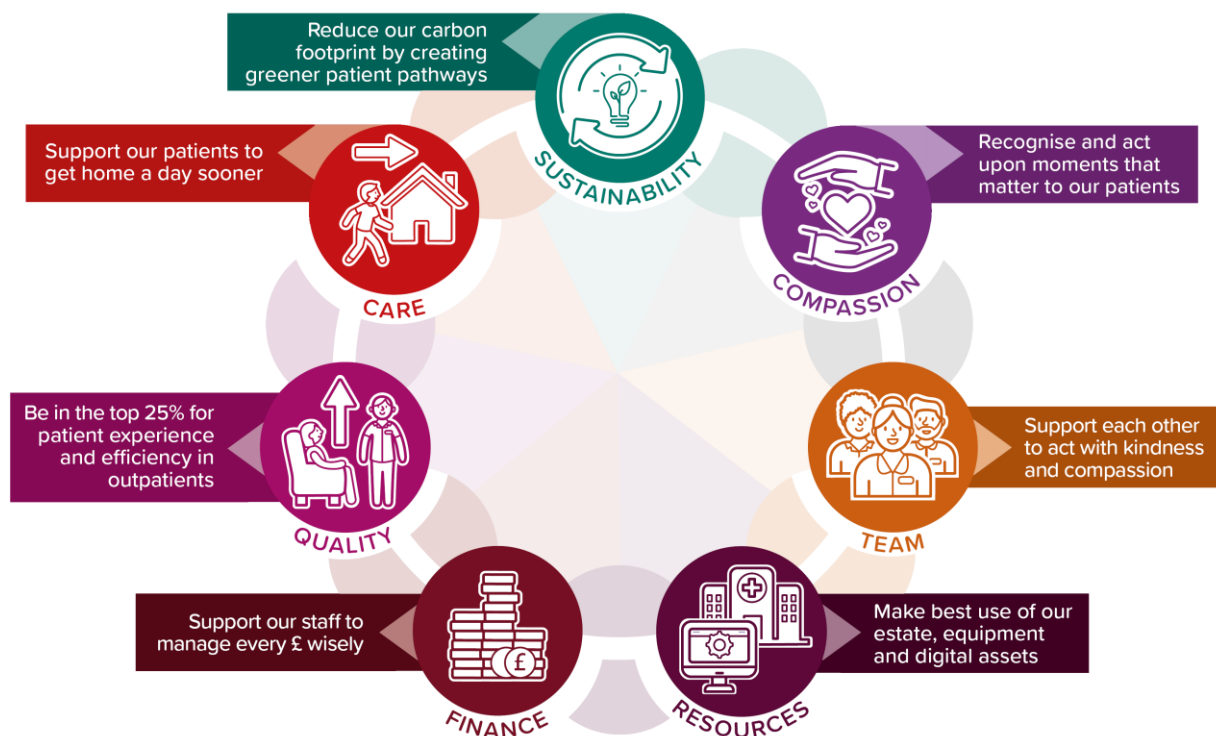


Integrated Quality & Performance Report

November 2025

7 Commitments



Summary - Performance

Performance

KPI	Latest month	Performance	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
AE Attendances per day	Oct 25	1037.0	-			947.3	821.2	1073.4
Ambulance Handovers <15mins LGI	Oct 25	00:14:42	00:15:00			00:16:38	00:15:00	00:18:16
Ambulance Handovers <15mins SJUH	Oct 25	00:17:43	00:15:00			00:21:26	00:17:19	00:25:34
Last Minute Cancelled Ops	Oct 25	116	-			84	37	131
Cancelled Ops 28days	Oct 25	23	-			19	3	36
Cancer 28day FSD	Sep 25	77.8%	75.0%			75.0%	66.6%	83.3%
Cancer 31day	Sep 25	93.6%	96.0%			88.7%	83.2%	94.2%
Cancer 62 day	Sep 25	63.8%	85.0%			57.9%	46.5%	69.4%
Diagnostics	Oct 25	93.1%	95.0%			91.6%	87.8%	95.3%
DNA Rate	Oct 25	6.53%	-			7.00%	6.26%	7.75%
Outpatient DNA Volumes	Oct 25	8640	-			8566	6429	10703
ECS Monthly	Oct 25	75.1%	78.0%			75.1%	70.3%	79.8%
Elective LoS	Oct 25	3.6	-			4.1	3.1	5.1
Elective Readmissions	Oct 25	3.05%	-			3.26%	2.93%	3.60%
Non- Elective LoS	Oct 25	7.5	-			7.3	6.5	8.0
Non- Elective Readmissions	Oct 25	5.20%	-			9.46%	7.82%	11.10%
OPFU3months	Oct 25	37787	-			36258	34289	38227
RTT Performance	Oct 25	66.8%	92.0%			63.9%	62.2%	65.7%
RTT Total Waiting list	Oct 25	87783	-			89992	87674	92309
RTT 52 Week Breach Backlog	Oct 25	1378	0			2440	1835	3044
RTT 78Week Breach Backlog	Oct 25	4	0			48	-6	103



