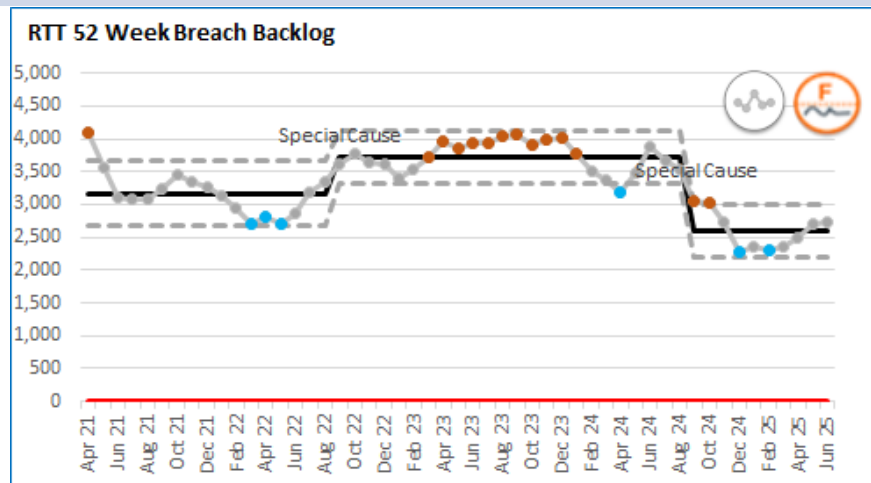
RTT 52 Weeks

June 2025

National Planning Priority Target 2025/26: 1% of TWL (c750)
Performance: 2,742

Executive Owner: Clare Smith (Chief Operating Officer)

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



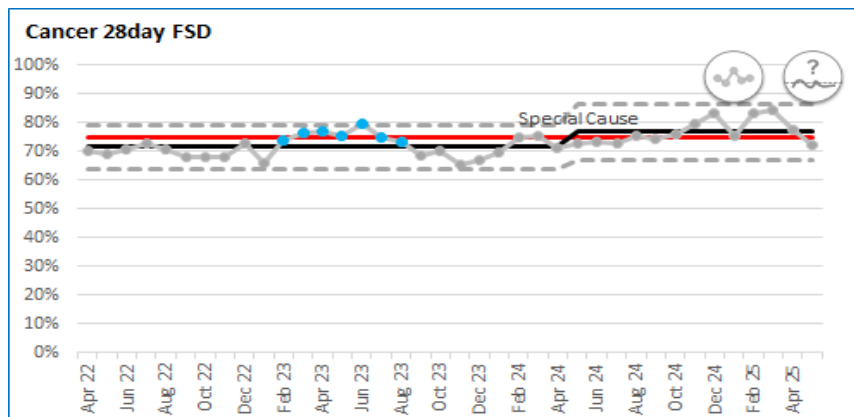
Background	Context	Action
<ul style="list-style-type: none"> Planning guidance for 2025/26 requires Trusts to ensure that fewer than 1% of patients on an RTT clock have waited over 52 weeks 	<ul style="list-style-type: none"> The number of patients waiting over 78 weeks was 3 (1 ENT, 1 Plastics and 1 Paed Plastics) The number of patients waiting over 65 weeks was 100 LTHT had 2,742 52+ week waiters against plan for 2,063 This represents 3% of total waiting list Our national ranking is 81 out of 118 Trusts 	<p>LTHT has been placed into Tier 1 escalation for elective care. A recovery plan has been developed and approved by the executive team</p> <p>The below actions related to both 65 weeks and 52 weeks risks.</p> <ul style="list-style-type: none"> 65-week meetings are in place with the COO, DCOO and CSU Tri Teams for CSUs with 65 weeks risks at month end (CNS, Head and Neck, TRS and Children's) Discussions to open Gilbert Scott Theatre on 3 additional days to add capacity for ENT T&A managing impact of paediatric anaesthetist gaps. 20 lists lost in April. Discussions with Airedale and Harrogate for anaesthetic support Continued support to CSUs to reallocate theatre capacity or seek mutual aid (Harrogate and Calderdale / Huddersfield may provide some support) Saturday all day theatre lists for paediatric surgery in June and July agreed Independent Sector support explored in areas where no additional capacity available Super-Saturday clinics planned for spinal surgery Extended lists planned for breast reconstruction to support listing of two cases



Cancer 28 Day Faster Diagnostic

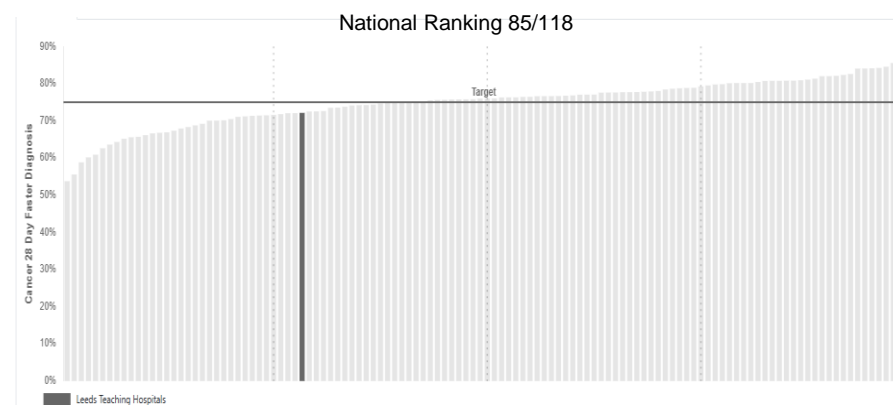
May 2025

Target: 75%
Performance: 72%



Executive Owner: Clare Smith (Chief Operating Officer)

Variance: Common cause variation. Hit and Miss variation indicated



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 NHSE expectation is that by March 2025, the % of patients being notified of their cancer status by day 28 is 77% 	<ul style="list-style-type: none"> 28 Day FDS reduced in May to 72% 3003 patients out of 4171 patients were informed of their diagnosis within 28 days LTHT ranked 85 of 118 Trusts LTHT performance has fallen below the 2025/26 trajectory but has recovered during June In month reduced performance in Lower GI at 53.6%, Gynae at 53.4%, Prostate at 57.9%, Bladder at 57.9% and NSS at 55% 	<ul style="list-style-type: none"> Higher than usual numbers of referrals in Lower GI mean that there was a backlog of patients waiting to be informed about colonoscopy results. This has been resolved but resulted in an impact on performance in month Waits for hysteroscopy and pathology on Gynae pathways remain problematic. There is a plan for recruitment and training for Hysteroscopy, but use of the independent sector is being explored to deliver short-term capacity Prostate diagnosis waits will begin to fall as newly trained advanced practitioners in Radiology undertake biopsies Bladder waits for CTU's are expected to reduce with additional CT capacity coming on-line NSS waits for CT scans will reduce as capacity increases Pathology backlogs are falling as additional staff come into post

