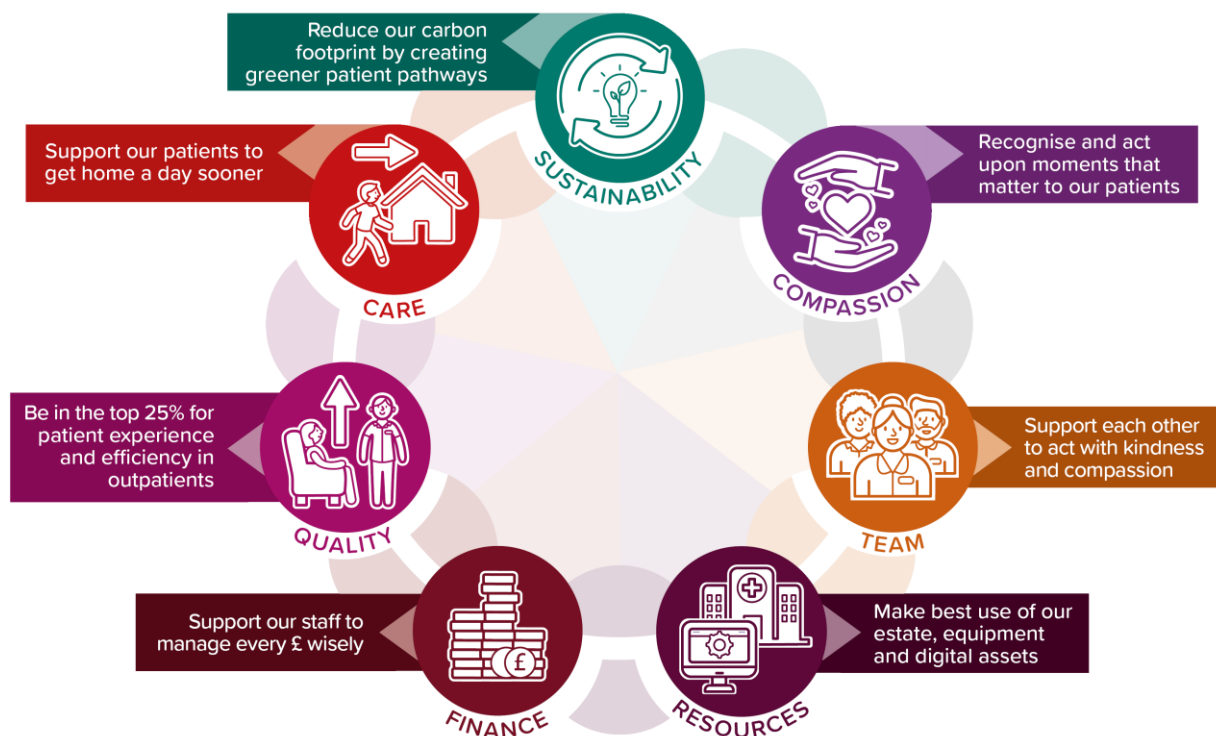


# **Integrated Quality & Performance Report**

## **September 2025**

# 7 Commitments



# Summary - Performance

## Performance

KPI	Latest month	Performance	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
AE Attendances per day	Aug 25	922.0	-			944.7	819.6	1069.7
Ambulance Handovers <15mins LGI	Aug 25	00:15:25	00:15:00			00:17:00	00:15:12	00:18:48
Ambulance Handovers <15mins SJUH	Aug 25	00:14:44	00:15:00			00:22:13	00:18:04	00:26:22
Last Minute Cancelled Ops	Aug 25	102	-			80	40	119
Cancelled Ops 28days	Aug 25	34	-			19	3	36
Cancer 28day FSD	Jul 25	75.2%	75.0%			74.8%	66.1%	83.4%
Cancer 31day	Jul 25	95.1%	96.0%			88.2%	82.4%	94.1%
Cancer 62 day	Jul 25	64.1%	85.0%			57.6%	45.5%	69.6%
Diagnostics	Aug 25	82.9%	95.0%			91.6%	88.4%	94.8%
DNA Rate	Aug 25	7.05%	-			7.05%	6.24%	7.86%
Outpatient DNA Volumes	Aug 25	7346	-			8560	6400	10719
ECS Monthly	Aug 25	78.4%	78.0%			75.0%	70.2%	79.8%
Elective LoS	Aug 25	4.4	-			4.1	3.1	5.1
Elective Readmissions	Aug 25	2.96%	-			3.25%	2.85%	3.66%
Non- Elective LoS	Aug 25	6.7	-			7.2	6.6	7.9
Non- Elective Readmissions	Aug 25	5.62%	-			9.66%	7.97%	11.35%
OPFU3months	Aug 25	37450	-			36206	34159	38252
RTT Performance	Aug 25	66.3%	92.0%			63.8%	62.0%	65.6%
RTT Total Waiting list	Aug 25	88326	-			90148	87739	92557
RTT 52 Week Breach Backlog	Aug 25	1790	0			2592	1977	3206
RTT 78Week Breach Backlog	Aug 25	1	0			51	-7	109



# Summary

KPI	Latest month	Performance	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
VTE	Aug 25	96.4%	95.0%			96.7%	95.4%	97.9%
CDI	Aug 25	15	-			14	6	22
MRSA	Aug 25	1	-			1	-2	3
E. Coli	Aug 25	24	-			25	9	40
Pseudomonas	Aug 25	4	-			4	-2	9
Klebsiella spp	Aug 25	7	-			12	1	22
Patient Level Metrics Score	Aug 25	95.3%	90.0%			95.1%	92.7%	97.4%
Environment Level Metrics Score	Aug 25	93.3%	90.0%			93.6%	91.0%	96.1%
Falls	Aug 25	182	-			196	164	227
Falls Rate per 1000 Bed Days	Aug 25	3.29	-			3.47	3.00	3.93
Developed Pressure Ulcers	Aug 25	27	-			47	30	64
Developed Pressure Ulcer Rate	Aug 25	0.89	-			0.88	0.55	1.21
Admitted with Pressure Ulcers	Aug 25	319	-			306	244	368
Admitted with Pressure Ulcers Rate	Aug 25	5.77	-			5.47	4.23	6.72
2222 Calls	Aug 25	47	-			59	37	82
Cardiac Arrest Calls	Aug 25	10	-			17	5	29
SHMI	Aug 25	112.4	100.0			112.3	110.8	113.7
Still Births	Aug 25	3.40	5.20			3.71	3.04	4.38
Rolling Extended Perinatal mortality rate (all NND)	Aug 25	8.88	-			9.32	8.64	10.00
Number of MNSI Referrals	Aug 25	0	-			1	-1	4
% Complaint Responses Sent Within Target Times (LR1 let	Aug 25	36%	80%			35%	17%	54%
% CSU Draft Comments Received Within Target Times (LR	Aug 25	44%	80%			49%	32%	66%
Median Response Lead Time (Days)	Aug 25	47	-			46	36	56
Defect Rate	Jul 25	3%	15%			11%	#N/A	#N/A
PALS Concerns - % Patients contacted in 2 w/days	Aug 25	80%	80%			79%	73%	84%



# Core Metrics

Measure	Commitment	Reporting Period	Performance	Target	Variance	Assurance
Rolling Overall Sickness Rate	Team	Aug-25	5.21%	4.90%		
Rolling Voluntary Turnover Rate	Team	Aug-25	5.88%	5.93%		
In-Month Agency Spend (as % of total pay bill)	Finance	Aug-25	0.67%	0.53%		
In-Month Bank Spend (as % of total pay bill)	Finance	Aug-25	4.84%	2.83%		
In-Month Vacancy Percentage	Finance	Aug-25	6.45%	N/A		
In-Month Mandatory Training Compliance Rate	Team	Aug-25	89.85%	85.00%		
YTD Number of concerns raised to FTSU Guardian	Team	Aug-25	96	N/A		
Quarterly Pulse Survey						
PS Engagement Score	Team	Jul-25	6.44	6.5		
PS Team Working Score	Team	Jul-25	6.21	TBC		
PS Line Management Score	Team	Jul-25	6.65	TBC		
Annual Staff Survey						
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

# Ambulance Handover

Reduce waits  
for patients



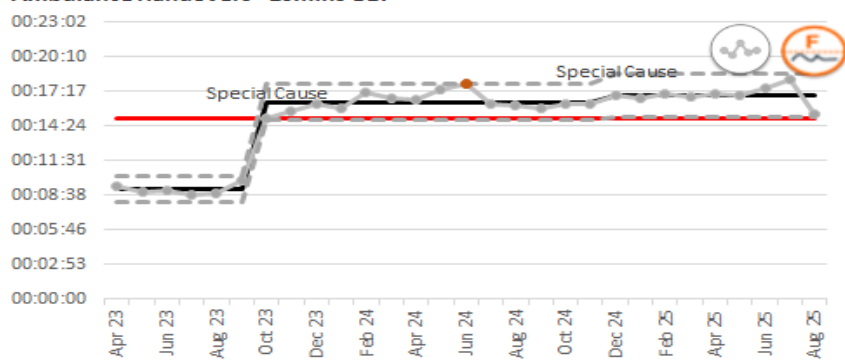
August 2025

**Target:** <15mins  
**Performance – LGI :** 00:15:25  
**Performance – SJUH :** 00:14:44

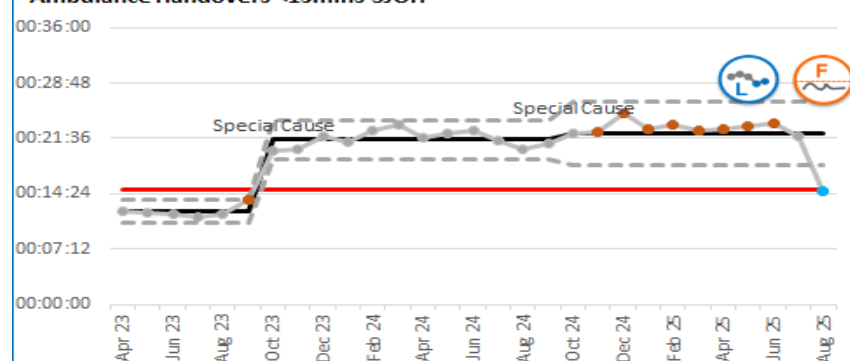
**Executive Owner:** Clare Smith (Chief Operating Officer)

**Variance:** Special cause variation.

**Ambulance Handovers <15mins LGI**



**Ambulance Handovers <15mins SJUH**



Background	Context	Action
<p><b>Background / target description:</b></p> <ul style="list-style-type: none"> <li>95% of all handovers should take place within 15 minutes</li> <li>Planning guidance target to improve CAT 2 response times to an average of 30 minutes</li> </ul>	<ul style="list-style-type: none"> <li>Increase in recorded ambulance handover times due to reporting changes made in October 2023. This added 5-8 minutes onto LTHT times. In July 2025 the YAS GPS trigger was changed from a 50m radius from A&amp;E to 25m which supported the ambulance handover clock start to be closer to the A&amp;E front door.</li> <li>Handover data is managed by YAS and submitted directly to NHSE. No in-flow data accuracy corrections made by YAS</li> <li>LGI – In August 2025 average handover time at LGI was 15:25 minutes</li> <li>SJUH - In August 2025 average handover time at SJUH was 14:44 minutes</li> <li>Out of 183 hospitals SJUH placed 17th and LGI placed 22nd for ambulance handovers for August 2025</li> </ul>	<ul style="list-style-type: none"> <li>LGI Ambulance Handover perfect week held during W/C 1st September with objective to redesign the handover process using A&amp;E nursing and paramedic feedback. This identified opportunity for higher number of patients being streamed from ambulance to 'fit to sit' &amp; rapid assessment area to support timeliness of ambulance handover. First 2 weeks in September LGI handover sustained 14 min 13 secs</li> <li>SJUH A&amp;E completed a test of change for ambulance handover which included a dedicated ambulance handover area and has also redesigned the handover process which has resulted in a reduction in handover time. Embedding of this test of change for September and October so winter ready.</li> <li>SDEC and PCAL pathways are the focus of work with YAS to ensure patients are in the right place at the right time, the PCAL team are planning to attend YAS training sessions to educate staff on the service over the next 2 months</li> </ul>