Summary

KPI	Latest month	Performance	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
VTE	Oct 25	96.6%	95.0%			96.6%	95.4%	97.8%
CDI	Oct 25	16	-			14	6	22
MRSA	Oct 25	0	-			1	-2	3
E. Coli	Oct 25	30	-			25	9	40
Pseudomonas	Oct 25	6	-			4	-2	9
Klebsiella spp	Oct 25	10	-			11	1	22
Patient Level Metrics Score	Oct 25	94.6%	90.0%			95.0%	92.8%	97.2%
Environment Level Metrics Score	Oct 25	91.6%	90.0%			93.4%	90.6%	96.2%
Falls	Oct 25	195	-			195	165	226
Falls Rate per 1000 Bed Days	Oct 25	3.30	-			3.45	3.02	3.89
Developed Pressure Ulcers	Oct 25	49	-			46	28	65
Developed Pressure Ulcer Rate	Oct 25	0.83	-			0.84	0.54	1.14
Admitted with Pressure Ulcers	Oct 25	328	-			307	246	368
Admitted with Pressure Ulcers Rate	Oct 25	5.67	-			5.48	4.29	6.67
2222 Calls	Jul 25	65	-			60	38	81
Cardiac Arrest Calls	Jul 25	18	-			17	5	29
SHMI	Oct 25	113.4	100.0			112.3	110.9	113.8
Still Births	Oct 25	4.10	5.20			3.75	3.05	4.46
Rolling Extended Perinatal mortality rate (all NND)	Oct 25	8.40	-			9.24	8.57	9.92
Number of MNSI Referrals	Oct 25	1	-			1	-2	4
% Complaint Responses Sent Within Target Times (LR1 let	Oct 25	41%	80%			35%	16%	54%
% CSU Draft Comments Received Within Target Times (LR	Oct 25	51%	80%			49%	32%	67%
Median Response Lead Time (Days)	Oct 25	53	-			47	35	60
Defect Rate	Jul 25	5%	15%			11%	#N/A	#N/A
PALS Concerns - % Patients contacted in 2 w/days	Oct 25	69%	80%			258%	-726%	1242%



Core Metrics

Measure	Commitment	Reporting Period	Performance	Target	Variance	Assurance
Rolling Overall Sickness Rate	Team	Oct-25	5.26%	4.90%		
Rolling Voluntary Turnover Rate	Team	Oct-25	5.50%	5.93%		
In-Month Agency Spend (as % of total pay bill)	Finance	Oct-25	0.79%	0.53%		
In-Month Bank Spend (as % of total pay bill)	Finance	Oct-25	4.62%	2.83%		
In-Month Vacancy Percentage	Finance	Oct-25	6.29%	N/A		
In-Month Mandatory Training Compliance Rate	Team	Oct-25	88.78%	85.00%		
YTD Number of concerns raised to FTSU Guardian	Team	Oct-25	151	N/A		
<i>Quarterly Pulse Survey</i>						
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		
<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

Ambulance Handover

Reduce waits
for patients



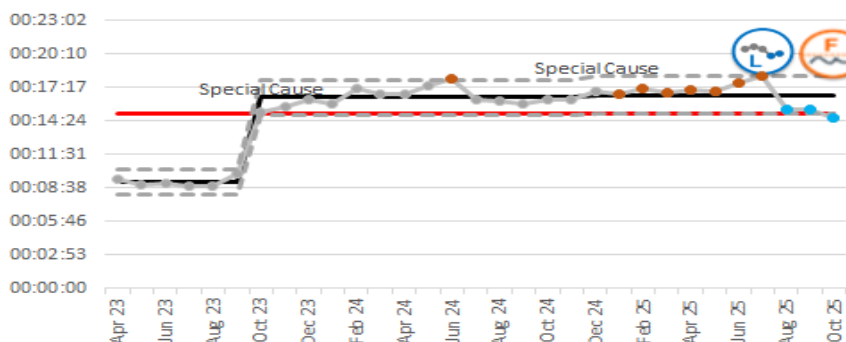
October 2025

Target: <15mins

Performance – LGI : 00:14:42

Performance – SJUH : 00:17:43

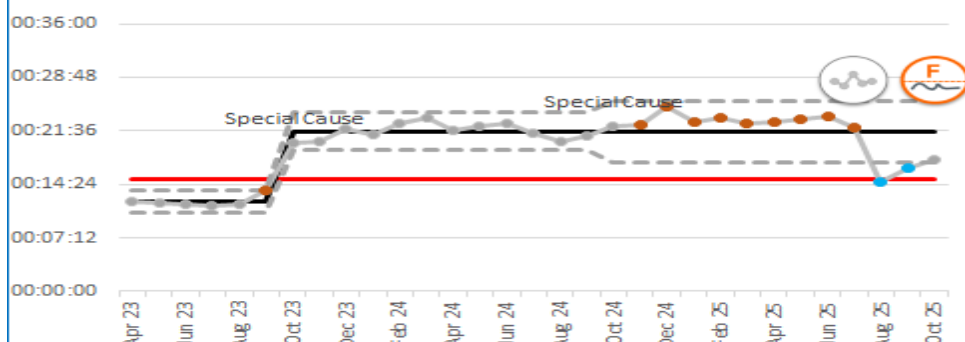
Ambulance Handovers <15mins LGI



Executive Owner: Tim Hiles (Chief Operating Officer)

Variance: Special cause variation.