Cancer 31 day

Reduce waits
for patients



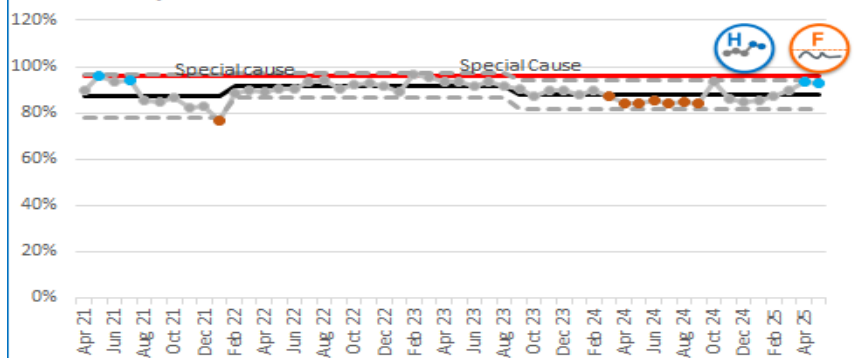
May 2025

Target: 96%
Performance: 93%

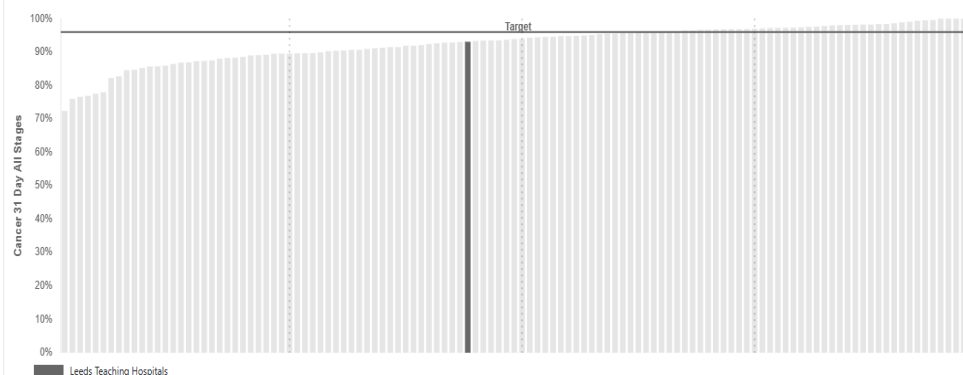
Executive Owner: Clare Smith (Chief Operating Officer)

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

Cancer 31day



National Ranking – 66/118



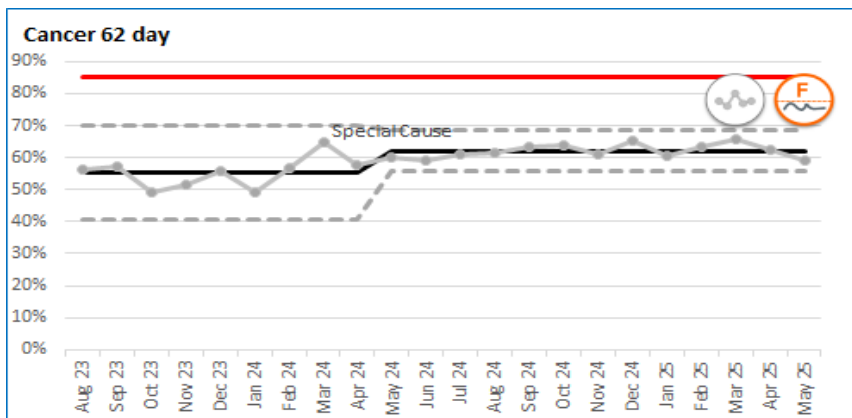
Background	Context	Action
<ul style="list-style-type: none"> 96% of patients should receive treatment within 31 days This includes patients receiving both first and subsequent Cancer treatments 	<ul style="list-style-type: none"> Overall performance for 31 days in May is 93% 99% of patients receiving chemotherapy are treated within 31 Day from decision to treat Surgical performance in May was: <ul style="list-style-type: none"> First – 88.8% Subs – 81.5% Radiotherapy waits further improved since Jan 2025 <ul style="list-style-type: none"> First – 96.9% Subs – 97.1% 	<ul style="list-style-type: none"> Radiotherapy improved performance sustained and all categories delivering under 31 days Consultant recruitment underway for Gynae Oncology surgery to reduce waits for procedures <ul style="list-style-type: none"> Waits for surgery for Melanoma, Skin and Sarcoma patients can be lengthy in TRS and alternative solutions for consultant cover are being sought to allow surgical capacity to be created All patients on 31 day pathways are monitored at the weekly PTL's and up to date information about relevant patients is provided to the CSU's at the weekly PTL meeting



Cancer 62 Days

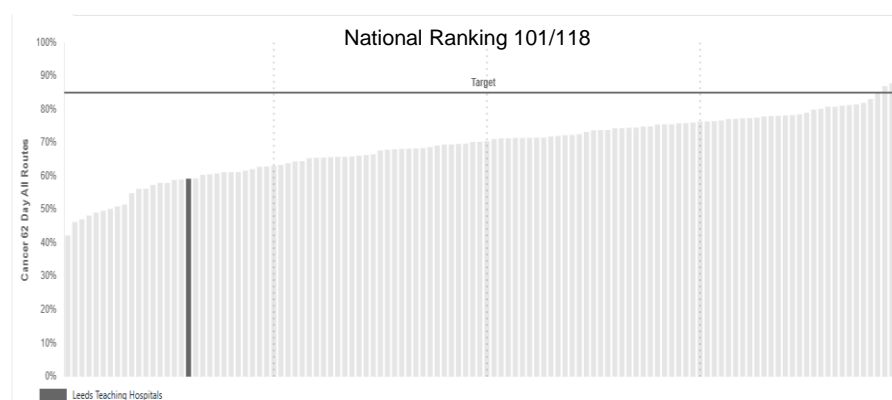
May 2025

Target: 85%
Performance: 59%



Executive Owner: Clare Smith (Chief Operating Officer)

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



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 2025/26 national planning guidance is an expectation from NHSE that all systems will achieve 75% by March 2025 62-day backlog for 2025/6 is planned to achieve 6% or less of the total patient numbers on a CWT pathway 	<ul style="list-style-type: none"> 254/430 of patients with cancer were treated within 62 days in May 2025 Performance has fallen from April 2025 and remains below the trajectories agreed at the start of the 2025/26 year The backlog at the end of May was 352. This was predicted with the increase in referrals that started in March 2025, but has decreased into June and July LTHT ranked 101st of 118 trusts in May 2025 	<ul style="list-style-type: none"> LTHT has been placed into Tier 1 for elective care and cancer, this is because a trust can only be in a single tier for any standard. CSU's are reviewing breaches on the pathways that they feed into, to investigate potential for breaches to be 'saved' and understand any pathway changes impacting on treatment within 62 days Waits for some procedures and biopsies in Radiology are improving (e.g. CTU, TpGBx) and turnaround times for Gynae and H&N samples are reducing in Pathology, this will assist in reducing both 28 Day FDS and 62 Day waits There is good clinical engagement in place for Lower GI and Lung Pathway reviews and meetings are in place to progress improvements in MDT outputs and timelines The intensive support team pathway analyser will be used to consider areas for improvement at pathway level Tier 1 funding will be used to support booking teams in radiology



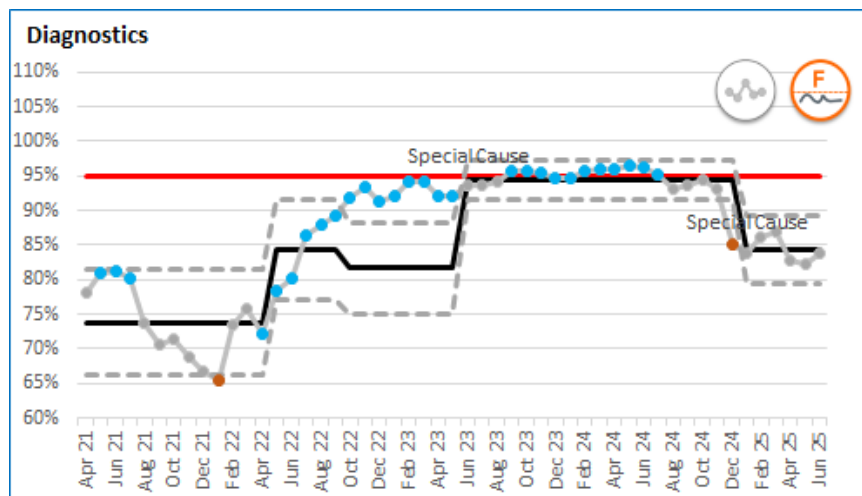
Diagnostic Waits

June 2025

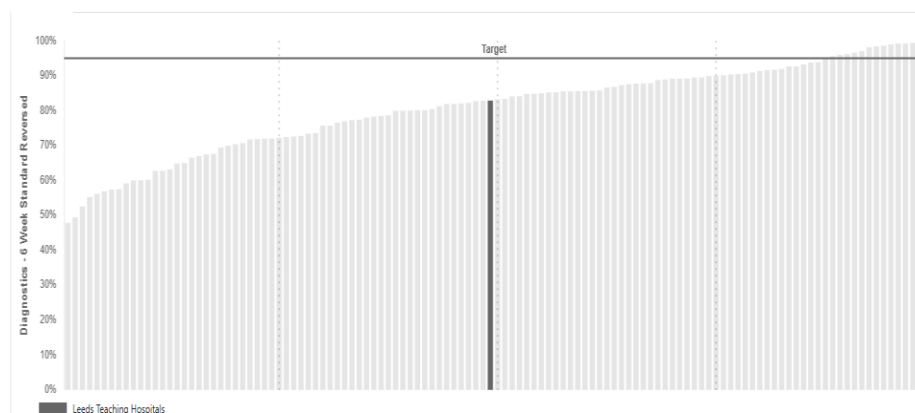
Target: 95%
Performance: 83.8%

Executive Owner: Clare Smith (Chief Operating Officer)