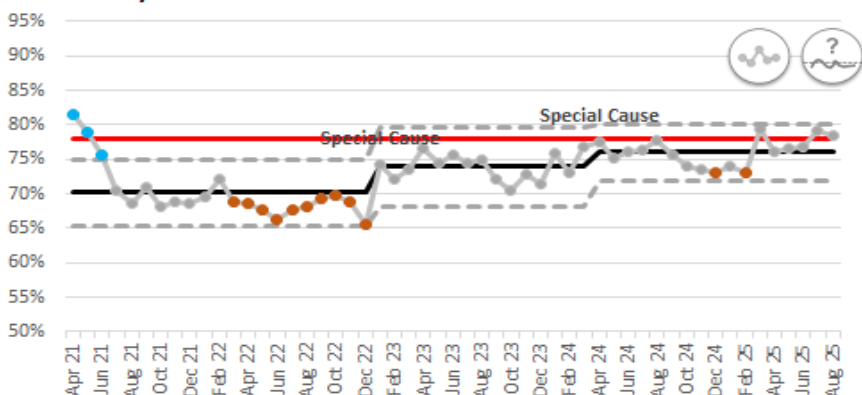


# Emergency Care Standard

August 2025

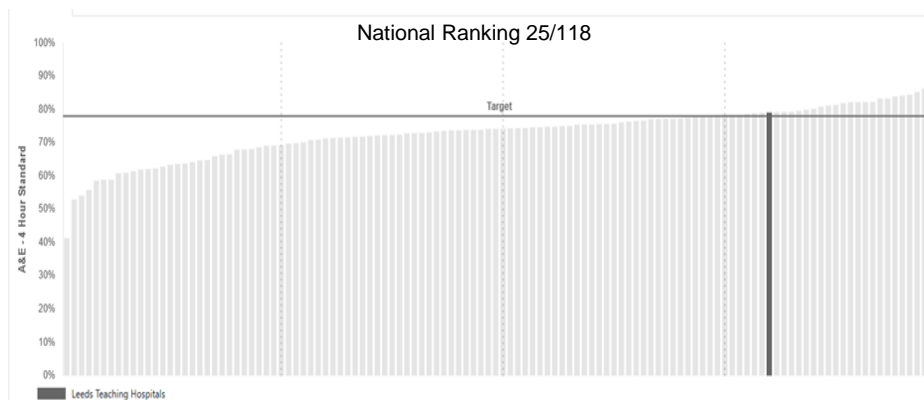
**National Planning Priority Target 2025/26: 78% by March 2026**  
**Performance: 78.4% against national trajectory**

ECS Monthly



**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"> <li>The constitutional standard is that 95% of attendees to A&amp;E will be admitted, transferred or discharged in 4 hours</li> <li>The 2025/26 national planning requirement is to deliver 78% by March 2026</li> </ul>	<ul style="list-style-type: none"> <li>ECS delivery for August 2025 was 78.4% against the trajectory of 78.2%</li> <li>National average ECS was 73.2% for August 2025</li> <li>LTHT ranked 25<sup>th</sup> out of 118 Trusts for ECS performance in August 2025</li> <li>Out of 10 peers, LTHT was 3<sup>rd</sup> for ECS delivery for August 2025</li> <li>LTHT had the second highest volume of attendances amongst peers</li> <li>Attendances across all sites in August 2025 increased by 5.7% compared to August 2024</li> <li>Ambulance conveyances in August 2025 (6121) increased by 2.3% compared to August 2024 (5985)</li> </ul>	<p>The urgent and emergency care team have reviewed A&amp;E performance pre-pandemic and taken learning from high performing Trusts within the region to plan improvement actions. These were scoped in August with focus on delivery in next 2 months;</p> <ul style="list-style-type: none"> <li>Streaming from the A&amp;E front door to the right speciality service for the patient in a booked and planned way (improving ECS and decongestion). September 2025</li> <li>LGI pathway improvement for chest pain patients through SDEC. September 2025</li> <li>Moving the minor illness service to booked appointments across both adult A&amp;E sites to maximise capacity and utilisation of this service. This will also enable booking of minor illness patients who present overnight, where safe to return in the morning for a booked slot rather than wait in A&amp;E overnight. This commenced on 15<sup>th</sup> September 2025</li> <li>'Knowing the business' standard work developed regarding 4-hour delivery co-produced with clinical and business teams and discussed both in flow and in review of 'yesterday's delivery'. Testing in September 2025 and embedding in</li> </ul>

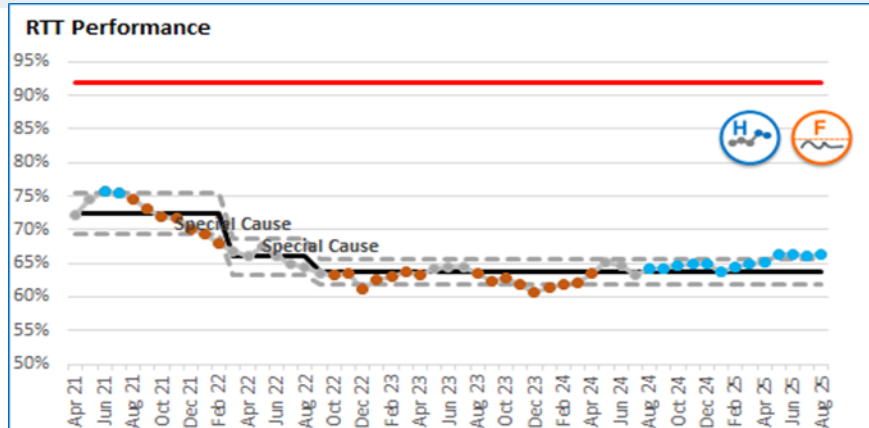




RTT

August 2025

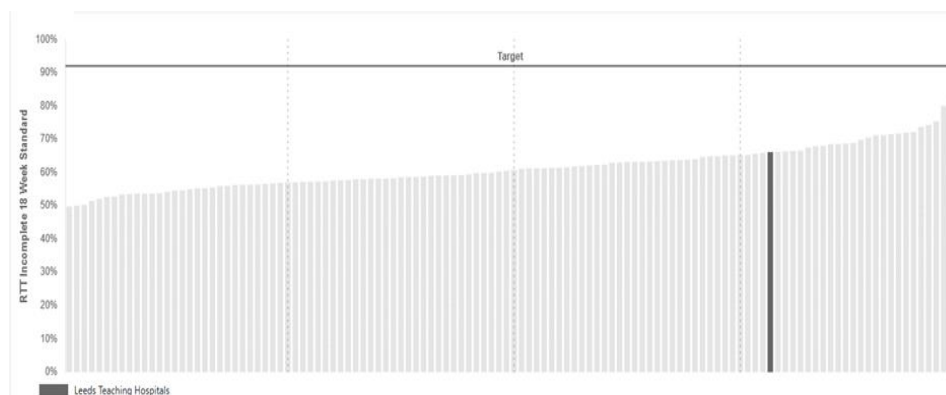
Target: 92%  
Performance: 66.3%



Executive Owner: Clare Smith (Chief Operating Officer)

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

National Ranking 25/118



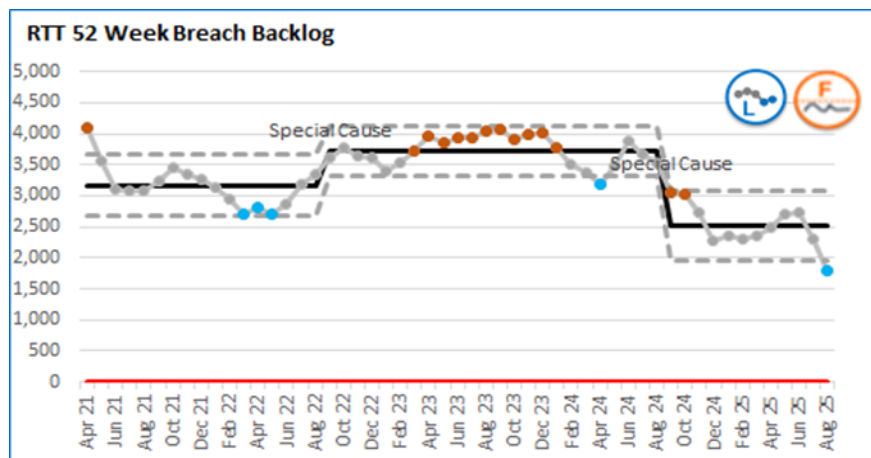
Background	Context	Action
<ul style="list-style-type: none"> <li>The constitutional standard is to ensure 92% of patients are treated within 18 weeks of referral</li> <li>In the 2025/26 national planning guidance there is a requirement for RTT delivery to improve by 5% by March 2026 (from 65% in Nov 24 to 70% by Mar 2026)</li> </ul>	<ul style="list-style-type: none"> <li>RTT slightly increased from 66.1% in July to 66.2% in August</li> <li>The Total Waiting List size in July 2025 position was 88,220 with August position of 88,476</li> <li>The number of patients waiting over 18 weeks was 29,893 in July which fell to 29,832 in August (61 patient decrease)</li> <li>National ranking for RTT is 25 out of 118 Trusts (July 25 latest data available)</li> </ul>	<ul style="list-style-type: none"> <li>Q2 Validation Sprint started 7<sup>th</sup> July 2025 running until 28<sup>th</sup> September with a plan to roll into FDP for Q3. All CSUs signed up and taking part.</li> <li>Federated Data Platform went live on Monday 14<sup>th</sup> July with 4 CSUs and was rolled out plan to all CSUs by the end of August</li> <li>Super-Saturday clinics started in Head and Neck and Neurosciences during September to reduce waiting list volume and waiting times</li> <li>Planning underway for additional activity to recover waiting list growth in Urology and Respiratory medicine- including Friday super clinics</li> <li>Outpatient Transformation Board and GIRFT Further Faster programme continues to focus on clinic utilisation, follow-up and DNA reductions throughout 2025/2026</li> <li>CAH reviewing the impact of a 20% increase in complex revision work on the throughput of CHOC theatres and impact on the elective Orthopaedic waiting lists in addition to cost and income impact</li> </ul>



# RTT 52 Weeks

August 2025

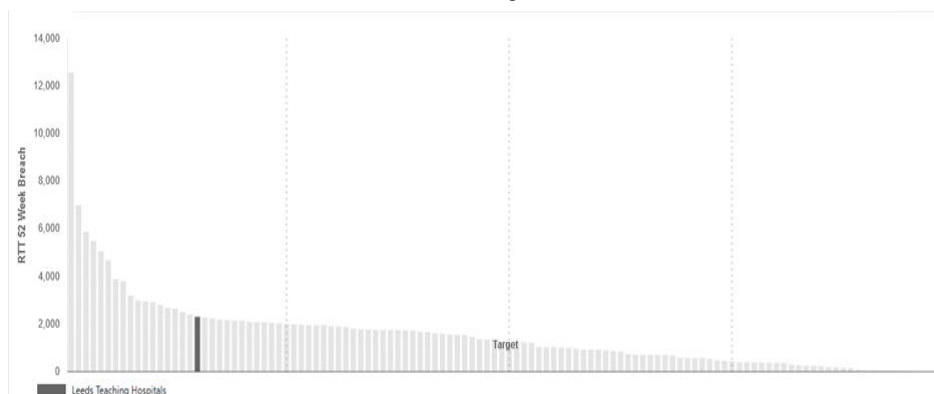
**National Planning Priority Target 2025/26: 1% of TWL (c750)**  
**Performance: 1,790**



**Executive Owner:** Clare Smith (Chief Operating Officer)

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

National Ranking 101/118



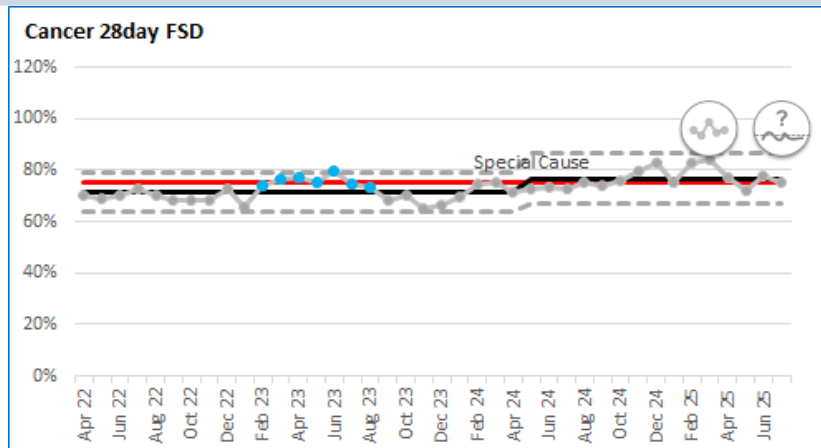
Background	Context	Action
<ul style="list-style-type: none"> <li>Planning guidance for 2025/26 requires Trusts to ensure that fewer than 1% of patients on an RTT clock have waited over 52 weeks</li> </ul>	<ul style="list-style-type: none"> <li>For August, the number of patients waiting over 65 weeks was 110, a decrease of 4 compared with July</li> <li>LTHT had 1,790 52+ week waiters against a recovery trajectory of 2,173 which was a reduction on the July position of 2,316</li> <li>This is 2% of total waiting list</li> <li>For July (latest data available) LTHT placed 101st out of 118 Trusts</li> <li>LTHT has been placed into Tier 1 escalation for elective care. A recovery plan has been developed and approved by the executive team</li> </ul>	<p>The below actions related to both 65 weeks and 52 weeks risks:</p> <ul style="list-style-type: none"> <li><b>Neurosciences:</b> Super Saturday clinics conversations commence in Sept 25</li> <li><b>Neurosciences:</b> Trial of outpatient clinic utilisation booking tool to support booking appointments – trial use with Super Saturdays</li> <li><b>H&amp;N:</b> CSU are working with theatres to convert Wharfedale activity from Ophthalmology to ENT</li> <li><b>TRS Plastics:</b> Hand locum started in Sept and has begun delivering additional clinics</li> <li><b>H&amp;N:</b> Super Saturdays for outpatients started</li> <li><b>TRS:</b> Double DIEP lists started</li> <li><b>Paediatrics:</b> Paeds anaesthetic insourcing (MEDACS) started in September to support delivery of activity against plan</li> <li><b>Productivity:</b> Key actions agreed following CSU self-assessment with updates weekly to the executive meeting and fortnightly at 52-week escalation meetings</li> </ul>