Ambulance Handovers <15mins SJUH



Background	Context	Action
<p>Background / target description:</p> <ul style="list-style-type: none"> 95% of all handovers should take place within 15 minutes 	<ul style="list-style-type: none"> Handover data is managed by YAS and submitted directly to NHSE. No in-flow data accuracy corrections are made The handover clock starts 25 metres from the A&E front door via a GPS trigger. On average the first 7 minutes of the 15-minute allocation for ambulance handover is taken by the ambulance crew parking the vehicle and "off loading" (YAS term) the patient from the ambulance and wheeling them to the ambulance handover desk in A&E. We have met our national submitted trajectory for ambulance handover for the last 3 months LGI – Oct 2025 average handover time at LGI was 14:42 SJUH – Oct 2025 average handover time at SJUH was 17:43 Out of 183 hospitals SJUH placed 8th and LGI placed 32nd for ambulance handovers for October 2025 	<ul style="list-style-type: none"> A piece of work is being conducted in November reviewing non-A&E conveyances to identify focus areas for handover time improvement. This data is part of the YAS handover data submissions Another request has been submitted to YAS in November requesting the GPS trigger point is moved to 10 metres from 25 metres from the A&E entrance to support more accurate recording of when the vehicle becomes stationary Request to YAS submitted in November requesting a 13- minute notification to crews they have 2 minutes to handover A national planning trajectory for 2026/2027 has been requested by each acute trust for the ambulance handover. Information has been requested on the impact of city demographic changes and predicted changes to number of conveyances



Emergency Care Standard

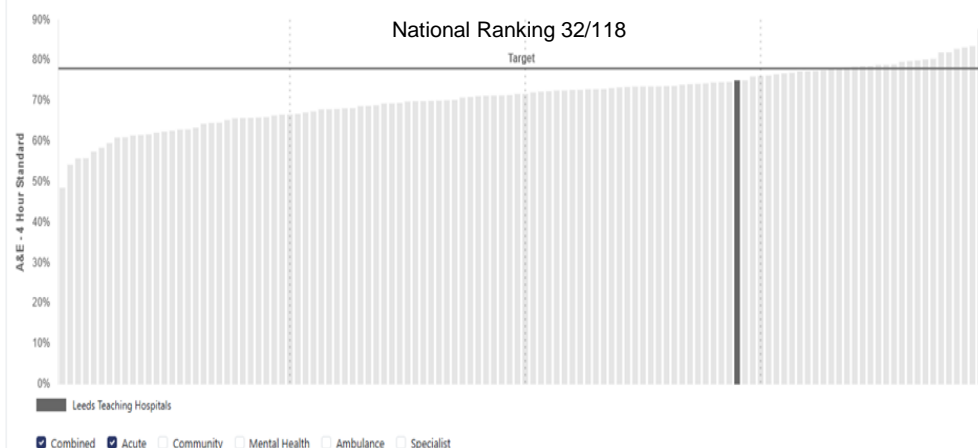
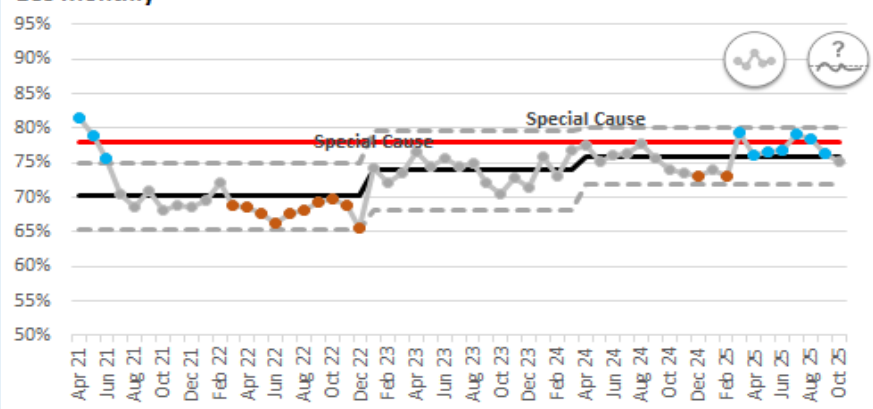
October 2025

National Planning Priority Target 2025/26: 78% by March 2026
Performance: 75.1% against national trajectory

Executive Owner: Tim Hiles (Chief Operating Officer)

Variance: Common cause variation. Hit and Miss variation indicated

ECS Monthly



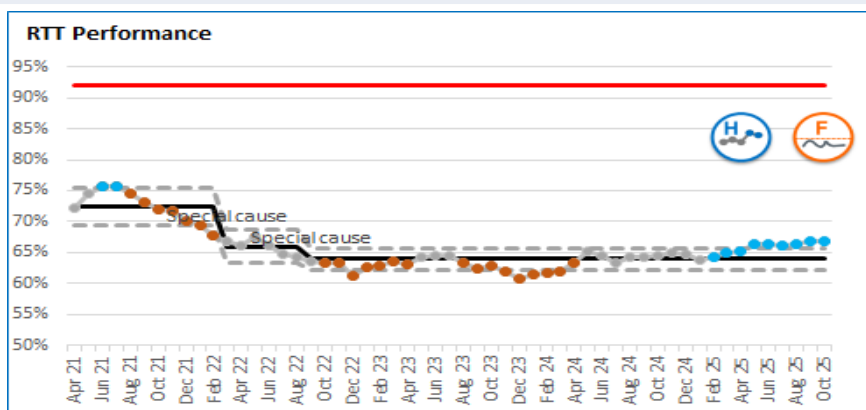
Background	Context	Action
<ul style="list-style-type: none"> The constitutional standard is that 95% of attendees to A&E will be admitted, transferred or discharged in 4 hours The 2025/26 national planning requirement is to deliver 78% by March 2026 LTHT has delivered ECS above trajectory each month since May 2025 	<ul style="list-style-type: none"> ECS delivery for October 2025 was 75.1% against the NHSE trajectory of 74.5% National average ECS was 71.8% for October 2025 LTHT ranked 32nd out of 118 Trusts for ECS performance in October 2025 Out of 10 peers, LTHT was third for ECS delivery for October 2025 LTHT had the second highest volume of attendances amongst peers Attendances across all sites in October 2025 increased by 2.8% compared to October 2024 	<ul style="list-style-type: none"> Best practice week was held during October at SJUH A&E to improve streaming from the front door to the right speciality services for the patient with an improved timeliness of care and reduction of congestion in the main A&E. This has seen an 11-minute reduction in the average time at the front door and increase in the number of admissions from the front door to assessment areas from an average of 29 per day to 35 per day LGI minor illness service overnight appointments have been implemented. Fewer slots are booked currently due to patient choice with the service reviewing how to increase uptake Making Every Day Count event planned for early January 2026 to reduce length of stay where possible ahead of winter pressures and supporting reduction of the length of time a patient who needs a ward bed placement waits, also decongesting the department and releasing staff time LGI Footprint change trial has been drafted and will take place in November Paediatric time out day taken place – front door model proposed Explore opportunities to deliver further on HomeFirst programme