Variance: Common Cause variation. Fail variation indicated



National Ranking 60/118



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 was to deliver 95% by March 2025 	<ul style="list-style-type: none"> MRI continue to have delays for Paediatric GA MRI due to theatre capacity Ultrasound have the greatest number of breaches due to staffing pressures and capacity shortfalls LTH national ranking 60 out of 118 Trusts for diagnostics performance in May 25 (latest data available) 	<ul style="list-style-type: none"> Radiology have completed re-vetting the US waiting lists to remove any referrals where imaging is no longer required. This removed around 14% of long waiting patients. Medicare staff have started in mid-June supporting US weekend working which will aid a reduction in waiting times. It is anticipated improvements will be seen from August 2025. MRI relocatable hybrid scanner at Chapel Allerton delayed until early August. Mobile MRI van remains in place Additional CT scanner delivered to Seacroft in April which is now operational and delivering additional capacity Children's endoscopy have limited capacity to recover the backlog of waits and have contacted WYAAT trusts to see if any additional capacity can be gained to recover the current backlog. Hull have offered capacity to support from September Monthly diagnostic escalation meetings in place to review performance and recovery plans



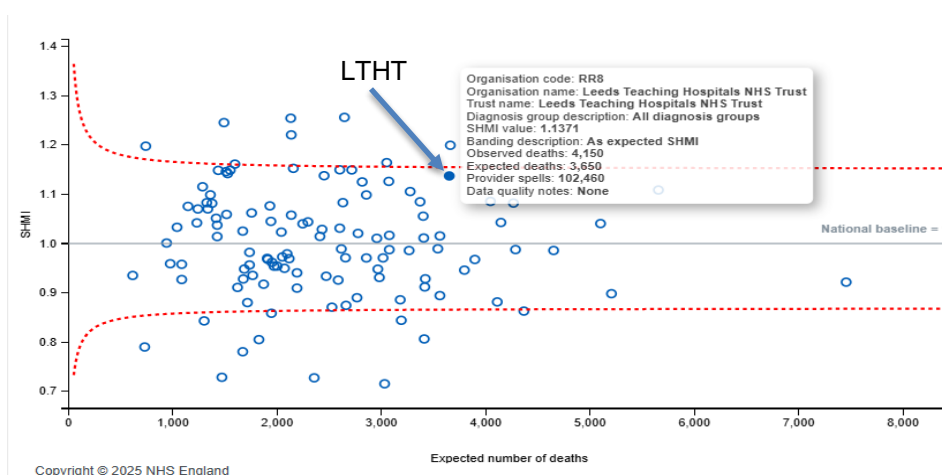
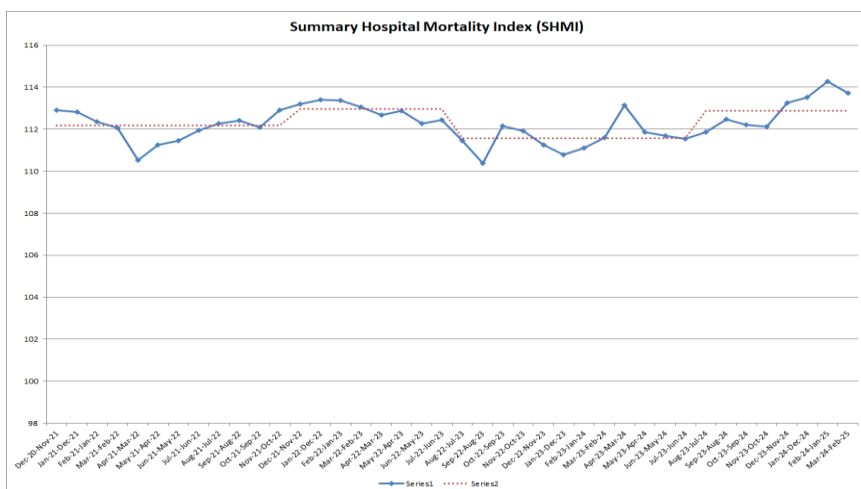
Mortality

March 2024 – February 2025

Target: 100
Performance – SHMI: 113.7 “As Expected”

Executive Owner: Dr Magnus Harrison (Chief Medical Officer)

Variance: Common cause variation.



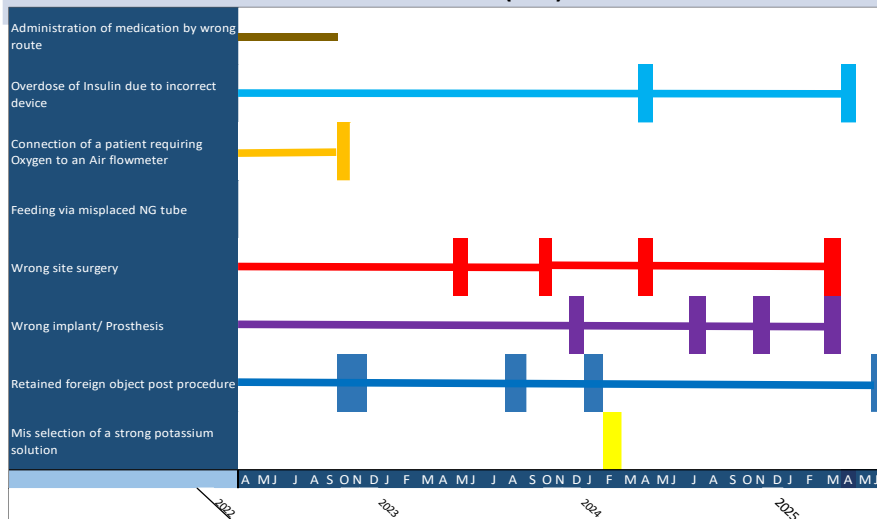
Background	Context	Action
<ul style="list-style-type: none"> There are two national Trust-level risk adjusted measures of mortality; the Summary Hospital Mortality Indicator (SHMI) and the Hospital Standard Mortality Rate (HSMR). These are used by NHSi and the CQC to inform the mortality alert process, and are calculated using a twelve month rolling average. 	<ul style="list-style-type: none"> The Trust SHMI for November 2023 – October 2024 was 113.7 and “As Expected”. The Upper Control Limit was 115.5 	<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 (SJR) methodology is used to identify learning and provide assurance on quality of care.



Never Events

Q1 (2025/26)

Target: 0
Performance : 2 (YTD)



Executive Owner: Dr Magnus Harrison (Chief Medical Officer)

Variance: Common cause variation.