# Cancer 28 Day Faster Diagnostic

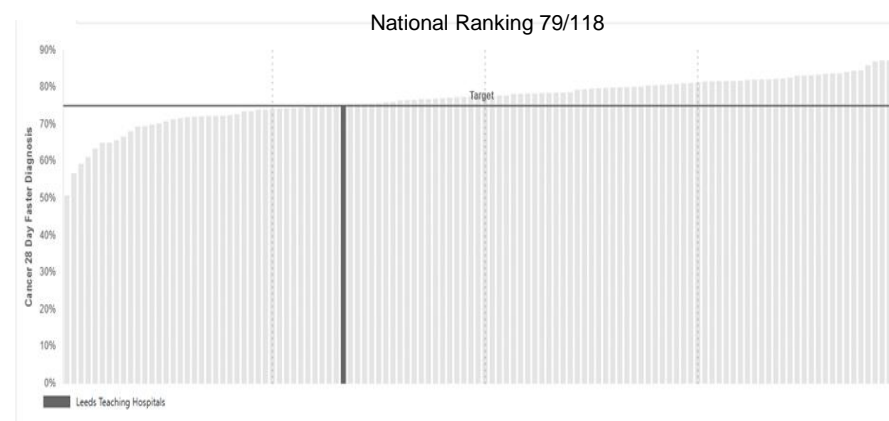
July 2025

Target: 75%  
Performance: 75.3%



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"> <li>Patients should not wait more than 28 days from referral to finding out whether they have cancer</li> <li>The NHSE expectation is that by March 2025, the % of patients being notified of their cancer status by day 28 is 77%</li> </ul>	<ul style="list-style-type: none"> <li>28 Day FDS performance was 75.3% in July 25</li> <li>3,836 patients out 5,097 patients were informed of their diagnosis within 28 days</li> <li>LTHT ranked 79 of 118 Trusts for July 25</li> <li>LTHT performance had fallen below the 2025/26 trajectory but has recovered during August</li> </ul>	<ul style="list-style-type: none"> <li>Staffing plan developed to delivery additional capacity for for hysteroscopy on Gynae pathways and options to secure short-term capacity are being pursued</li> <li>Waiting times for prostate biopsies have improved but the diagnostic pathway overall including MRI, biopsy and pathology waits continues to present challenges. CSU teams have developed plans to undertake MRI and biopsy within 48 hours</li> <li>CT recovery plan to reduce diagnostic backlog is on track but NSS pathway focus continues to be on improving CT scan reporting times</li> <li>Pathology backlogs continue to fall as additional staff come into post. Samples are now out of the lab in less than a week (previously up to 15 days)</li> <li>Focus on pathology reporting times as backlogs reduced. Reporting times are also falling</li> </ul>

# Cancer 31 day

Reduce waits  
for patients



July 2025

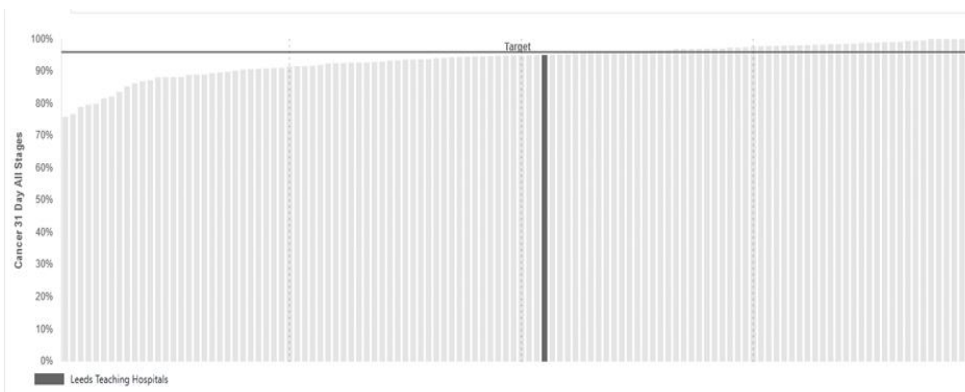
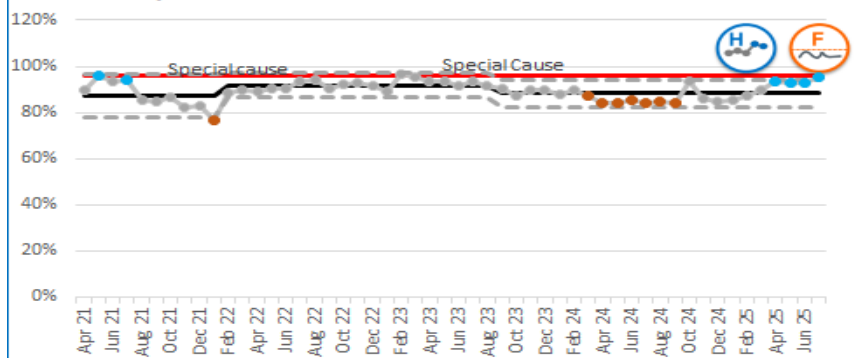
**Target: 96%**  
**Performance: 93.8%**

**Executive Owner:** Clare Smith (Chief Operating Officer)

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

National Ranking – 56/118

Cancer 31day



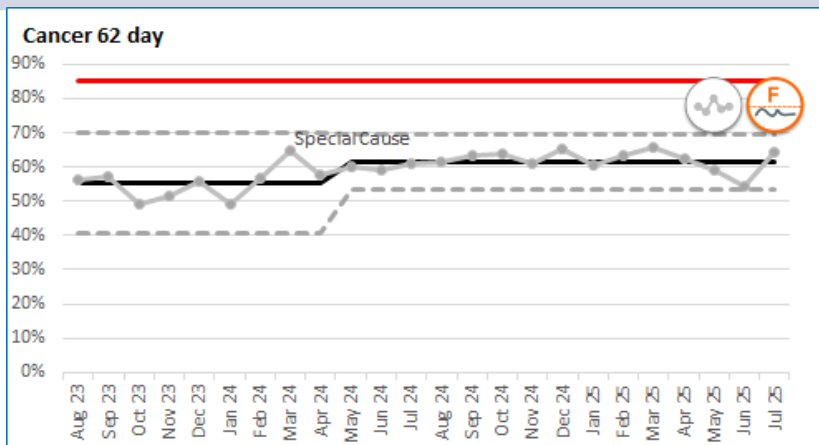
Background	Context	Action
<ul style="list-style-type: none"> <li>96% of patients should receive treatment within 31 days</li> <li>This includes patients receiving both first and subsequent Cancer treatments</li> </ul>	<ul style="list-style-type: none"> <li>Overall performance for 31 days in July was 93.8%</li> <li>99% of patients receiving chemotherapy are treated within 31 Day from decision to treat</li> <li>Surgical performance in July was: <ul style="list-style-type: none"> <li>First – 88.7%</li> <li>Subs – 84%</li> </ul> </li> <li>Radiotherapy waits further improved since Jan 2025 <ul style="list-style-type: none"> <li>First – 98.4%</li> <li>Subs – 99.6%</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Radiotherapy improved performance sustained and all categories delivering under 31 days</li> <li>Consultant recruitment underway for Gynae Oncology surgery to reduce waits for procedures</li> <li>Options for additional surgical capacity are being explored to try and shorten waits for surgery for Melanoma, Skin and Sarcoma patients</li> <li>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</li> </ul>



# Cancer 62 Days

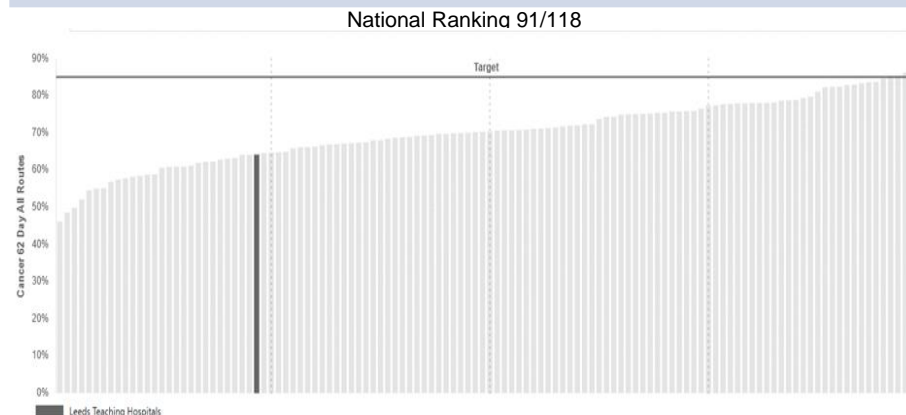
July 2025

**Target: 85%**  
**Performance: 64%**



**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"> <li>The constitutional standard is that 85% of patients receive their first definitive treatment for cancer within 62 days of a referral for suspected cancer</li> <li>2025/26 national planning guidance is an expectation from NHSE that all systems will achieve 75% by March 2025</li> <li>62-day backlog for 2025/6 is planned to achieve 6% or less of the total patient numbers on a CWT pathway</li> </ul>	<ul style="list-style-type: none"> <li>340/530.5 of patients with cancer were treated within 62 days in July 2025</li> <li>Performance improved from May 2025 but remains below the trajectories agreed at the start of the 2025/26 year</li> <li>The backlog at the end of July was 293, an improvement from the end of June of 7 patients</li> <li>LTHT ranked 91st of 118 trusts in July 2025</li> <li>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</li> </ul>	<ul style="list-style-type: none"> <li>The Intensive support team IST tool has been trialled in AMS and has now been completed for all pathways. CSUs are reviewing the results in order to agree further actions with trajectories for improvement</li> <li>Extraordinary meeting with MDT Leads and CDs arranged for w/c 22/9/25 to review pathway data and agree actions led by the clinicians</li> <li>Weekly Radiology and Pathology PTL meetings are now in place, with actions arising where blockages are identified</li> <li>Funding from Tier 1 assigned to support delivery of additional capacity, including weekend sessions in Urology, 6 months additional Robotic surgery capacity, additional Lung Consultant Locum to reduce waiting times for 1st OPA's, agency staffing in Radiology reduce CT and US waiting times.</li> <li>Short-term focus on reducing 62-day backlog to levels evidenced from other providers that support sustainable delivery of care within 62-days</li> <li>Pathology backlogs are falling as additional staff come into post. Samples are now out of the lab in less than a week (previously up to 15 days) – and</li> </ul>



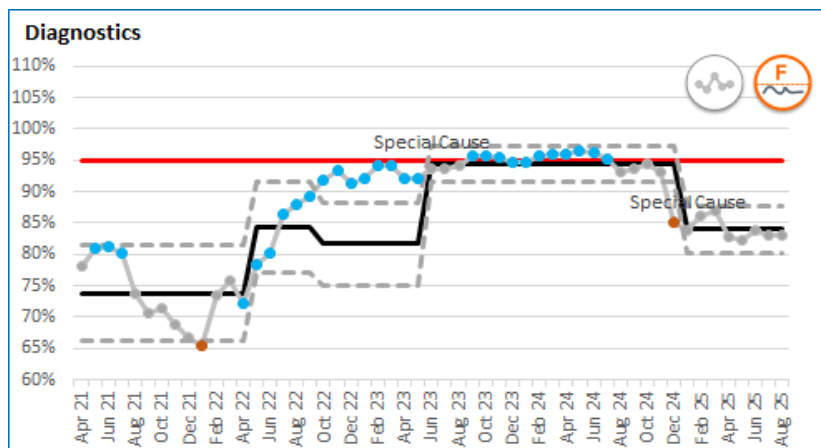
# Diagnostic Waits

August 2025

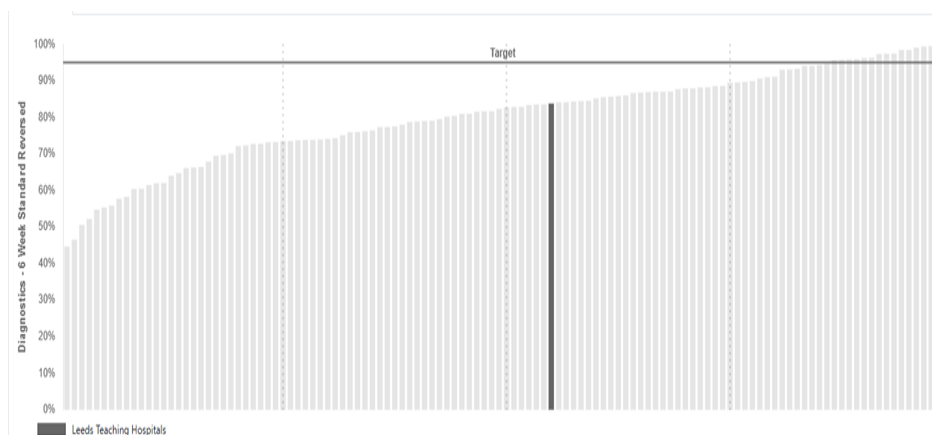
**Target: 95%**  
**Performance: 82.9%**