RTT

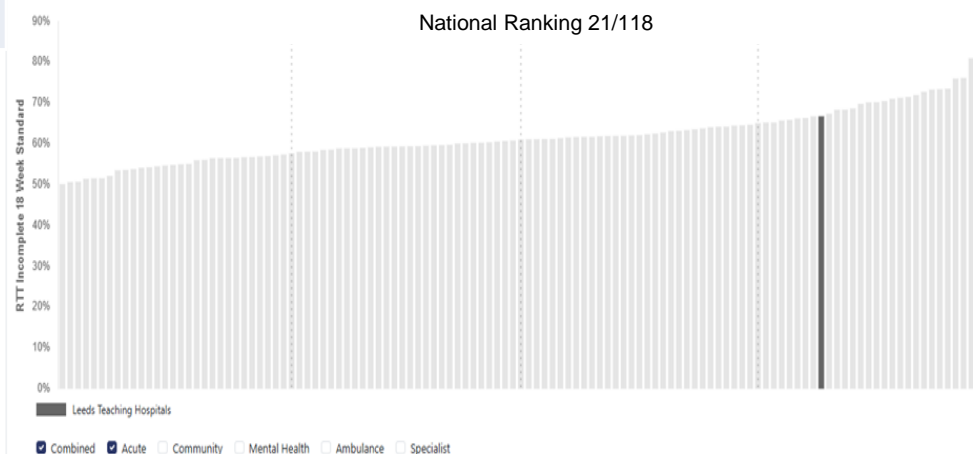
October 2025

Target: 92%
Performance: 66.7%



Executive Owner: Tim Hiles (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% by March 2026 (from 65% in Nov 24 to 70% by Mar 2026) 	<ul style="list-style-type: none"> RTT was 66.72% in September and 66.76% in October The Total Waiting List size in September 2025 position was 87,667 with the October position 87,783 The number of patients waiting over 18 weeks was 29,183 in October compared with 29,207 in September National ranking for RTT is 21 out of 118 Trusts (September 25 latest data available) 	<ul style="list-style-type: none"> Q3 Validation Sprint started on Monday 3rd November and will be a 6-week sprint rather than the standard 12-weeks and will be run via FDP Federated Data Platform was rolled out as business as usual to all CSUs at the end of September and is enabling more robust validation processes Challenged CSUs continue to deliver 'super' clinics for outpatients, reprofiling of the waiting list trajectories, insourcing for operating theatres sessions, use of Medacs to provide additional anaesthetic cover for ENT to address TWL and over 52-week reductions Outpatient transformation to reduce focus onto follow-up activity and DNA reductions



RTT 52 Weeks

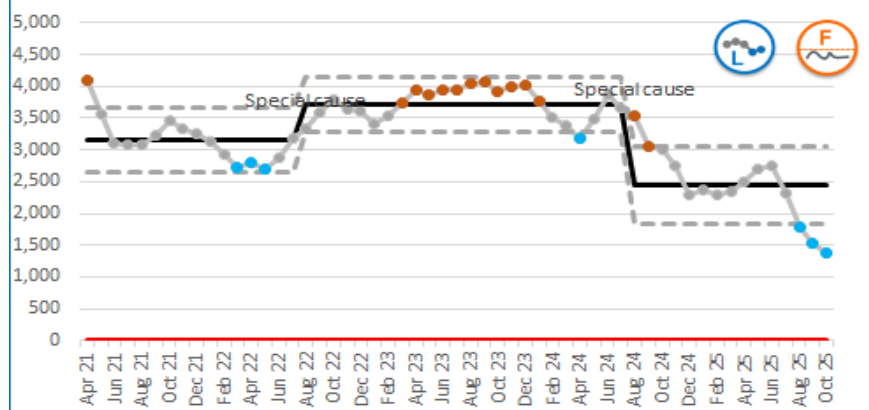
October 2025

National Planning Priority Target 2025/26: 1% of TWL (c750)
Performance: 1,378

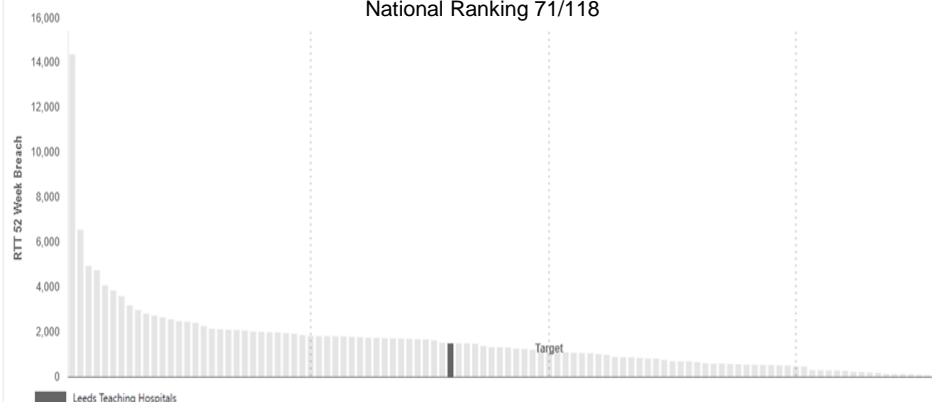
Executive Owner: Tim Hiles (Chief Operating Officer)