Never Events 2024/25 - 2025/26	Q1 24-25	Q2 24-24	Q3 24-25	Q4 24-25	Q1 25-26
Wrong site surgery	1	0	0	1	0
Wrong implant/ Prosthesis	0	2	1	1	0
Retained foreign object post-procedure	0	0	0	0	1
Overdose of insulin due to abbreviation or incorrect device	1	0	0	0	1
Total	2	2	1	2	2

Background	Context	Action
<p>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> <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>The number of Never Event incidents are reported to our commissioners each quarter via the national Strategic Information System (SteIS).</p> <p>There have were 7 Never Events reported in 2024/25.</p> <p>2 Never Events have been reported in 25/26:</p> <ol style="list-style-type: none"> Overdose of Insulin due to wrong device (ACC). Retained surgical item (ENT Theatres WGH). 	<p>All Never Event incidents are subject to a Patient Safety Incident Investigation (PSII).</p> <p>Learning and actions from Never Events are subject to review at the WYAAT shared learning group chaired by LTHT.</p>



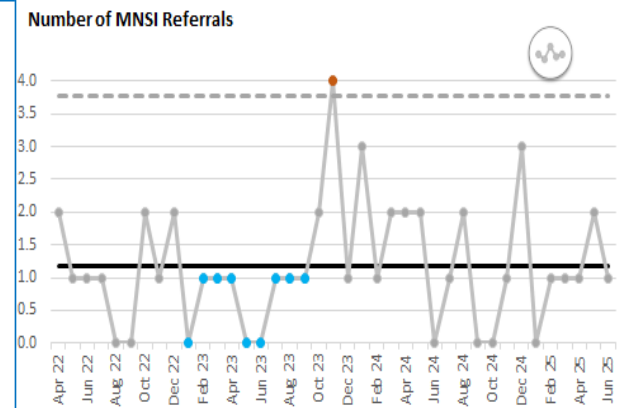
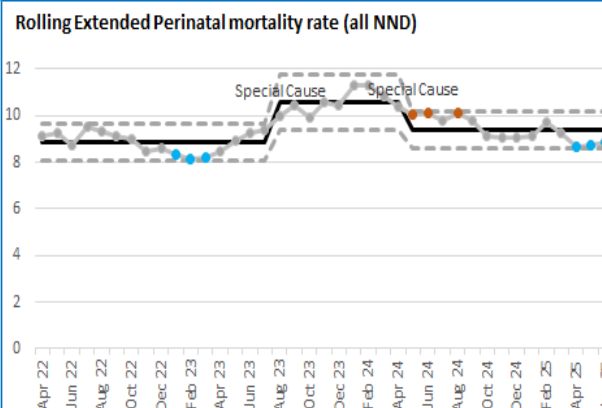
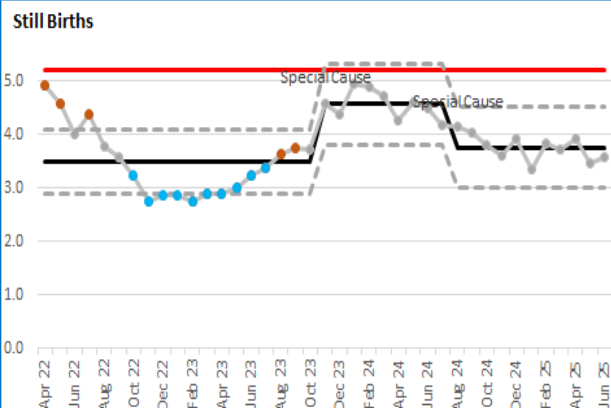
Maternity

June 2025

Still Birth Rate: 3.56
Extended Perinatal Mortality Rate: 8.85
Number of MNSI Referrals: 1

Executive Owner: Rabina Tindale (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 expected survival rates.

- There was 2 stillborn babies during June 2025**
- Intrauterine death of 1 twin at 31 weeks and 1 day. Fetal medicine unit (fmu) scan confirmed twin 1 had absent cardiac activity, breech, oligohydramnios and multiple structural concerns.
- Seen in FMU after Spina Bifida, ventriculomegaly, banana shaped cerebellum and right talipes were seen on anatomy scan. Conditions confirmed in FMU. Parents continued with the pregnancy, mother developed essential hypertension and thrombocytopenia at 25 weeks and 1 day. Mother opted for fetocide, but prior to procedure it was noted that the baby had passed away in utero.
- There was 3 inborn neonatal deaths in June 2025:**
- Romanian family, interpreter used, spontaneous preterm labour at 22 weeks and 2 days. Care was reorientated on NNU and the baby sadly passed away at 0 days of age.
- Mother attended MAC at LGI at 21 weeks and 2 days with vaginal bleeding, admitted onto antenatal ward. Baby boy was born at 22 weeks and 3 days with signs of life, comfort cares given. Baby passed away at 0 days of age.
- Mother booked at Grimsby for birth at LTHT. seen in FMU and

- 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

June 2025

Target: 4.9 %

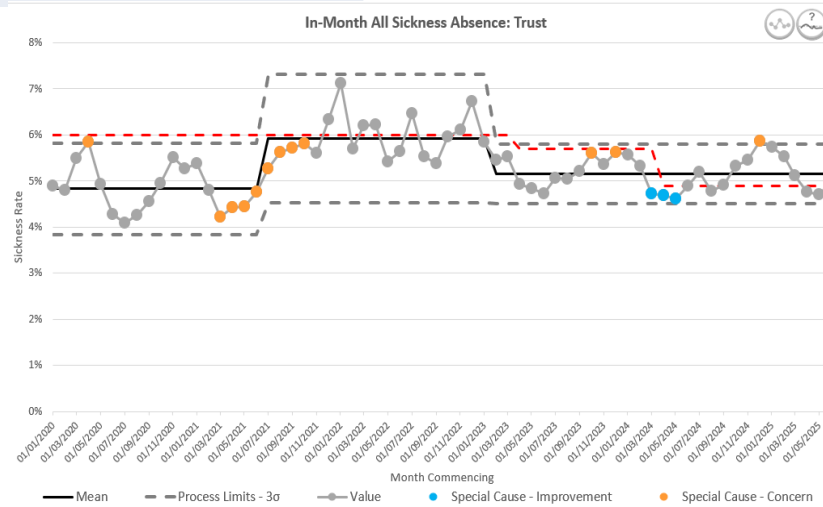
Performance (Rolling Sickness Absence Rate): 5.19%

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 2025/26 target for Rolling 12-month Sickness Absence has been maintained at 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 month sickness absence rates are within SPC limits. Q1 2025/26 in-month rates are higher than Q1 2024/25 indicating a slight deterioration in year-on-year 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. New Burnout Group established and led by Deputy Chief Medical Officer, Dr Liz Garthwaite and Jo Buck, Deputy Director of HR, and reported to Workforce Management Group (WGM) on 27 August 2024 and Workforce Committee (WFC) on 19 September 2024. Supporting Attendance Policy has been reviewed and consultation with staff side colleagues is on-going. However, the process improvements detailed in the revised policy have already been implemented. Review of stress management process also under review, with a scheduled completion by the end of the calendar year. Thrive at Work pilot running for 12 months to help reduce / prevent long term sickness absence. 	N/A



Voluntary Turnover

June 2025

Target: 5.93%

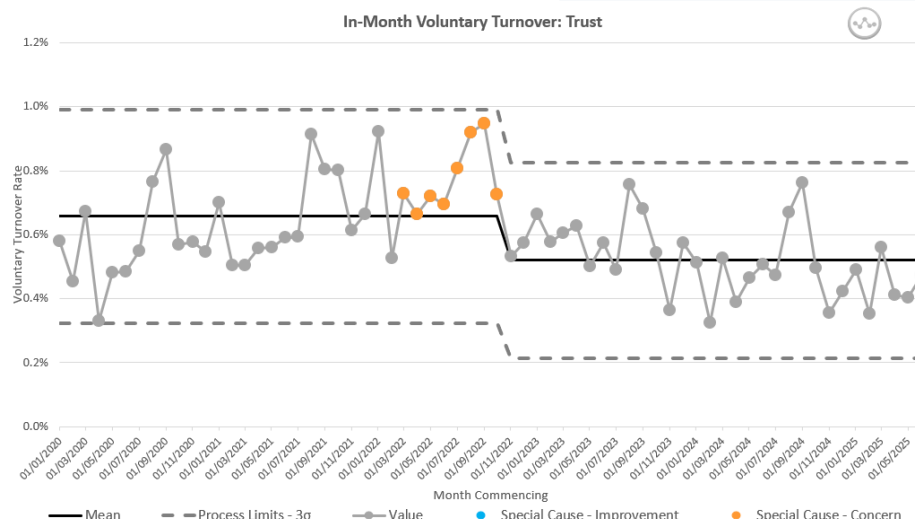
Performance (Rolling Voluntary Turnover Rate): 5.87%

Variance: Common cause variation.