**Executive Owner:** Clare Smith (Chief Operating Officer)

**Variance:** Common Cause variation. Fail variation indicated



National Ranking 53/118



Background	Context	Action
<ul style="list-style-type: none"> <li>99% of patients wait no more than 6 weeks for a routine diagnostic test</li> <li>2024/25 National Planning priority was to deliver 95% by March 2025</li> </ul>	<ul style="list-style-type: none"> <li>MRI continue to have delays for Paediatric GA MRI due to theatre capacity</li> <li>Ultrasound have the greatest number of breaches due to staffing pressures and capacity shortfalls</li> <li>Paediatric audiology capacity challenges</li> <li>LTHT national ranking 53 out of 118 Trusts for diagnostics performance in June 25 (latest data available)</li> </ul>	<ul style="list-style-type: none"> <li>Medicare staff started from mid-June supporting US weekend working. Backlogs reducing during September 2025 in line with recovery plan as more staff are inducted and additional sessions are provided.</li> <li>MRI relocatable hybrid scanner at Chapel Allerton delayed until winter. Mobile MRI van remains in place until this is available</li> <li>Significant improvement in CT 6ww. Discussions between Radiology and Cardiology services about further actions to improve Cardiac CT with training to begin for Radiographer to run lists which are planned to begin in Jan 26</li> <li>Children's endoscopy have limited capacity to recover the backlog of waits. Hull have offered capacity to support from September. Governance arrangements are now being finalised.</li> <li>Conversations between LCH and LTHT for support with Paediatric Audiology to help aid recovery of overdue waits</li> <li>Monthly diagnostic escalation meetings in place to review performance and recovery plans</li> </ul>



# Mortality

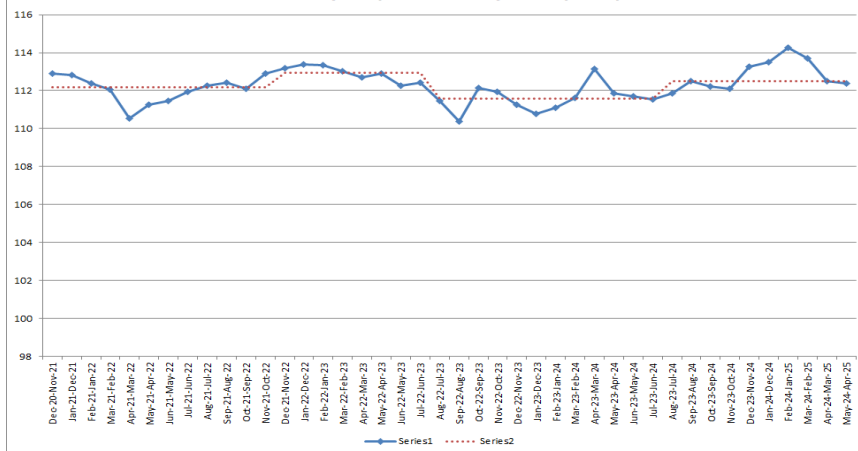
May 2024 – April 2025

**Target: 100**  
**Performance – SHMI: 112.4 “As Expected”**

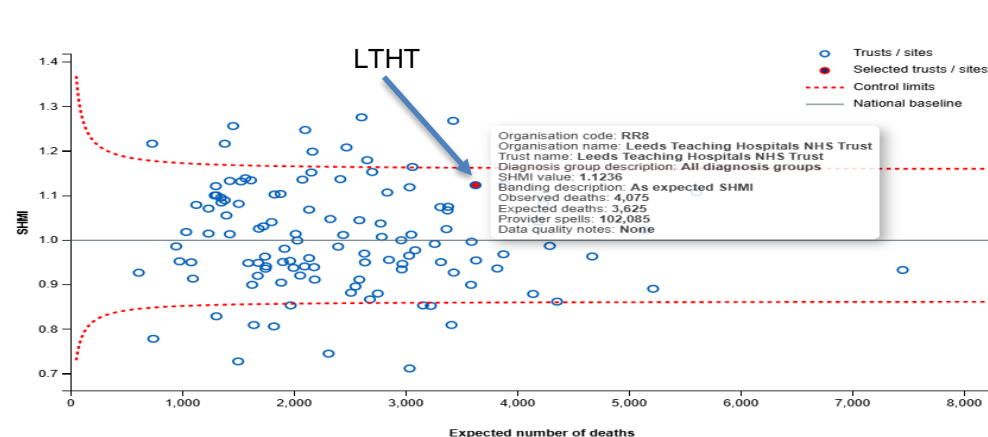
Executive Owner: Dr Magnus Harrison (Chief Medical Officer)

Variance: Common cause variation.

Summary Hospital Mortality Index (SHMI)



SHMI funnel plot



Copyright © 2025 NHS England

Background	Context	Action
<ul style="list-style-type: none"> <li>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.</li> </ul>	<ul style="list-style-type: none"> <li>The Trust SHMI for May 2024 – April 2025 was 112.4 and “As Expected”.</li> <li>The Upper Control Limit was 116.3</li> </ul>	<ul style="list-style-type: none"> <li>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.</li> <li>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.</li> </ul>

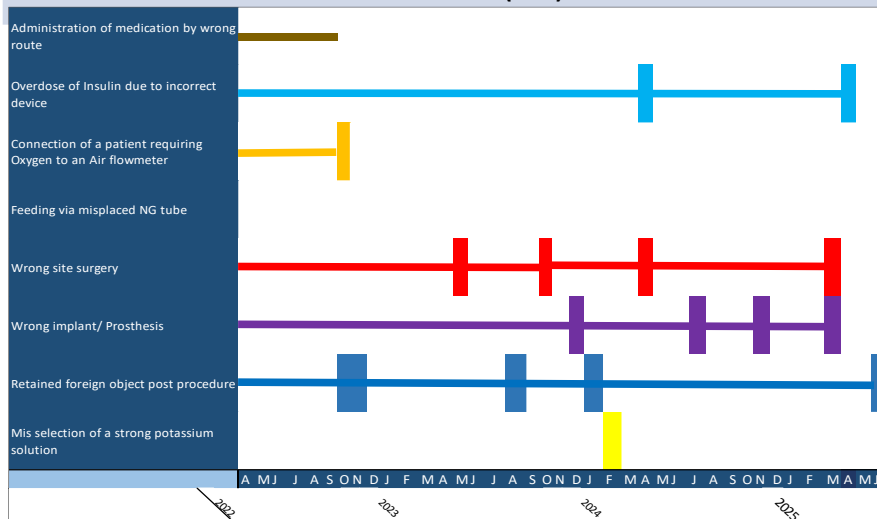




# Never Events

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"> <li>Overdose of Insulin due to wrong device (ACC).</li> <li>Retained surgical item (ENT Theatres WGH).</li> </ol>	<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

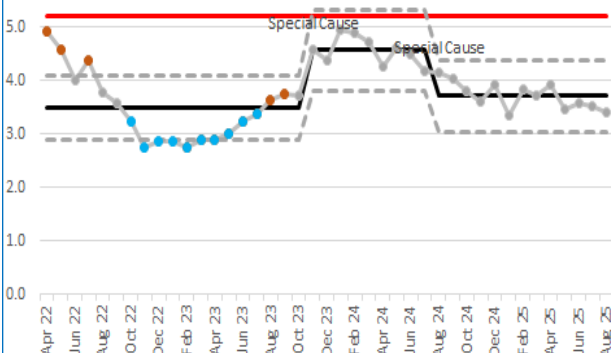
August 2025

**Still Birth Rate: 3.4**  
**Extended Perinatal Mortality Rate: 8.88**  
**Number of MNSI Referrals: 0**

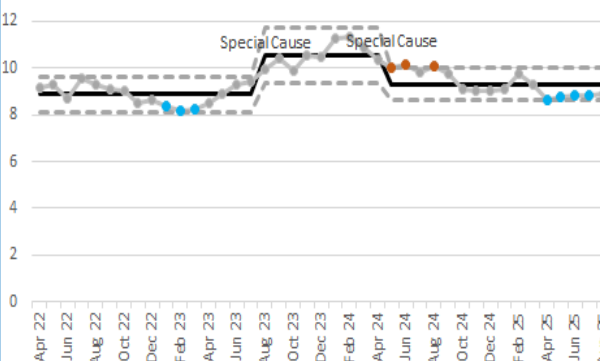
Executive Owner: Rabina Tindal (Chief Nurse)

**Variance: – Common Cause Variation.**

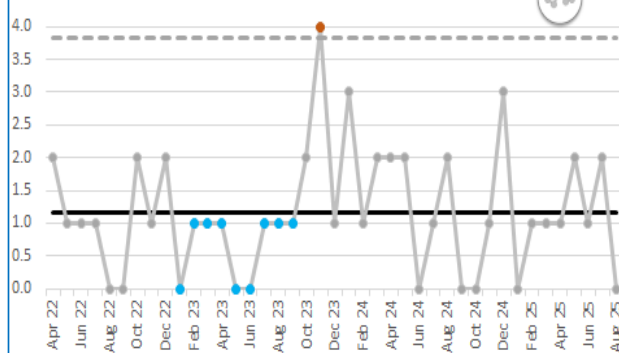
Still Births



Rolling Extended Perinatal mortality rate (all NND)



Number of MNSI Referrals



### 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 4 stillborn babies during August 2025**
- Antepartum Stillbirth – Ethnicity Pakistani (no interpreter required), non-smoker, 2 previous emergency Caesarean sections, previous gestational diabetes in both pregnancies. Referred for consultant led care. Essentially well in pregnancy, with normal scans and findings. At 32+4 weeks gestation, the mother attended hospital with a first episode of reduced baby movements, at which time, sadly, it was confirmed that the baby had died in utero. There was a delay in the mother's admission to continue induction of labour due to acuity (4hrs), and staff were unable to provide one to one care in labour, due to acuity. The mother did not progress in labour, and a Category 3 Caesarean section was performed. The baby girl was born weighing 1870g, and the mother recovered well.
- The case has been escalated for MDT Maternity Risk Review
- Antepartum Stillbirth - Ethnicity Black African, (no interpreter required), non-smoker, first pregnancy, midwifery led care. Baby's father was a carrier for Sickle Cell Disease, the mother a carrier for Beta Thalassaemia, Low PAPP-A result, and high chance result for Trisomy 21 (1 in 24). NIPT screening showed a low chance result for Trisomy 21. At the anomaly scan, baby very

- 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

Aug 2025

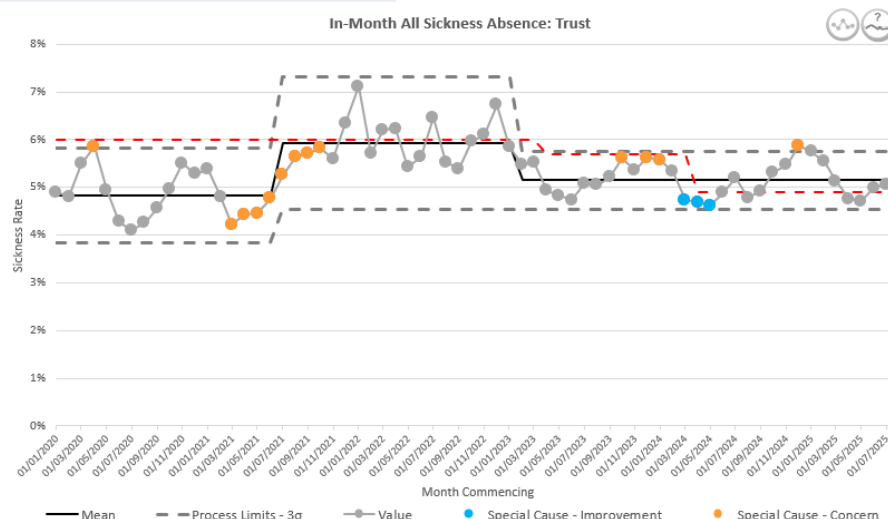
**Target: 4.9 %**  
**Performance (Rolling Sickness Absence Rate): 5.21%**