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

RTT 52 Week Breach Backlog



National Ranking 71/118



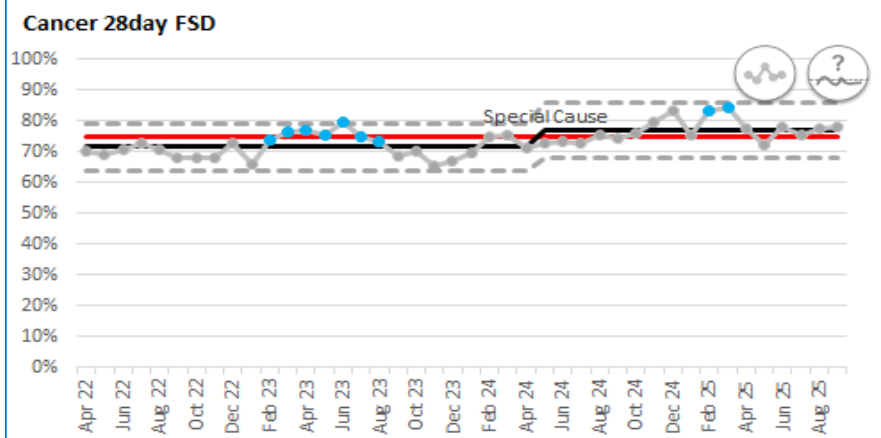
Background	Context	Action
<ul style="list-style-type: none"> Planning guidance for 2025/26 requires Trusts to ensure that fewer than 1% of patients on an RTT clock have waited over 52 weeks 	<ul style="list-style-type: none"> For October, the number of patients waiting over 65 weeks was 87, a reduction from 97 in September LHT had 1,378 52+ week waiters against a submitted NHSE plan of 1479 for October. LHT remains ahead of plan This is 1.5% of total waiting list LHT has been in Tier 1 escalation for elective care 	<p>The below actions relate to 65 weeks, 52 weeks and TWL risks;</p> <ul style="list-style-type: none"> Neurosciences: Super Saturday clinics running until November H&N: Wharfedale activity has been converted from Ophthalmology to ENT H&N: Additional sessions secured for Q3 with insourcing provider in GSOT H&N: Super Saturdays for outpatients started running until December Plastics: use of IS provision and additional workforce in hand surgery Paediatrics: 52-week incentive payment for medical staff SBAR for extension presented at execs in November and agreed for H&N TWL: reductions in TWL being seen across challenged CSUs where recovery trajectories were worked up and are being delivered against



Cancer 28 Day Faster Diagnostic

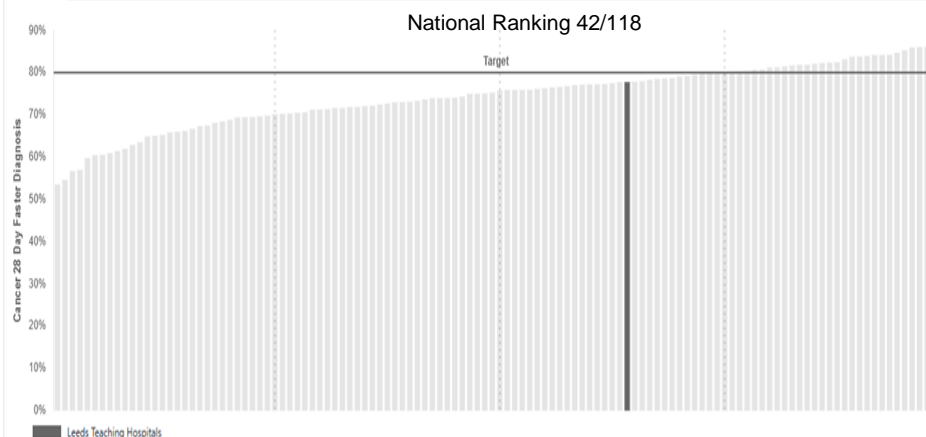
September 2025

Target: 80%
Performance: 77.8%



Executive Owner: Tim Hiles (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 2026, 80% of patients will be notified of their cancer status by day 28 	<ul style="list-style-type: none"> 28-day FDS performance was 77.8% in September 2025 3,350 patients out of 4,303 patients were informed of their diagnosis within 28 days LTHT ranked 42 of 118 Trusts in Sept 25 LTHT performance remains just under the 2025/26 trajectory 	<ul style="list-style-type: none"> Gynae pathway focus group arranged to remap and reduce delays in endometrial and cervical pathways Work underway to reduce the front-end waiting times on skin pathway with focus on completing biopsies in a more timely way Pathology TAT's continue to improve across many pathways as lab turnaround times have improved with new staff in post but are still longer than desired predominantly in Head & Neck (consultant capacity) Radiology PTL focuses on reducing delays for patients waiting for cancer diagnostics. Actions have been undertaken to improve vetting and reporting times, as well as identifying specific patient groups to reduce DNA's