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

Management/Clinical Owner: Jo Buck

Sub-Groups: Resource Management Group, Workforce Management Group



Background	What the chart tells us	Issues	Actions	Context
<ul style="list-style-type: none"> Following the Trust Commitment in 2024/25, we have set the target at maintaining current performance in relation to turnover. 	<ul style="list-style-type: none"> While the in-month rates remain around the mean, the overall rolling rate has now dipped below the target of 5.93% 	N/A	<ul style="list-style-type: none"> Annual self-assessment process embedded into Staff Engagement Group's Forward Plan, informed by the NHS Staff Survey Results and aligning to In-Year Commitments. Retention plans are incorporated into all CSU Operational Workforce Plans and are part of their 'business and usual'. Longevity Strategy implemented to support embedding of retention activity into standard work. Longevity Strategy includes the CSU support to embed Retention Conversations into standard work, to fit local contexts: Exit interviews, stay conversations, health and wellbeing conversations, Staff Survey conversations, appraisals, scope for growth, 1-1s etc. 	<ul style="list-style-type: none"> During 2024/25 the national 'NHS People Promise Exemplar Programme' structure underpinned the progression against the retention in-year commitment. Significant improvement over the two years of the commitment. Target now to maintain closing position.



Agency Spend

June 2025

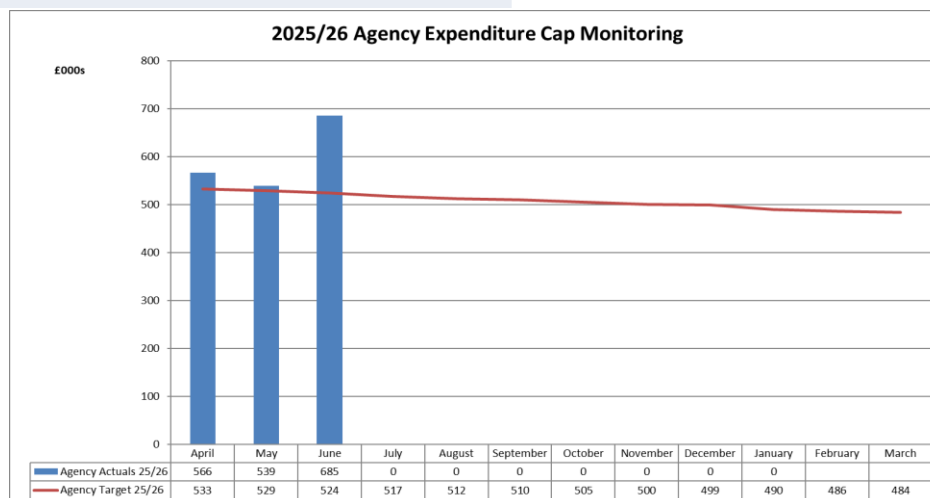
Target: 0.53% **Performance:** 0.66%

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

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

Management/Clinical Owner: Chris Ellison

Sub-Groups: Resource Management Group and Workforce Management Group



Background	What the chart tells us	Issues	Actions	Context
<ul style="list-style-type: none"> This was an area of strong performance for the Trust in 2024/25. The agency cap for 2025/26 is set as a 5% reduction on agency spend against 2024/25 with a decreasing spend target per month phased across the year. This target will be monitored as we progress through 2025/26. 	<ul style="list-style-type: none"> To support achievement of the target it has been phased across the financial year. Agency spend was tracking slightly above the target in April and May, however, has increased by £146k in June. Agency nursing has increased mainly within Urgent Care and Women's and Agency AHPs spend has increased within Radiology. 	N/A	<ul style="list-style-type: none"> During 2024/25 the Trust worked hard to reduce the reliance on agency staff and this was achieved by aligning our workforce plans to service delivery along with our success in retaining our workforce. The Leeds Improvement Method (LIM) principles of daily management also supported further reductions in the use of agency spend and other variable pay. As at March 2025 LTHT is ranked as having joint third lowest overall spend on agency and bank staffing out of 119 providers in total. The Workforce Plan Delivery Group continues to manage the further reductions required on temporary workforce spend. Deep dives are planned into Agency spend across specific CSUs where agency spend had been higher than anticipated. We will continue to monitor CSU agency spend throughout 2025/26 and put actions in place where appropriate. We will also continue with agency until around mid-July to support Pathology implementing the LIMS project the costs for which continue to be charged against the capital scheme. HR and Finance Business Partners continue to work with CSUs to develop workforce action plans to address the situation. 	N/A



Bank and Overtime Spend

June 2025

Target for Bank Spend: 2.71% (bank only)

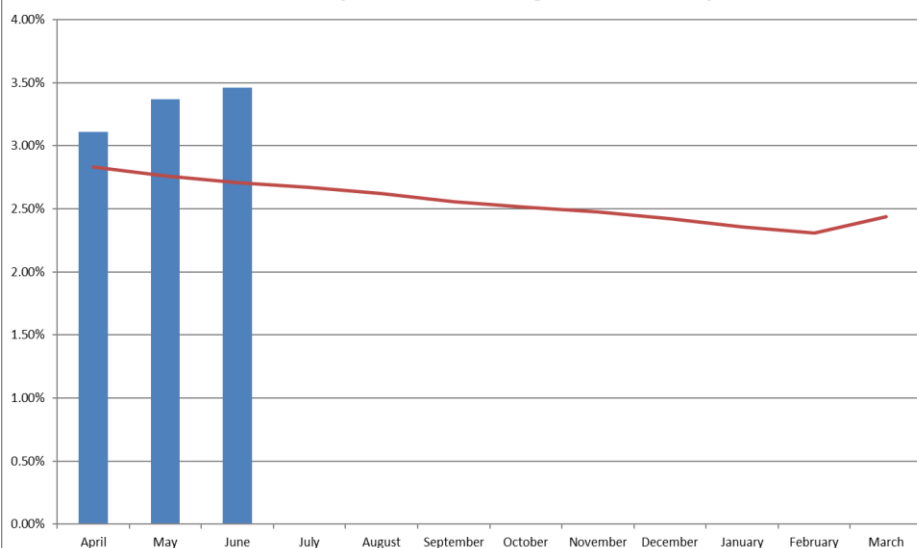
Performance: 3.47% (bank only)

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

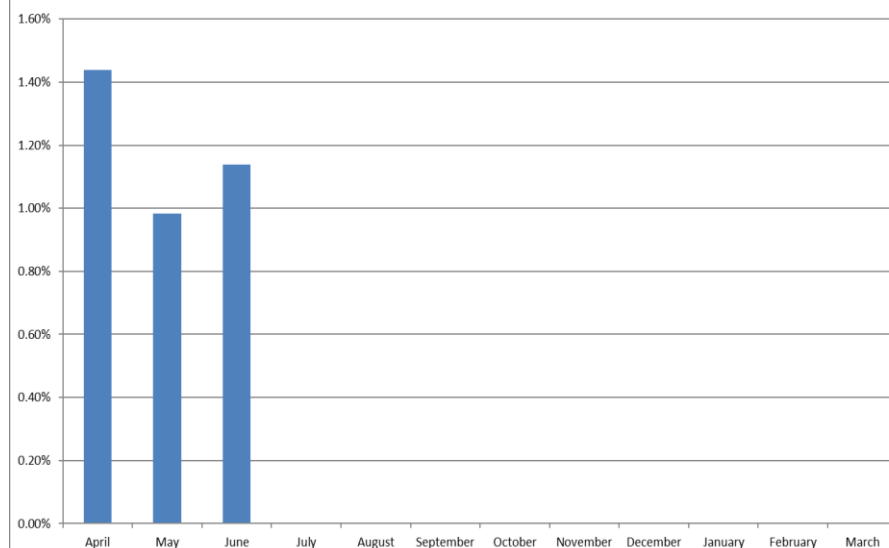
Management/Clinical Owner: Chris Ellison