**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"> <li>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.</li> </ul>	<ul style="list-style-type: none"> <li>In month sickness absence rates are within SPC limits however remain slightly above target.</li> </ul>	N/A	<ul style="list-style-type: none"> <li>Additional coaching and bespoke training provided to managers to support them with managing attendance.</li> <li>Strengthened assurance process with CSU ownership supported by Operational HR.</li> <li>Continued focus on improving access and usage of data and information to enable managers to proactively manage sickness and special leave in their teams.</li> <li>Increased focus on supporting attendance for medical and dental staff. Absence management and assurance process for M&amp;D staff now operational in all CSUs.</li> <li>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) 26 August 2025 and Workforce Committee (WFC) 10 September 2025.</li> <li>Supporting Attendance Policy has been reviewed and amendments with staff side colleagues, subject to confirmation through TCNC sign-off. However, the process improvements detailed in the revised policy have already been implemented.</li> <li>Review of stress management process also under review, with a scheduled completion by the end of the calendar year.</li> <li>Thrive at Work pilot running for 12 months to help reduce/prevent long term sickness absence.</li> </ul>	N/A

# Voluntary Turnover

Aug 2025

Target: 5.93%

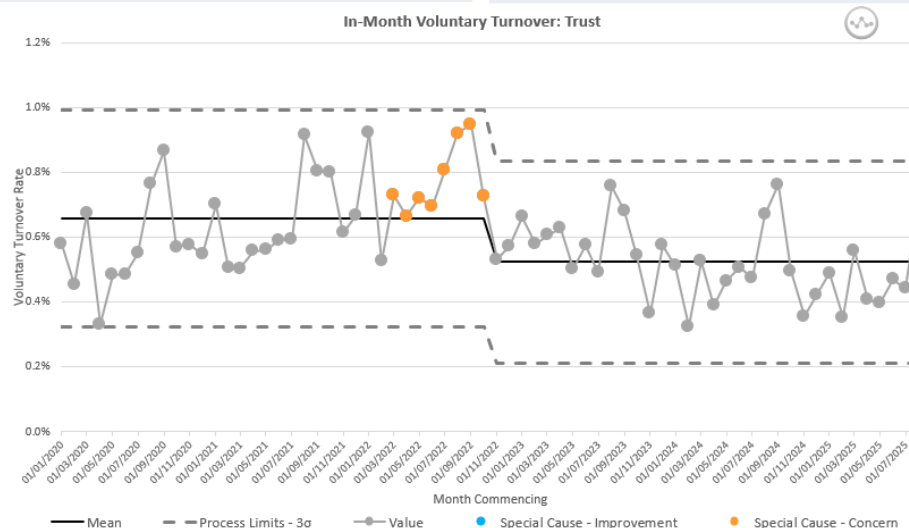
Performance (Rolling Voluntary Turnover Rate): 5.88%

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"> <li>Following the Trust Commitment in 2024/25, we have set the target at maintaining current performance in relation to turnover.</li> </ul>	<ul style="list-style-type: none"> <li>The in-month rates remain within the wide control limits. The rolling rate is below target as of August 2025.</li> </ul>	N/A	<ul style="list-style-type: none"> <li>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.</li> <li>Retention plans are incorporated into all CSU Operational Workforce Plans and are part of their 'business and usual'.</li> <li>Longevity Strategy implemented to support embedding of retention activity into standard work.</li> <li>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.</li> </ul>	<ul style="list-style-type: none"> <li>During 2024/25 the national 'NHS People Promise Exemplar Programme' structure underpinned the progression against the retention in-year commitment.</li> <li>Significant improvement over the two years of the commitment. Target now to maintain closing position.</li> </ul>

# Agency Spend

Aug 2025

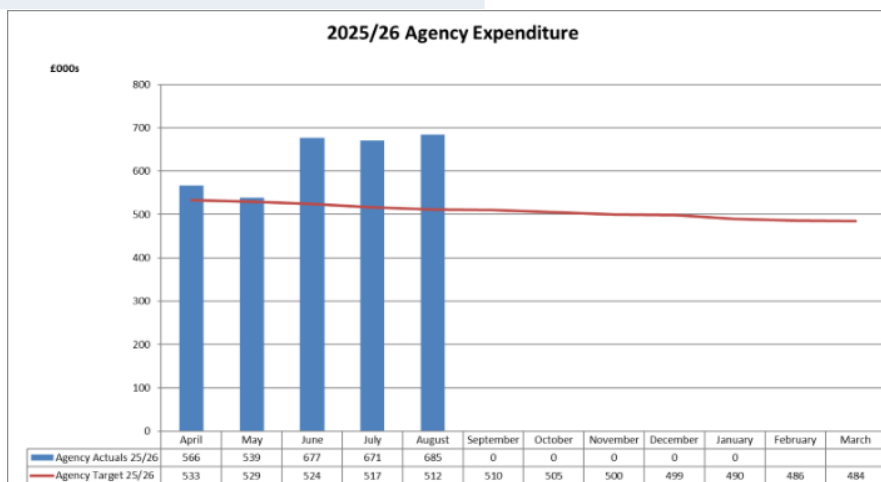
**Target:** 0.53% **Performance:** 0.67%

**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"> <li>This was an area of strong performance for the Trust in 2024/25.</li> <li>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.</li> <li>This target will be monitored as we progress through 2025/26.</li> </ul>	<ul style="list-style-type: none"> <li>To support achievement of the target it has been phased across the financial year.</li> <li>Agency spend was tracking slightly above the target in April and May, however, has increased in June and again in August. In August, agency nursing increased mainly within Pathology and Children's CSU.</li> </ul>	N/A	<ul style="list-style-type: none"> <li>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 was ranked as having joint third lowest overall spend on agency and bank staffing out of 119 providers in total.</li> <li>The Workforce Plan Delivery Group continues to manage the further reductions required on temporary workforce spend. Deep dives are continuing 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.</li> <li>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.</li> <li>HR and Finance Business Partners continue to work with CSUs to develop workforce action plans to address the situation.</li> </ul>	N/A

# Bank and Overtime Spend

Aug 2025

**Target for Bank Spend:** 2.62% (bank only)

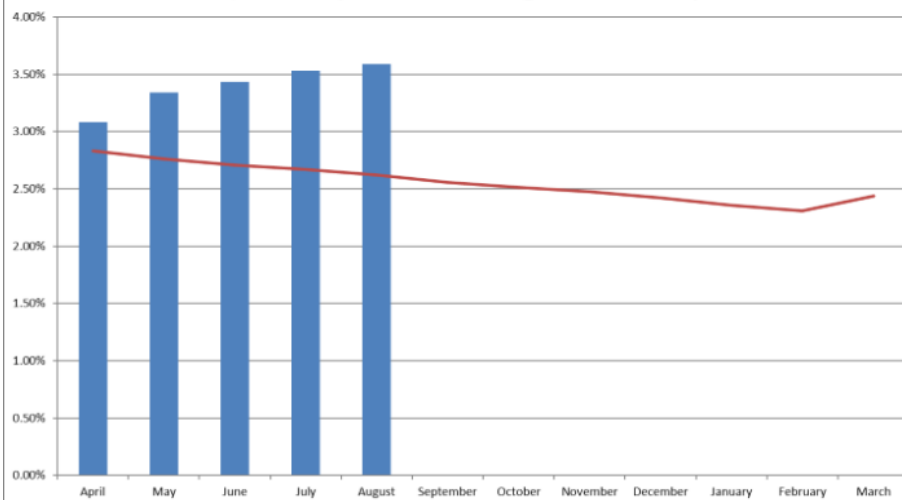
**Performance:** 3.59% (bank only)

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

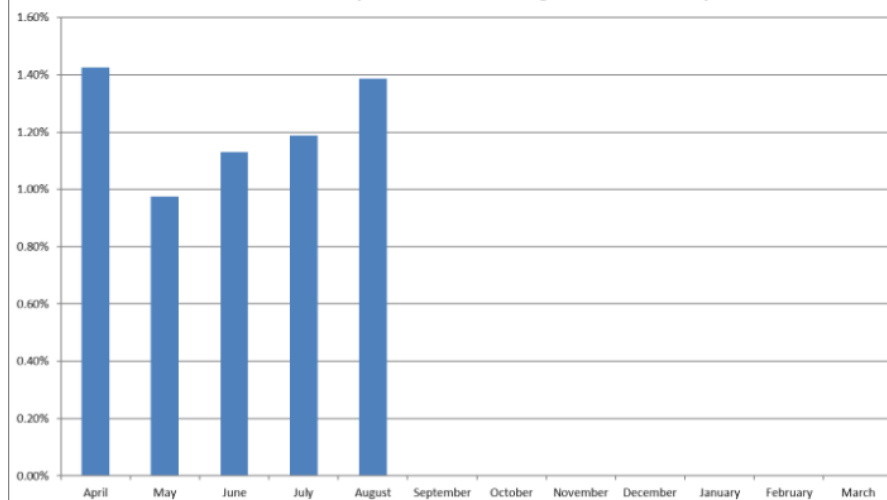
**Management/Clinical Owner:** Chris Ellison

**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"> <li>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.</li> <li>The total spend on bank for 2025/26 needs to remain under £30.5m</li> <li>This target will be monitored as we progress through 2025/26.</li> </ul>	<ul style="list-style-type: none"> <li>The red line on the bank graph shows our target across the year.</li> <li>Bank spend for August 2025 is 3.59% of total staff spend against an August target of 2.62%. Bank costs in August are £0.9m higher than anticipated. The year to date bank overspend is partly driven by the extension of L12 into April and J32 which was open as a winter ward staying open longer than planned, resident doctors industrial action cover and bank reduction plans not delivering as expected. There is no target against which to measure overtime spend.</li> </ul>	N/A	<ul style="list-style-type: none"> <li>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 was ranked as having joint third lowest overall spend on agency and bank staffing out of 119 providers in total.</li> <li>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.</li> <li>HR and Finance Business Partners continue to work with CSUs to develop workforce action plans to address the situation.</li> </ul>	N/A

# Vacancy Rate

Aug 2025

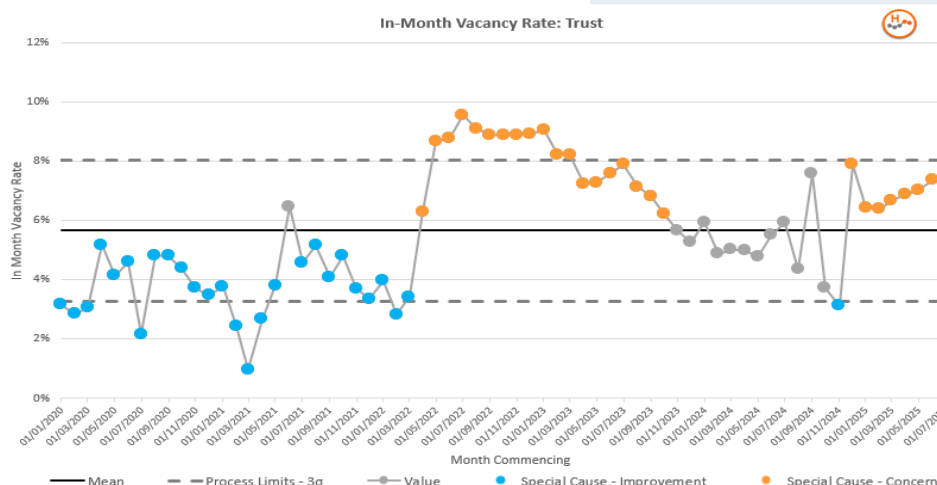
**Target:** N/A  
**Performance:** 6.45%

**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"> <li>Changes in budget are not aligned to recruitment patterns, particularly with relation to the recruitment of newly qualified registered staff.</li> <li>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.</li> </ul>	<ul style="list-style-type: none"> <li>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.</li> </ul>	N/A	<ul style="list-style-type: none"> <li>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 the Trust Expenditure Review Group (TERG).</li> <li>Our registered nurse vacancies are improving and whilst we have seen a slight increase in our clinical support worker vacancies, cohort recruitment is taking place monthly to close this gap.</li> <li>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.</li> </ul>	N/A