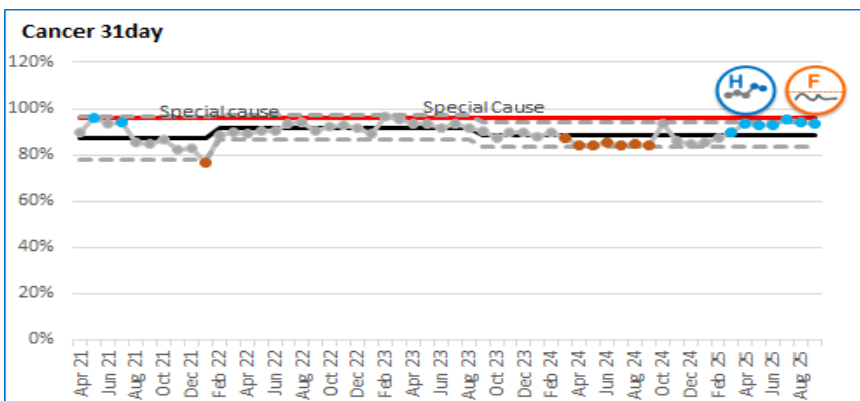
Cancer 31 day

Reduce waits
for patients



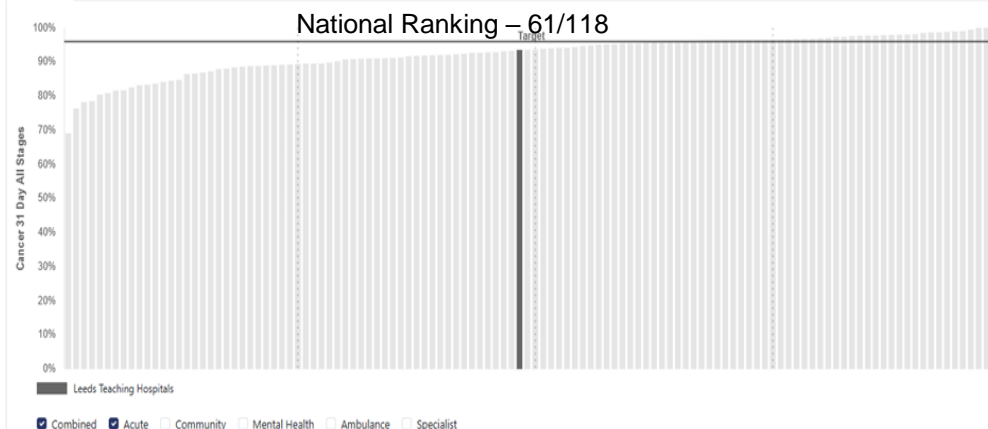
September 2025

Target: 96%
Performance: 93.6%



Executive Owner: Tim Hiles (Chief Operating Officer)

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



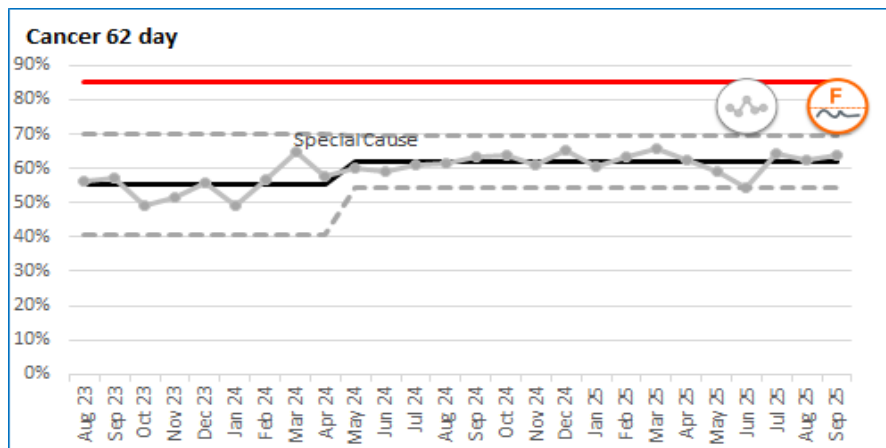
Background	Context	Action
<ul style="list-style-type: none"> 96% of patients should receive treatment within 31 days This includes patients receiving both first and subsequent Cancer treatments 	<ul style="list-style-type: none"> Overall performance for 31 days in September was 93.6% 100% of patients receiving chemotherapy are treated within 31 Day from decision to treat National ranking is 61/118 providers Surgical performance in September was: <ul style="list-style-type: none"> First – 83.9% Subs – 84.6% Radiotherapy waits in September were: <ul style="list-style-type: none"> First – 100% Subs – 99.6% 	<ul style="list-style-type: none"> Radiotherapy improved performance sustained, and all categories delivering under 31 days Focus for improving 31-day performance remains in surgical treatments Options for additional surgical capacity are being explored to try and shorten waits for surgery for Melanoma, Skin and Sarcoma patients as well as H&N, Thyroid