Sub-Groups: Resource Management Group and Workforce Management Group

2025/26 Bank Spend as a Percentage of Total Staff Spend



2025/26 Overtime Spend as a Percentage of Total Staff Spend



Background	What the chart tells us	Issues	Actions	Context
<ul style="list-style-type: none"> The bank spend cap for 2025/26 is set as a 5% reduction on bank spend against 2024/25 with a decreasing spend target per month phased across the year. The total spend on bank for 2025/26 needs to remain under £30.5m This target will be monitored as we progress through 2025/26. 	<ul style="list-style-type: none"> The red line on the bank graph shows our target across the year. Bank spend for June 2025 is 3.46% of total staff spend against a June target of 2.71%. Bank costs are £0.9m higher than anticipated partly driven by J32 winter ward remaining open into May and bank reduction plans not yet delivering as expected. There is no target against which to measure overtime spend. 	N/A	<ul style="list-style-type: none"> During 2025/26 the Leeds Improvement Method (LIM) principles of daily management supported reductions in the use of bank spend and other variable pay and as at March 2025 LTHT is ranked as having joint third lowest overall spend on agency and bank staffing out of 119 providers in total. The Workforce Plan Delivery Group continues to manage the further reductions required on temporary workforce spend. Deep dives are therefore occurring into bank and overtime spend to identify appropriate actions and monthly KPIs are being monitored. HR and Finance Business Partners continue to work with CSUs to develop workforce action plans to address the situation. 	N/A



Vacancy Rate

June 2025

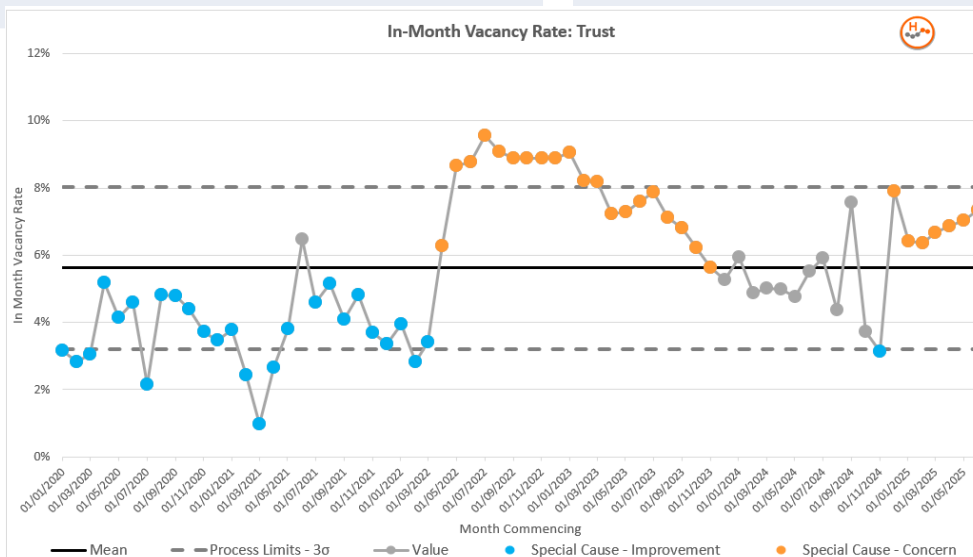
Target: N/A
Performance: 7.35%

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"> We have now seen 7 consecutive months above mean leading to special cause concern however this may be at least in part due to the Trust's action on vacancy control means some roles have a 13-week lead in time before they are advertised. 	N/A	<ul style="list-style-type: none"> To support achievement of the 2025/26 financial plan, the Trust has a vacancy control process currently in place which involves a 13-week lead in time for adverts for some CSUs to support them achieving financial balance. There are, however, exceptions to the 13-week lead in time where there are particular service requirements these exceptions are agreed by Tier 2 and TERG. 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. 	N/A



Staff Engagement Rate

April 2025

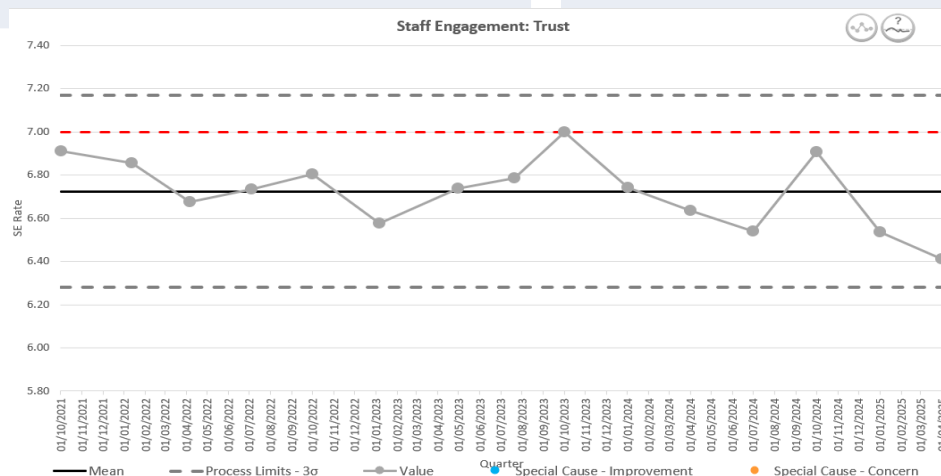
Target: 7
Performance: 6.4

Variance: Common cause variation.

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"> Staff engagement scores fell nationally in the 2024 staff survey. LTHT was not an exception, although we retain an above average score. 2025/26 is expected to be another challenging year and the target is to maintain staff engagement at the 2024/25 level. 	<ul style="list-style-type: none"> While the staff engagement score has not hit the target since the staff survey in 2023 the scores currently remain within control limits 	<p>Annual Staff survey:</p> <ul style="list-style-type: none"> Participation in 2024 is 48% slightly lower than national average 49%. Staff Engagement Score in the staff survey in 2024 is 6.9 (from 7.0). The deterioration mirrors the national trend, and remains above the national average of 6.8. 	<p>NHS Staff Survey results:</p> <ul style="list-style-type: none"> Considered as part of the annual Staff Engagement Group review (Feb 2025), and priorities identified. Priorities built into the Group's Forward Plan. Utilised to inform the re-refresh of the LTHT In-Year Commitments. presented and discussed as part of Workforce Management Group and Committee meetings. Triangulated and discussed alongside patient and quality metrics., in relevant networks, sub-committees and forums. CSU level results utilised to inform CSU Operational Workforce Plans, and team level action. Assurance of CSU activity gained via Staff Engagement Group rolling presentation schedule, and HR Business Partner/Tri Team Joint Accountability and Assurance Framework meeting. 	<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.

I&E Position 2025/26



June 2025

Executive Owner: Jenny Ehrhardt (Director of Finance)

The financial plan submitted for 2025/26 is a breakeven position and includes a waste reduction programme (WRP) of £89m.

In June the Trust reported an in-month deficit of £4m, which was in line with the planned deficit. For the financial year to date the deficit is £12.7m, which is £0.9m adverse to the NHSE plan. The biggest driver of the adverse position is pay expenditure being higher than planned.