# Staff Engagement Rate

Jul 2025

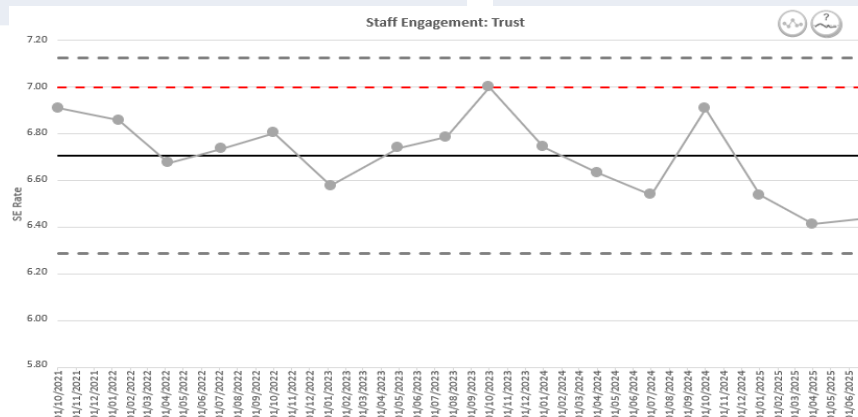
**Target: 7**  
**Performance: 6.4**

**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"> <li>Staff engagement scores fell nationally in the 2024 staff survey.</li> <li>LTHT was not an exception, although we retain an above average score.</li> <li>2025/26 is expected to be another challenging year and the target is to maintain staff engagement at the 2024/25 level.</li> </ul>	<ul style="list-style-type: none"> <li>While the staff engagement score has not hit the target since the staff survey in 2023 the scores currently remain within control limits.</li> </ul>	<p>Annual Staff survey:</p> <ul style="list-style-type: none"> <li>Participation in 2024 is 48% slightly lower than national average 49%.</li> <li>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.</li> </ul>	<p>NHS Staff Survey results:</p> <ul style="list-style-type: none"> <li>Considered as part of the annual Staff Engagement Group review (February 2025), and priorities identified. Priorities built into the Group's Forward Plan.</li> <li>Utilised to inform the re-refresh of the LTHT In-Year Commitments.</li> <li>Presented and discussed as part of Workforce Management Group and Committee meetings.</li> <li>Triangulated and discussed alongside patient and quality metrics., in relevant networks, sub-committees and forums.</li> <li>CSU level results utilised to inform CSU Commitment A3s, CSU Operational Workforce Action Plans, and team level action.</li> <li>Assurance of CSU activity gained via Staff Engagement Group (SEG) and Workforce Management Group (WMG) rolling presentation schedule, and HR Business Partner/Tri Team Joint Accountability and Assurance Framework meeting.</li> <li>Risk and escalation routes via CSU IAMs and HR Monthly CSU Performance Meeting.</li> <li>Senior Leaders, SEG members (delivery arm), and Trust Line Managers comms/support to act and deliver close the loop communications.</li> <li>Assurance paper, including CSU level activity, submitted at September Workforce Management Group (WMG and Workforce Committee (WFC).</li> <li>2025 Survey response rate target agreed with SEG and Senior Leaders – 5% CSU increase, and CSU targeted of under-represented teams. HR Manager aligned to support CSUs in response rates.</li> <li>Staff Survey and Pulse survey metrics aligned to Team Commitment and triangulated in a CSU Culture Dashboard</li> </ul>	<ul style="list-style-type: none"> <li>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.</li> </ul>

# I&E Position 2025/26



August 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 August the Trust reported an in-month deficit of £2m, which was £0.9m adverse to the planned deficit. For the financial year to date the deficit is £20.4m, which is £6.5m adverse to the NHSE plan. The biggest driver of the adverse position is pay expenditure being higher than planned.

Pay expenditure to date is £514.9m, £6m adverse to the NHSE plan partly driven by J32 winter ward remaining open longer than planned, cover for the resident doctor's industrial action in July and bank reduction plans not yet delivering as expected. Non-pay expenditure to date is £371.3m (including depreciation and finance costs), £1.2m adverse to the plan. The non pay adverse variance relates mainly to the Maternity Incentive Scheme Year 6 rebate clawback, building and engineering maintenance to ensure safety standards and clinical supplies and services associated with activity.

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.

Under the new National Oversight Framework, the M5 YTD deficit and adverse variance to plan would result in a NOF score of 3. Other individual metrics within the Finance domain from the latest published assessment are 'Implied Productivity Level' 2.24 (56 out of 134) and 'Planned Surplus/Deficit' 2.00 (51 out of 134).



# Capital & Cash Position



August 2025

Executive Owner: Jenny Ehrhardt (Director of Finance)

## Capital

The Trust's capital expenditure forecast for 2025/26 has reduced by £21.6m to £87.8m. This is due to the reduction of £22.6m to the RtCS Elective Theatres allocation for 25/26 to £2.75m. This was marginally offset by additional PDC of £0.5m for Histopathology, £0.2m for Diagnostics - Physiological Sciences, £0.1m for Diagnostics - Community Diagnostic Centres scheme and a £0.7m uplift to the PDC funded Estates Safety Fund, however this was offset by the reduction of £0.7m to operational capital. Grant funded MND Centre also had additional funding of £0.3m. Finally, there was a budget virement of £0.4m that was actioned from the risk reserve to B&E for the Feasibility for Interventional Radiology Estate in Lincoln Wing. The decarbonisation programme has been reprofiled due to a reduction of Phase 4 to £1.8m forecast for 25/26 and £4.8m in 26/27; which was marginally offset by the increase of £0.6m to the MND Centre. The programme is broken down as follows:

Programme	Forecast 2025/26 £000
Medical Equipment	12,946
Informatics	5,489
Building & Engineering	60,147
Building the Leeds Way	1,000
Contingency	5,261
Leases	3,000
<b>Total</b>	<b>87,843</b>

The Expenditure to 31st August 2025 was £14.8m which was £0.4m behind forecast. M&SE YTD spend is £1.9m which was in line with forecast. Informatics YTD spend was £3m, which was in line with forecast. B&E YTD spend was £9m which was behind forecast by £0.4m due delays to the Installation of the Radiology Single plane as a result of compliance requirements under the Building Safety Act. YTD Lease expenditure was £0.6m. BtLW YTD spend was £0.2m, a reduction from July due to the recharge of Park Lane and Joseph's Well YTD costs to revenue. The programme is now showing a YTD spend of £0.2m to reflect the general programme fees for Hospitals of the Future and the New Hospitals Programme.

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 August 2025 closing cash balance is £87.8m, a decrease of £3.6m from the previous month. This is £17.8m better than the latest fundamental review (£70m), due to the timing of settling capital invoices and R&D income received from DHSC a month early.

Total receipts for the month amounted to £178m which included £3.1m for the June VAT return, which was the final opportunity to reclaim VAT relating to 2024/25 following a review completed with the VAT advisers (KPMG). The July VAT return has been submitted to HMRC during the first week of September and payment will be received next month.

Total payments in month were £183m, comprising £106m for payroll which included the pay award and arrears (£10m) and £78m for accounts payable. National insurance and pension contributions on the pay award will be paid over to HMRC and the Pensions Agency in September.

To counteract the reduced interest rates, the Trust is utilising the additional interest rate offered by the National Loans Fund (NLF) on short-term deposits, currently at 3.96%. A total of £13.5k additional interest income has been received from the investments made to date. This activity will continue throughout the year providing higher interest rates are offered by the NLF.

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



August 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)	1,289.6	106.8	107.2	0.4	533.4	536.0	2.6
	Non-PbR Drugs, Blood and Devices	395.9	33.0	31.2	(1.8)	164.9	159.4	(5.5)
	<b>Sub-Total Commissioner Income</b>	<b>1,685.5</b>	<b>139.8</b>	<b>138.4</b>	<b>(1.4)</b>	<b>698.4</b>	<b>695.4</b>	<b>(2.9)</b>
	Other Clinical Income	11.8	1.0	1.2	0.3	4.9	5.9	1.0
	<b>Total Clinical Income</b>	<b>1,697.2</b>	<b>140.8</b>	<b>139.6</b>	<b>(1.1)</b>	<b>703.3</b>	<b>701.3</b>	<b>(2.0)</b>
	Other Income (non Covid)	305.3	24.8	25.1	0.3	123.5	126.4	2.9
	Other Income (Covid Top Up; Testing; Vaccination)	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	<b>Total Income</b>	<b>2,002.5</b>	<b>165.6</b>	<b>164.7</b>	<b>(0.8)</b>	<b>826.8</b>	<b>827.7</b>	<b>0.9</b>
EXPENDITURE	Pay Costs	(1,207.0)	(101.0)	(102.2)	(1.1)	(508.9)	(514.9)	(6.0)
	<b>Sub-Total Pay</b>	<b>(1,207.0)</b>	<b>(101.0)</b>	<b>(102.2)</b>	<b>(1.1)</b>	<b>(508.9)</b>	<b>(514.9)</b>	<b>(6.0)</b>
	Non Pay Costs (excl Non-PbR Drugs, Blood and Devices)	(389.0)	(32.4)	(33.6)	(1.2)	(166.5)	(174.8)	(8.3)
	Non-PbR Drugs, Blood and Devices	(396.4)	(33.0)	(30.8)	2.2	(165.2)	(158.2)	7.0
	<b>Sub-Total Non Pay</b>	<b>(785.4)</b>	<b>(65.4)</b>	<b>(64.4)</b>	<b>1.0</b>	<b>(331.7)</b>	<b>(333.0)</b>	<b>(1.3)</b>
	<b>Total Expenditure</b>	<b>(1,992.4)</b>	<b>(166.4)</b>	<b>(166.5)</b>	<b>(0.1)</b>	<b>(840.6)</b>	<b>(847.9)</b>	<b>(7.3)</b>
	<b>EBITDA</b>	<b>10.2</b>	<b>(0.9)</b>	<b>(1.8)</b>	<b>(0.9)</b>	<b>(13.8)</b>	<b>(20.2)</b>	<b>(6.4)</b>
	<b>EBITDA%</b>			<b>(1.1%)</b>			<b>(2.4%)</b>	
OTHER	Depreciation	(54.3)	(4.5)	(4.3)	0.2	(20.7)	(21.5)	(0.8)
	Amortisation	(4.5)	(0.4)	(0.4)	(0.0)	(1.9)	(2.0)	(0.1)
	Impairments	(10.5)	0.0	0.0	0.0	0.0	0.0	0.0
	Investment Revenue	4.1	0.3	0.4	0.1	1.7	2.7	1.0
	Other Gains and (Losses)	0.0	0.0	0.0	0.0	0.0	0.1	0.1
	Finance Costs	(24.0)	(1.2)	(1.2)	0.0	(6.0)	(17.2)	(11.2)
	Dividends payable on Public Dividend Capital (PDC)	(10.8)	(0.9)	(0.9)	0.0	(4.5)	(4.5)	0.0
	<b>Retained Surplus/(Deficit) BEFORE ERF/TIF</b>	<b>(89.9)</b>	<b>(7.5)</b>	<b>(8.2)</b>	<b>(0.7)</b>	<b>(45.2)</b>	<b>(62.6)</b>	<b>(17.3)</b>
ADJUSTED	<b>Allowed Technical Adjustments</b>							
	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	(0.3)	(0.4)	(0.1)	(1.3)	(1.2)
	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
	<b>Adjusted Surplus/(Deficit) BEFORE ERF</b>	<b>(86.6)</b>	<b>(7.4)</b>	<b>(8.5)</b>	<b>(1.1)</b>	<b>(45.3)</b>	<b>(63.8)</b>	<b>(18.5)</b>
	Elective Recovery Fund (ERF)	97.7	8.1	8.2	0.1	40.3	40.8	0.6
	<b>Adjusted Surplus/(Deficit) INCLUDING ERF</b>	<b>11.0</b>	<b>0.7</b>	<b>(0.3)</b>	<b>(1.0)</b>	<b>(5.0)</b>	<b>(23.0)</b>	<b>(18.0)</b>
	Adjust PFI revenue costs to UK GAAP basis	(11.0)	(1.8)	(1.7)	0.1	(8.8)	2.6	11.5
	<b>Adjusted financial performance surplus/(deficit)</b>	<b>0.0</b>	<b>(1.1)</b>	<b>(2.0)</b>	<b>(0.9)</b>	<b>(13.9)</b>	<b>(20.4)</b>	<b>(6.5)</b>

# Statement of Financial Position



August 2025

Executive Owner: Jenny Ehrhardt (Director of Finance)