Cancer 62 Days

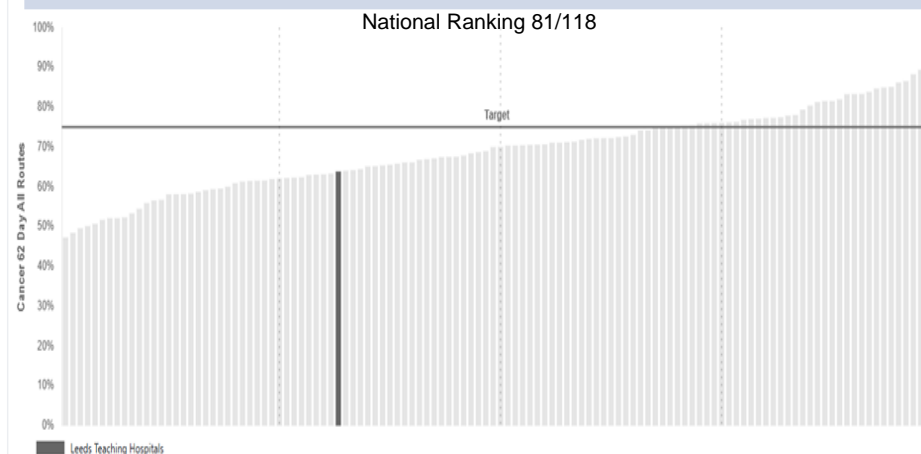
September 2025

Target: 75%
Performance: 63.8%



Executive Owner: Tim Hiles (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"> 304/478 of patients with cancer were treated within 62 days in September 2025 NHSE have agreed a revised trajectory with a March 2026 position of 67% The backlog at the end of September was 343, a reduction of 31 patients from the end of August LTHT ranked 81st of 118 trusts in September 2025 Fortnightly updates to ICB and NHSE at tiering meetings 	<ul style="list-style-type: none"> MDT Leads, CDs, GM's and Matrons have all engaged at separate meetings. CSU's have now got the responsibility for undertaking detailed assessments at access/PTL meetings with escalations direct to the GM Increased clinical 'ownership' of cancer pathways Ongoing discussion in Tiering meetings regarding 62-day position and recovery actions All CSU's have been asked for revised trajectories on their pathways and individual milestones by the end of November Funding for equipment for H&N theatre equipment has been secured that will allow thyroid procedures to be completed sooner Medical Director in discussion about improving MDT processes with MDT Leads Support from Cancer Alliance agreed for review of the Lung Pathway, IPT's and data management



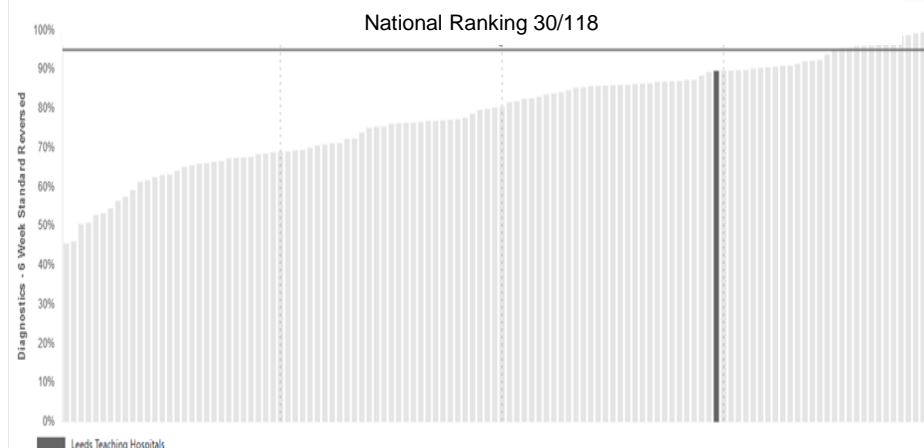
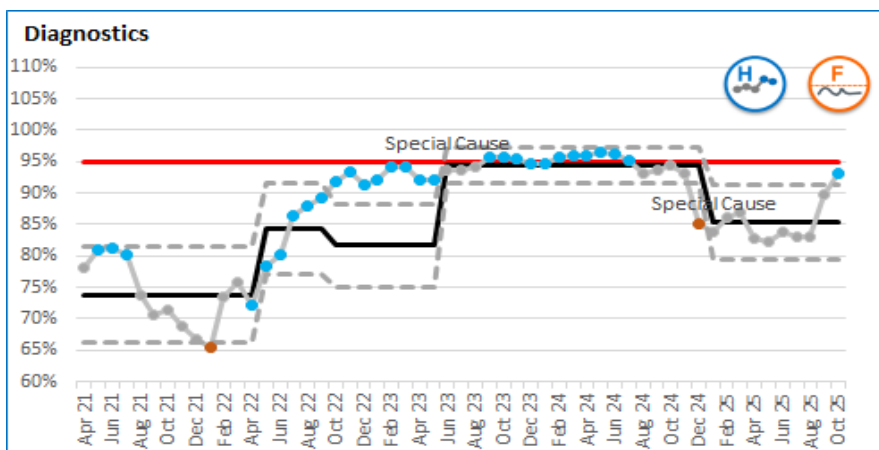
Diagnostic Waits

October 2025

Target: 95%
Performance: 93.08%

Executive Owner: Tim Hiles (Chief Operating Officer)

Variance: Special Cause of improving nature. Fail variation indicated



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"> Ultrasound have the greatest number of breaches due to staffing pressures and capacity shortfalls MRI continue to have delays for Paediatric GA MRI due to Anaesthetist & theatre capacity Children's endoscopy and cystoscopy have long waiters Audiology have overdue waits for Paediatric follow up appointments/reviews LTHT national ranking 30 out of 118 Trusts (acute and combined) for diagnostics performance in Sept 25 	<ul style="list-style-type: none"> Medicare from mid-June supporting US. Backlogs continue to reduce in line with recovery plan MRI relocatable hybrid scanner at Chapel Allerton delayed until winter. Mobile MRI van remains in place until this is available Significant improvement in CT 6ww. Cardiac CT training taking place for Radiographer run lists which are planned to start in Jan 26 Discussions with Hull to support with capacity for children's endoscopy are ongoing despite a proposed October start date. Quotes for options to insource are being reviewed with a paper being written to consider cost and benefits due in November. Options for recovery for overdue paediatric audiology follow up patients are being developed Risk to diagnostic 6ww performance if these patients are to be moved onto a 6ww diagnostic waiting list which is being assessed