Pay expenditure to date is £305.7m, £1.6m adverse to the NHSE plan partly driven by J32 winter ward remaining open longer than planned and bank reduction plans not yet delivering as expected. Non-pay expenditure to date is £218.9m (including depreciation and finance costs), £4.8m favourable to the plan. The non pay favourable variance relates mainly to high cost drugs and devices which is offset with income.

There are a number of significant risks to achieving the financial plan, particularly around risks to delivery of the waste reduction programme, the ability to absorb inflationary pressures, other cost pressures to achieve operational performance standards and risks around assumed levels of funding. The Trust continues to explore further mitigations to reduce the financial risk within the plan.

Capital & Cash Position



June 2025

Executive Owner: Jenny Ehrhardt (Director of Finance)

Capital

The Trust's capital expenditure forecast for 2025/26 has decreased by £4.2m to £109.3m. This is due to a reduction of £4.8m to the PSDS Phase 4 (£1.8m forecast for 25/26 and £4.8m in 26/27), which is marginally offset by the increase of £0.6m to the MND Centre. Both schemes have been adjusted to be in line with the revised 25/26 forecast. The programme is broken down as follows:

Programme	Forecast 2025/26 £000
Medical Equipment	12,147
Informatics	5,489
Building & Engineering	82,062
Building the Leeds Way	1,000
Contingency	5,611
Leases	3,000
Total	109,309

Expenditure to 30th June 2025 was £7.5m which was £0.3m behind with forecast. M&SE YTD spend is £1.4m which was in line with forecast. Informatics YTD spend was £1.0m, which was in line with forecast. B&E YTD spend was £3.5m which was behind forecast by £0.3m due to works behind schedule on the BE requirements for Cardiology MES Jubilee Wing, the Elective Theatres, CAH - Constitutional Standards funded scheme and the Security Investments Trustwide scheme. Leases YTD spend was £0.6m due to the remeasurement to Moor House, Moor Lane, Westbourne Green Community Hospital and Calderdale Royal Hospital (Halifax) in M3 which was based on the agreed rent charge in 25/26. BtLW YTD spend was £0.4m, which was in line with forecast. Risk reserve YTD spend is £0.6m.

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.

Cash

The June 2025 closing cash balance is £69.5m, a decrease of £8.3m from the previous month. This is £8.6m better than the latest fundamental review (£60.9m), mainly due to the slower movement of year-end capital creditors than anticipated during the first quarter of the year.

Total receipts for the month amounted to £164m which included £1.9m for the May VAT return. Total payments in month were £172m, comprising £98m for payroll, and £74m for accounts payable, which included £2.5m of capital invoices relating to 2025/26. The Better Payments Practice Code ("BPPC") compliance for the month was 97%.

Bank interest of £0.6m was received in total for the month, £0.5m with an interest rate of 4.14%, and £0.1m from short term deposits at rate of 4.22%. Short term deposits continue to be made with the National Loan Funds to mitigate the reduction in interest rates set by the Bank of England.

The latest cash forecast shows that the Trust will not require revenue cash support for the remainder of the calendar year. This is predicated on delivery of the Trust revenue position, including full delivery of the waste reduction programme.

Statement of Comprehensive Income



June 2025

Executive Owner: Jenny Ehrhardt (Director of Finance)

		Annual Plan £m	In Month			Year to Date		
			Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
INCOME	Commissioner Income (excluding Non-PbR Drugs, Blood and Devices)	1,280.1	105.8	106.3	0.5	317.4	318.7	1.3
	Non-PbR Drugs, Blood and Devices	395.9	33.0	32.1	(0.9)	99.0	94.0	(5.0)
	Sub-Total Commissioner Income	1,676.0	138.8	138.4	(0.4)	416.4	412.7	(3.7)
	Other Clinical Income	11.8	1.0	0.9	(0.1)	2.9	2.9	0.0
	Total Clinical Income	1,687.7	139.8	139.3	(0.5)	419.3	415.6	(3.7)
	Other Income (non Covid)	303.8	24.6	26.0	1.4	73.6	73.4	(0.2)
	Other Income (Covid Top Up; Testing; Vaccination)	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Total Income	1,991.6	164.4	165.3	0.9	493.0	489.0	(3.9)
EXPENDITURE	Pay Costs	(1,196.1)	(101.6)	(102.3)	(0.7)	(304.1)	(305.7)	(1.6)
	Sub-Total Pay	(1,196.1)	(101.6)	(102.3)	(0.7)	(304.1)	(305.7)	(1.6)
	Non Pay Costs (excl Non-PbR Drugs, Blood and Devices)	(389.0)	(33.8)	(34.9)	(1.1)	(101.9)	(102.1)	(0.3)
	Non-PbR Drugs, Blood and Devices	(396.4)	(33.0)	(31.7)	1.3	(99.1)	(93.9)	5.2
	Sub-Total Non Pay	(785.4)	(66.9)	(66.6)	0.2	(200.9)	(196.0)	4.9
	Total Expenditure	(1,981.4)	(168.4)	(168.9)	(0.5)	(505.0)	(501.7)	3.3
	EBITDA	10.2	(4.0)	(3.6)	0.4	(12.1)	(12.7)	(0.6)
	EBITDA %			-2.2%			-2.6%	
OTHER	Depreciation	(54.3)	(4.0)	(4.3)	(0.2)	(12.0)	(12.8)	(0.8)
	Amortisation	(4.5)	(0.4)	(0.4)	(0.0)	(1.1)	(1.2)	(0.0)
	Impairments	(10.5)	0.0	0.0	0.0	0.0	0.0	0.0
	Investment Revenue	4.1	0.3	0.6	0.2	1.0	1.7	0.6
	Other Gains and (Losses)	0.0	0.0	0.0	0.0	0.0	0.1	0.1
	Finance Costs	(24.0)	(1.2)	(12.7)	(11.5)	(3.7)	(14.9)	(11.3)
	Dividends payable on Public Dividend Capital (PDC)	(10.8)	(0.9)	(0.9)	0.0	(2.7)	(2.7)	0.0
	Retained Surplus/(Deficit) BEFORE ERF/TIF	(89.9)	(10.2)	(21.2)	(11.1)	(30.6)	(42.6)	(12.0)
ADJUSTED	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	(7.2)	(0.1)	(0.6)	(0.4)	(0.1)	(0.7)	(0.6)
	Impairments	10.5	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	(86.6)	(10.3)	(21.8)	(11.5)	(30.7)	(43.3)	(12.7)
	Elective Recovery Fund (ERF)	97.7	8.1	8.2	0.2	24.2	24.5	0.3
	Adjusted Surplus/(Deficit) INCLUDING ERF	11.0	(2.2)	(13.6)	(11.3)	(6.5)	(18.8)	(12.3)
	Adjust PFI revenue costs to UK GAAP basis	(11.0)	(1.8)	9.5	11.3	(5.3)	6.1	11.4
	Adjusted financial performance surplus/(deficit)	0.0	(4.0)	(4.0)	(0.0)	(11.8)	(12.7)	(0.9)

Statement of Financial Performance



June 2025

Executive Owner: Jenny Ehrhardt (Director of Finance)