	Year to date movement			In Month	
	Closing 31st March 2025 £m	As at 31st August 2025 £m	Year to date movement £m	Prior Month £m	In-month movement £m
<b>Non-Current Assets:</b>					
Property, Plant And Equipment	804.1	797.4	(6.7)	798.9	(1.5)
Intangible Assets	10.8	8.9	(2.0)	9.3	(0.4)
Trade And Other Receivables	12.5	14.0	1.4	13.4	0.6
<b>Total Non-Current Assets</b>	<b>827.5</b>	<b>820.2</b>	<b>(7.2)</b>	<b>821.5</b>	<b>(1.3)</b>
<b>Current Assets:</b>					
Inventories	29.4	31.6	2.2	30.8	0.7
Trade And Other Receivables	72.3	80.9	8.6	90.2	(9.3)
Cash and Cash Equivalents	82.2	87.8	5.6	91.3	(3.6)
Non-Current Assets Held for Sale	0.0	0.0	0.0	0.0	0.0
<b>Total Current Assets</b>	<b>183.8</b>	<b>200.2</b>	<b>16.4</b>	<b>212.4</b>	<b>(12.2)</b>
<b>Total Assets</b>	<b>1,011.3</b>	<b>1,020.4</b>	<b>9.1</b>	<b>1,033.9</b>	<b>(13.5)</b>
<b>Current Liabilities:</b>					
NHS Trade Payables	(4.4)	(1.5)	2.9	(7.3)	5.8
Trade and Other Payables	(211.0)	(241.9)	(30.9)	(247.9)	6.0
Borrowing / DH Loans	(2.1)	(2.2)	(0.2)	(2.2)	(0.0)
Other Financial Liabilities - PFI	(21.8)	(22.6)	(0.7)	(22.5)	(0.1)
Provisions For Liabilities And Charges	(7.9)	(7.8)	0.0	(7.9)	0.0
<b>Total Current Liabilities:</b>	<b>(247.2)</b>	<b>(276.1)</b>	<b>(28.8)</b>	<b>(287.7)</b>	<b>11.7</b>
<b>Net Current Assets/ (Liabilities)</b>	<b>(63.4)</b>	<b>(75.8)</b>	<b>(12.5)</b>	<b>(75.4)</b>	<b>(0.5)</b>
<b>Total Assets Less Current Liabilities</b>	<b>764.1</b>	<b>744.4</b>	<b>(19.7)</b>	<b>746.2</b>	<b>(1.8)</b>
<b>Non-Current Liabilities:</b>					
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)	(280.9)	(2.2)	(282.7)	1.8
Provisions For Liabilities And Charges	(10.0)	(9.8)	0.2	(9.8)	0.0
<b>Total Non-Current Liabilities</b>	<b>(297.9)</b>	<b>(299.9)</b>	<b>(2.0)</b>	<b>(301.7)</b>	<b>1.8</b>
<b>Total Assets Employed</b>	<b>466.2</b>	<b>444.5</b>	<b>(21.7)</b>	<b>444.5</b>	<b>(0.0)</b>
<b>Financed By Taxpayers Equity</b>					
Public Dividend Capital	641.8	641.8	0.0	641.8	0.0
Retained Earnings	(175.6)	(197.3)	(21.7)	(197.3)	(0.0)
Revaluation Reserve	0.0	0.0	0.0	0.0	0.0
<b>Total Taxpayers Equity</b>	<b>466.2</b>	<b>444.5</b>	<b>(21.7)</b>	<b>444.5</b>	<b>(0.0)</b>

# Cash Flow Statement



August 2025

Executive Owner: Jenny Ehrhardt (Director of Finance)

Cash Flow	Closing 31st March 2025 £m	As at 31st August 2025 £m	Previous Month £m
<b><u>Operating Activities</u></b>			
EBITDA	112.1	20.7	14.3
Donated assets received credited to revenue but non cash	(7.3)	(2.9)	(2.2)
Interest paid	(14.6)	(5.7)	(4.6)
Dividend paid	(7.0)	0.0	0.0
Decrease/(increase) in inventories	(0.8)	(2.2)	(1.4)
Decrease/(increase) in trade and other receivables	13.9	(6.5)	(16.3)
(Decrease)/Increase in trade and other payables	(9.8)	35.8	49.6
(Decrease)/Increase in provisions	1.6	(0.2)	(0.2)
<b>Net cash inflow/(outflow) from Operating Activities</b>	<b>88.2</b>	<b>39.1</b>	<b>39.1</b>
<b><u>Cash Flows from Investing Activities</u></b>			
Interest received	4.6	2.7	2.3
(Payments) for property, plant and equipment	(79.4)	(27.9)	(25.6)
Proceeds from disposal of property, plant and equipment	0.2	0.1	0.1
(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	2.9	2.2
PFI lifecycle prepayments (cash outflow)	(6.2)	(2.8)	(2.3)
<b>Net cash outflow from Investing Activities</b>	<b>(75.9)</b>	<b>(25.1)</b>	<b>(23.2)</b>
<b>Net cash inflow before Financing</b>	<b>12.3</b>	<b>14.0</b>	<b>15.9</b>
<b><u>Cash Flows from Financing Activities</u></b>			
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)	(8.4)	(6.7)
<b>Net cash inflow/(outflow) from Financing Activities</b>	<b>21.7</b>	<b>(8.4)</b>	<b>(6.7)</b>
<b>Increase/(decrease) in cash</b>	<b>34.0</b>	<b>5.6</b>	<b>9.2</b>
<b>Cash at the beginning of the year</b>	<b>48.2</b>	<b>82.2</b>	<b>82.2</b>
<b>Cash at the end of the financial period</b>	<b>82.2</b>	<b>87.8</b>	<b>91.3</b>

# Supplementary Metrics Produced by Exception



# Cancelled Ops

June 2025

Target: 0

Performance – LMCO: 129

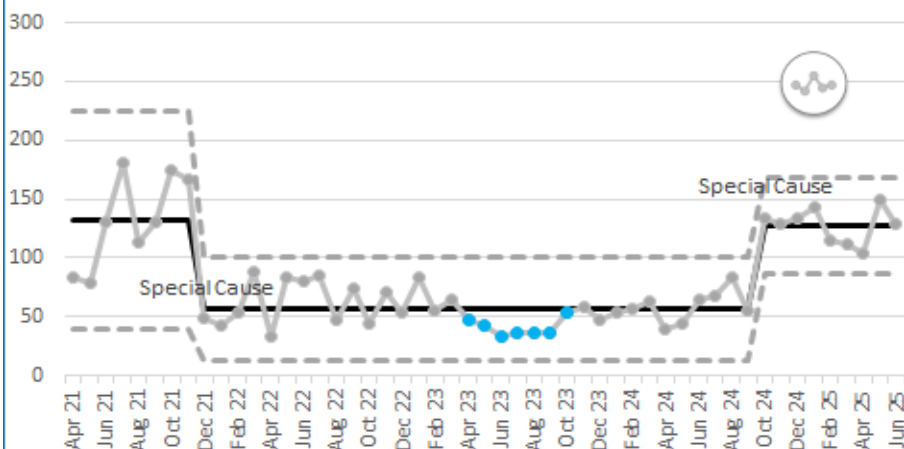
Performance – 28 day Standard: 22

Executive Owner: Clare Smith (Chief Operating Officer)

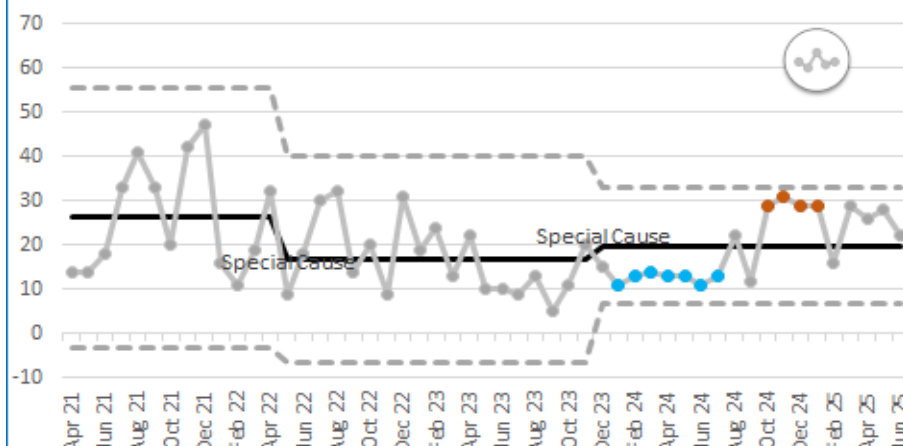
Variance: LMCO – Common cause variation.

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><b>Cancelled Operations</b></p> <ul style="list-style-type: none"> <li>There were 129 LMCO in June 2025. The main reasons for LMCO were 'ran out of theatre time' and 'ward bed capacity'.</li> <li>For Q4 LTHT ranked 93rd out of 118</li> </ul> <p><b>28 Day Breaches</b></p> <ul style="list-style-type: none"> <li>There were 22 breaches of the 28-day standard in June 2025.</li> </ul>	<ul style="list-style-type: none"> <li>Daily escalation process for potential cancellations to support with bed pressures intended to reduce cancellations</li> <li>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</li> <li>28 day breach volumes will be monitored through the Service Delivery Accountability meetings (SDAMs)</li> <li>Strategic Theatre Utilisation Group oversight of productivity metrics and HVLC list delivery</li> <li>Review of acute flows into neurosciences as volume of acute work has resulted in cancellations during June and July 2025</li> </ul>

# Supplementary Metrics NHS Oversight Framework

Average number of days between discharge ready date and actual date of discharge

Reduce waits  
for patients

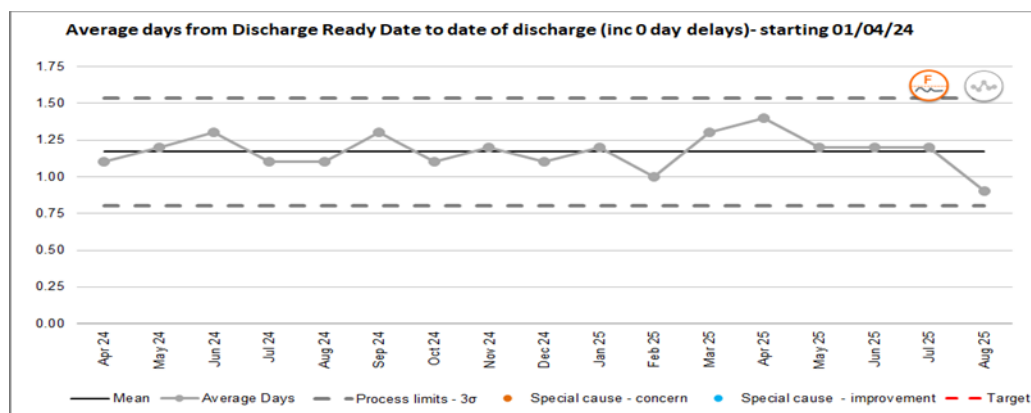


August 2025

Target:  
Performance: 4

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.



Background	Context	Action
<ul style="list-style-type: none"> <li>The discharge ready date records the date the patient no longer meets the 'Criteria to Reside' in a hospital bed.</li> <li>Measure is to determine how long patients are waiting to leave hospital after their discharge ready date so that local systems can work together to reduce those waits</li> </ul>	<ul style="list-style-type: none"> <li>This is a new metric displayed on the NHSE Oversight Framework dashboard for Q1 for this year</li> <li>For August 2025, the average number of days between discharge ready date and actual date of discharge was 0.9 days</li> </ul>	<ul style="list-style-type: none"> <li>Development of an internal dataset that describes opportunity based on discharge pathway- date of completion October 2025</li> <li>Making Every Day Count structured Gemba walks by CSU and Director tri teams beginning in September 2025 with a report out to executive team in October 2025 and a written report to follow. Wards notified and provided with MEDC packs and bundles 6-weeks in advance.- This will be to explore how we support reducing delays for discharge.</li> <li>Multi agency transport event supported by KPO took place 10<sup>th</sup> September 2025 to improve communication between teams and develop suggestions for improvement: report and recommendations will be delivered by October 2025</li> <li>City action plan developed for patients requiring ongoing system support that are over 21 day past their DRD. To be reported and impact measured through the Active System Executive Leadership Group from October 2025</li> </ul>



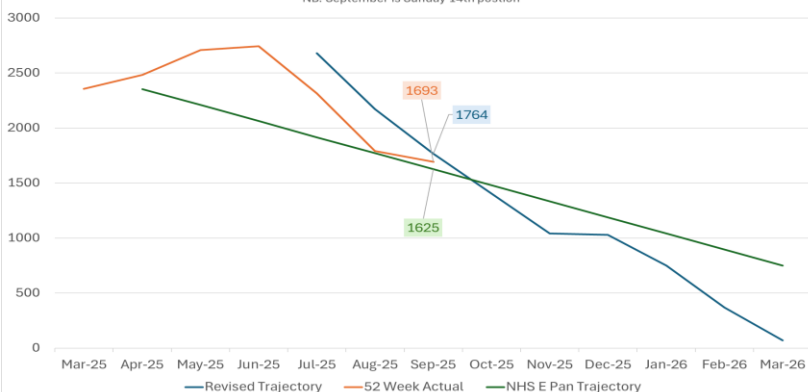
## Tier 1 Recovery Trajectory

Reduce waits  
for patients



### August 2025

Tier 1 52 Week Waiters  
NB. September is Sunday 14th position



Executive Owner: Clare Smith (Chief Operating Officer)