	Year to date movement			In Month	
	Closing 31st March 2025 £m	As at 30th June 2025 £m	Year to date movement £m	Prior Month £m	In-month movement £m
Non-Current Assets:					
Property, Plant And Equipment	804.1	798.8	(5.2)	798.6	0.3
Intangible Assets	10.8	9.7	(1.2)	10.1	(0.4)
Trade And Other Receivables	12.5	15.4	2.9	13.7	1.7
Total Non-Current Assets	827.5	823.9	(3.5)	822.4	1.6
Current Assets:					
Inventories	29.4	30.2	0.8	28.3	1.9
Trade And Other Receivables	72.3	89.1	16.8	81.5	7.6
Cash and Cash Equivalents	82.2	69.4	(12.8)	77.8	(8.4)
Non-Current Assets Held for Sale	0.0	0.0	0.0	0.0	0.0
Total Current Assets	183.8	188.7	4.8	187.5	1.2
Total Assets	1,011.3	1,012.6	1.3	1,009.9	2.7
Current Liabilities:					
NHS Trade Payables	(4.4)	(7.2)	(2.8)	(5.8)	(1.4)
Trade and Other Payables	(211.0)	(221.3)	(10.2)	(216.6)	(4.6)
Borrowing / DH Loans	(2.1)	(2.2)	(0.1)	(2.1)	(0.0)
Other Financial Liabilities - PFI	(21.8)	(22.4)	(0.6)	(22.4)	(0.1)
Provisions For Liabilities And Charges	(7.9)	(7.9)	0.0	(7.9)	0.0
Total Current Liabilities:	(247.2)	(261.0)	(13.7)	(254.8)	(6.1)
Net Current Assets/ (Liabilities)	(63.4)	(72.3)	(8.9)	(67.3)	(5.0)
Total Assets Less Current Liabilities	764.1	751.6	(12.4)	755.0	(3.4)
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	(9.2)	(9.2)	0.0	(9.2)	0.0
Other Financial Liabilities - PFI	(278.7)	(284.5)	(5.8)	(274.8)	(9.6)
Provisions For Liabilities And Charges	(10.0)	(9.9)	0.1	(9.9)	0.0
Total Non-Current Liabilities	(297.9)	(303.5)	(5.7)	(293.9)	(9.6)
Total Assets Employed	466.2	448.1	(18.1)	461.1	(13.0)
Financed By Taxpayers Equity					
Public Dividend Capital	641.8	641.8	0.0	641.8	0.0
Retained Earnings	(175.6)	(193.7)	(18.1)	(180.7)	(13.0)
Revaluation Reserve	0.0	0.0	0.0	0.0	0.0
Total Taxpayers Equity	466.2	448.1	(18.1)	461.1	(13.0)

Cash Flow Statement



June 2025

Executive Owner: Jenny Ehrhardt (Director of Finance)

Cash Flow	Closing 31st March 2025 £m	As at 30th June 2025 £m	Previous Month £m
<u>Operating Activities</u>			
EBITDA	112.1	11.8	7.1
Donated assets received credited to revenue but non cash	(7.3)	(1.7)	(0.8)
Interest paid	(14.6)	(3.5)	(2.2)
Dividend paid	(7.0)	0.0	0.0
Decrease/(increase) in inventories	(0.8)	(0.8)	1.1
Decrease/(increase) in trade and other receivables	13.9	(18.1)	(8.6)
(Decrease)/Increase in trade and other payables	(9.8)	22.8	17.8
(Decrease)/Increase in provisions	1.6	(0.1)	(0.1)
Net cash inflow/(outflow) from Operating Activities	88.2	10.4	14.5
<u>Cash Flows from Investing Activities</u>			
Interest received	4.6	1.7	1.1
(Payments) for property, plant and equipment	(79.4)	(19.9)	(16.4)
Proceeds from disposal of property, plant and equipment	0.2	0.1	0.0
(Payments) for intangible assets	(2.4)	0.0	0.0
Proceeds from disposal of intangible assets	0.0	0.0	0.0
Receipt of cash donations to purchase capital assets	7.3	1.7	0.8
PFI lifecycle prepayments (cash outflow)	(6.2)	(1.7)	(1.1)
Net cash outflow from Investing Activities	(75.9)	(18.2)	(15.6)
Net cash inflow before Financing	12.3	(7.8)	(1.1)
<u>Cash Flows from Financing Activities</u>			
Public dividend capital received	44.3	0.0	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	(2.1)	0.0	0.0
Capital element of finance lease and PFI	(20.6)	(5.0)	(3.3)
Net cash inflow/(outflow) from Financing Activities	21.7	(5.0)	(3.3)
Increase/(decrease) in cash	34.0	(12.8)	(4.4)
Cash at the beginning of the year	48.2	82.2	82.2
Cash at the end of the financial period	82.2	69.4	77.8

Supplementary Metrics Produced by Exception



Cancelled Ops

June 2025

Target: 0

Performance – LMCO: 129

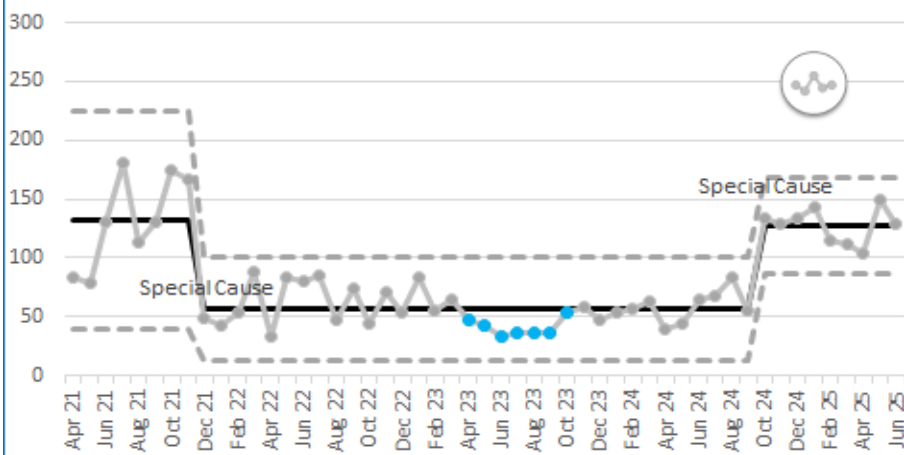
Performance – 28 day Standard: 22

Executive Owner: Clare Smith (Chief Operating Officer)

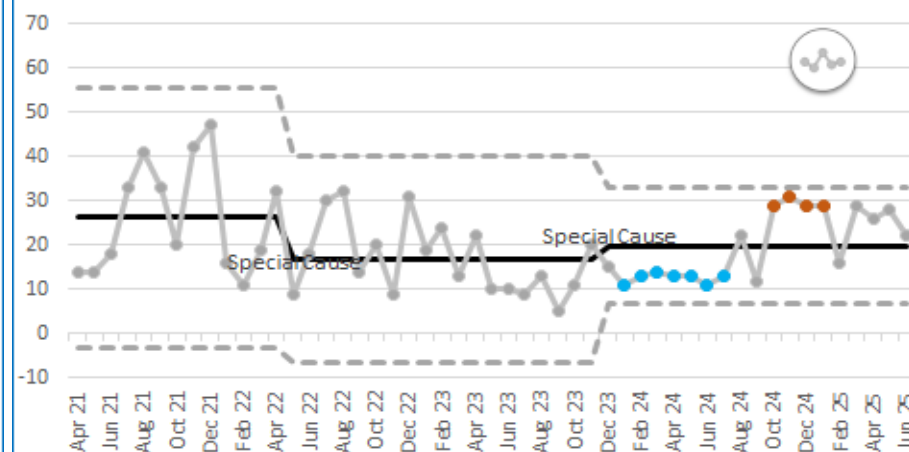
Variance: LMCO – Common cause variation.

28 day – Common cause variation

Last Minute Cancelled Ops



Cancelled Ops 28days










Background	Context	Action
<p>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>	<p>Cancelled Operations</p> <ul style="list-style-type: none"> There were 129 LMCO in June 2025. The main reasons for LMCO were 'ran out of theatre time' and 'ward bed capacity'. For Q4 LTHT ranked 93rd out of 118 <p>28 Day Breaches</p> <ul style="list-style-type: none"> There were 22 breaches of the 28-day standard in June 2025. 	<ul style="list-style-type: none"> Daily escalation process for potential cancellations to support with bed pressures intended to reduce cancellations LTHT's cancellation rate is 1.3% against a target of 1.1% for teaching hospitals. Theatre team have reached out to top performing organisations to determine what lessons can be learned 28 day breach volumes will be monitored through the Service Delivery Accountability meetings (SDAMs) Strategic Theatre Utilisation Group oversight of productivity metrics and HVLC list delivery Review of acute flows into neurosciences as volume of acute work has resulted in cancellations during June and July 2025

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