Background	Context	Action
<ul style="list-style-type: none"> <li>This is in addition to the F&amp;P RTT and 52 week Constitutional Standard Slides featured earlier in the pack</li> <li>LTHT has been in Tier 1 escalation since?</li> <li>As part of recovery select CSUs are called fortnightly to Tier 1 meetings to review 65, 52 week risks and Total Waiting list size</li> </ul>	<ul style="list-style-type: none"> <li>The following CSUs are part of fortnightly escalation. AMS – Total Waiting List (TWL), Cardio Respiratory – TWL, CNS, 52, 65 and TWL, H&amp;N 52, 65 and TWL, Pathology TWL</li> <li>CAH &amp; TRS were in escalation for 65, 52 weeks and TWL and have this month been de escalated</li> <li>LDI TWL is showing growth with recommendation of bringing to next escalation round</li> </ul>	<p><b>Overview of Actions:</b></p> <p>Validation – The roll out of FDP RTT tool across all CSUs with 180 staff now trained will support 12 week validation standard</p> <p>Outpatient Clinic Review matching Capacity to Demand – Women’s Outpatient Utilisation Tool trialling with CSUs with aim of filling additional clinics efficiently.</p> <ul style="list-style-type: none"> <li>Super Saturday Clinics CNS agreed for October and November – booking of patients to begin</li> </ul> <p>Theatres are working with multiple CSUs to provide theatre capacity to support delivery of long waiters being operated on</p> <ul style="list-style-type: none"> <li>Saturday Theatre Lists CNS</li> <li>Additional Theatre Lists H&amp;N</li> <li>T&amp;A and H&amp;N: joint theatre access review meeting held on the 11/09</li> </ul> <p>Using &amp; Exploring further use of IS</p> <ul style="list-style-type: none"> <li>Women’s: paper regarding using Nuffield who want above tariff</li> <li>H&amp;N: increased number of patients agreed through Pioneer</li> </ul>

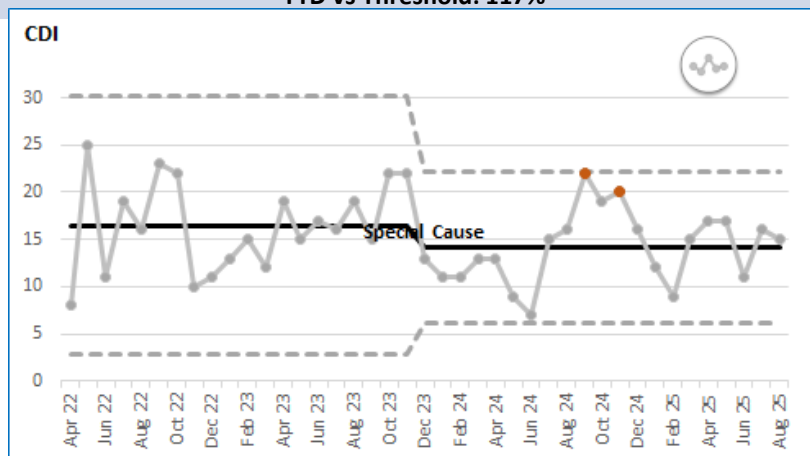


Recognise and act  
upon moments that  
matter to our patients

# CDI

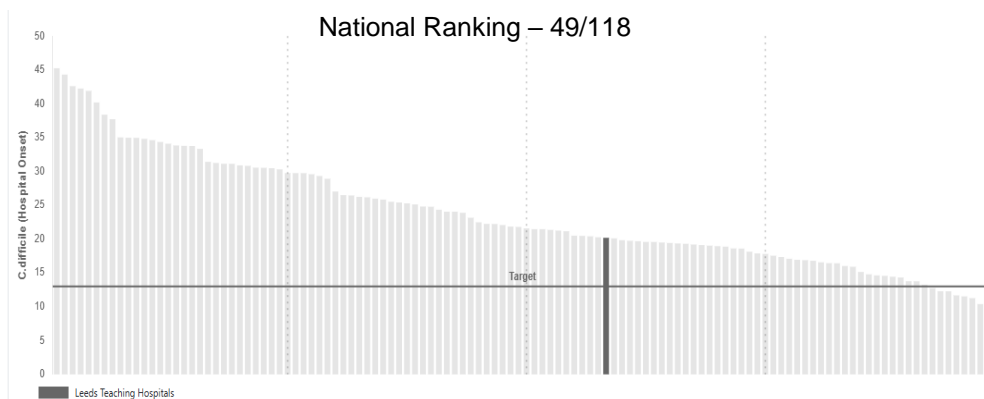
August 2025

Target: 13  
Performance: 15  
YTD vs Threshold: 117%



Executive Owner: Magnus Harrison Chief Medical Officer and Director of Infection Prevention & Control

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



Background	Context	Action
<ul style="list-style-type: none"> <li>The Trust HCAI thresholds for <i>Clostridioides difficile</i> infection (CDI), Meticillin Resistant <i>Staphylococcus aureus</i> (MRSA) and Gram-negative bloodstream infections (GNBSI) are determined nationally from NHSE and form part of the NHS Standard Contract. Publication occurred on June 9, 2025, and shared across the organisation.</li> </ul>	<ul style="list-style-type: none"> <li>The SPC chart demonstrates fluctuation above the mean. The number of cases for August 2025 is 15.</li> <li>National comparator Hospital Onset data shows LTHT position remaining in the third quartile ranked 49 out of 118 NHS Trusts, this is a slight improvement from our previous position of 51.</li> </ul>	<ul style="list-style-type: none"> <li>New strategies for cleaning will focus on equipment cleaning, with equitable responsibility for all professional groups.</li> <li>CDI MDT ward round recommenced June 2025 following microbiology laboratory move. Facilitates identifying practice gaps and development of bespoke actions to influence change.</li> </ul>

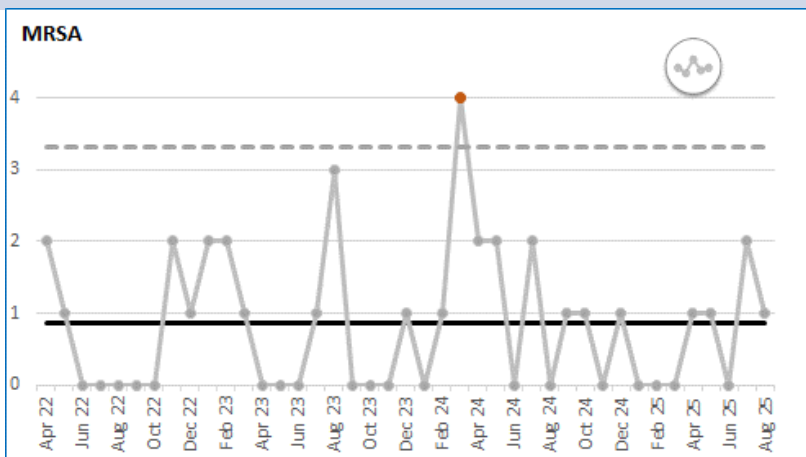


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# MRSA

August 2025

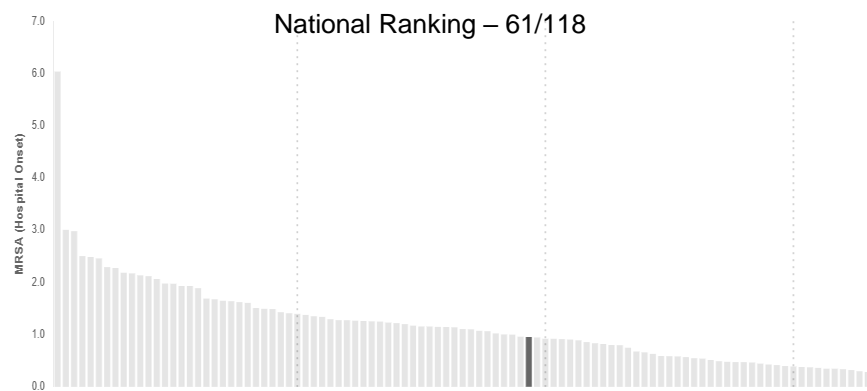
Target: 0  
Performance: 1  
YTD vs Threshold: 500%



Data as at 5/08/25

Executive Owner: Magnus Harrison Chief Medical Officer and Director of Infection Prevention & Control

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



Data Source: Fingertips

Data Period: April 2025

Background	Context	Action
<ul style="list-style-type: none"> <li>There is a National 'zero tolerance' approach to MRSA bloodstream infections.</li> </ul>	<ul style="list-style-type: none"> <li>The SPC chart shows LHTT has recorded 1 case in August 2025 against a zero-tolerance approach.</li> <li>National comparator Hospital Onset data shows LHTT position remaining within the second quartile of the table and is ranked 61 out of 118 NHS Trusts. This is a slight improvement from the previous position of 63.</li> </ul>	<ul style="list-style-type: none"> <li>2nd Trust Vascular Access Device Safety( VADS) group meeting held. Scoping exercise to understand the range of devices and locations where our patients will be receiving central vascular access procedures completed</li> <li>Trust review of Aseptic Non-Touch Technique training and implementation underway. Proposal presented at IPCSC in August- request for revision following consultation paper to follow.</li> </ul>



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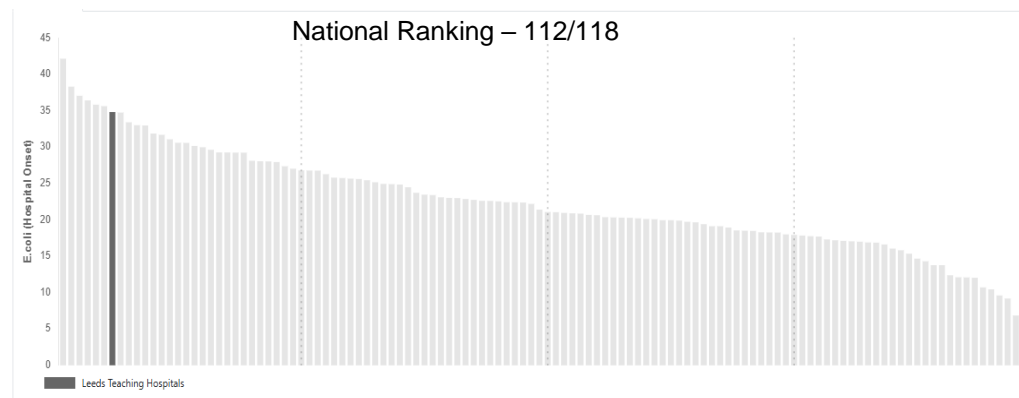
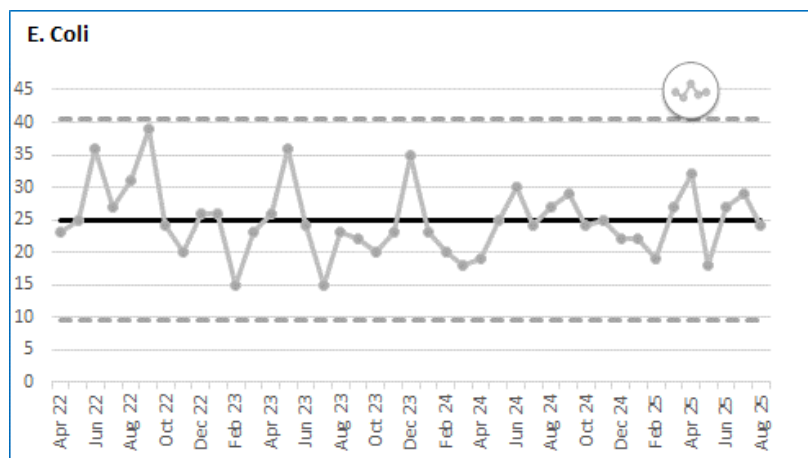
# E. Coli

August 2025

Target: 22  
Performance: 24  
YTD vs Threshold: 118%

Executive Owner: Magnus Harrison, Chief Medical Officer and Director of Infection Prevention & Control

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



Data Source: Fingertips

Data Period: April 2025








Background	Context	Action
<ul style="list-style-type: none"> <li>The Trust HCAI thresholds for <i>Clostridioides difficile</i> infection (CDI), Methicillin Resistant <i>Staphylococcus aureus</i> (MRSA) and Gram-negative bloodstream infections (GNBSI) are determined nationally from NHSE and form part of the NHS Standard Contract. Publication occurred on June 9, 2025, and shared across the organisation.</li> </ul>	<ul style="list-style-type: none"> <li>The SPC chart demonstrates fluctuation of cases around the mean. The number of E. coli cases for August 2025 is 24.</li> <li>National comparator Hospital onset data shows LTHT position remaining within the first quartile of the table and is ranked 112 out of 118 NHS Trusts, a slight improvement on the previously recorded position of 113.</li> <li>It should be noted, that good blood culture</li> </ul>	<ul style="list-style-type: none"> <li>Key areas of focus are urinary tract infection and biliary infection; a meeting was held in May with city-partners to look at an approach targeting the patient pathway for these topics.</li> <li>A Trust wide task and finish group has been convened to implement the updated LTHT ANTT guidelines, including redesign of the supporting education programme and associated staff competency.</li> </ul>

## 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