Mortality

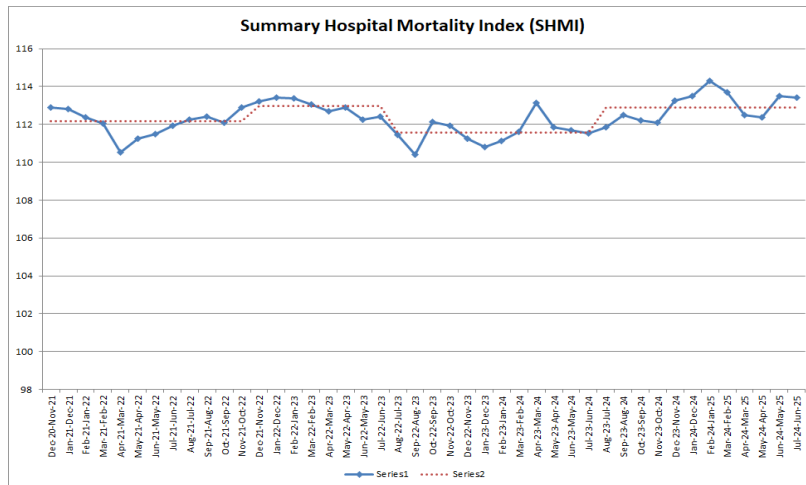
July 2024 – June 2025

Target: 100
Performance – SHMI: 113.4 “As Expected”

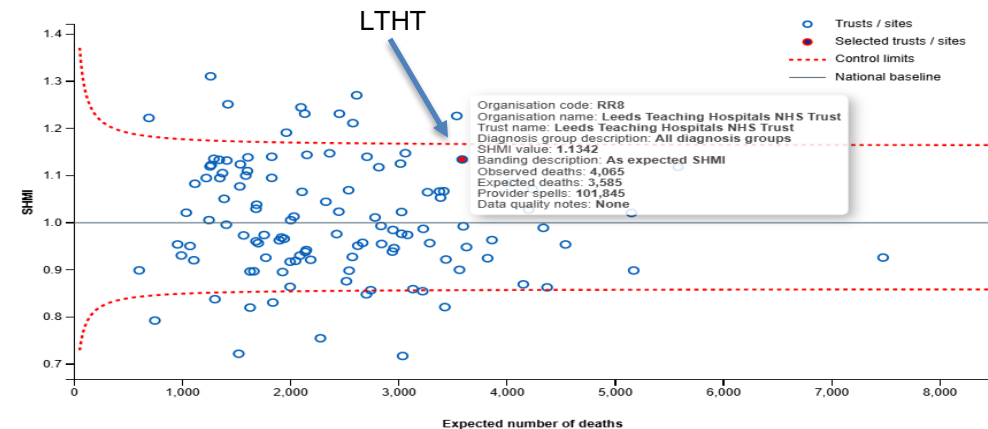
Executive Owner: Dr Magnus Harrison (Chief Medical Officer)

Variance: Common cause variation.

Summary Hospital Mortality Index (SHMI)



SHMI funnel plot

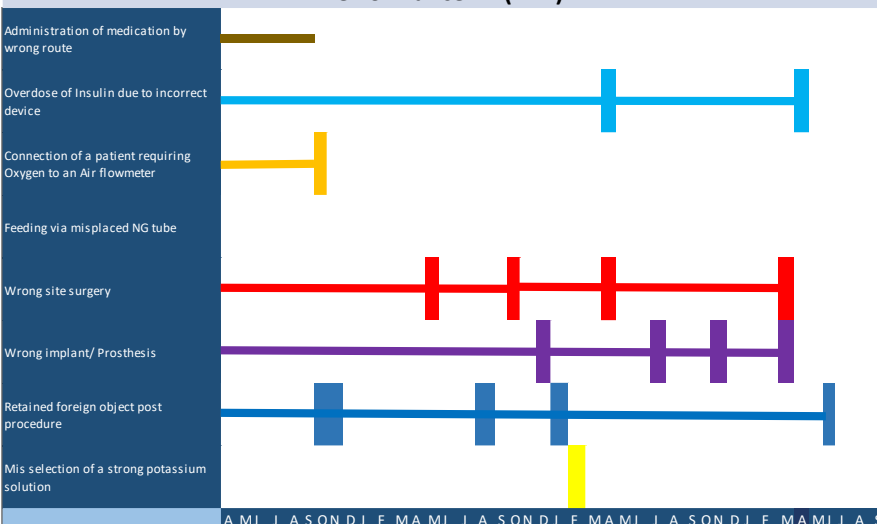


Background	Context	Action
<ul style="list-style-type: none"> There are two national Trust-level risk adjusted measures of mortality; the Summary Hospital Mortality Indicator (SHMI) and the Hospital Standard Mortality Rate (HSMR). These are used by NHSi and the CQC to inform the mortality alert process, and are calculated using a twelve month rolling average. 	<ul style="list-style-type: none"> The Trust SHMI for July 2024 – June 2025 was 113.4 and “As Expected”. The Upper Control Limit was 116.7 	<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

Q2 (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	Q2 25-26
Wrong site surgery	1	0	0	1	0	0
Wrong implant/ Prosthesis	0	2	1	1	0	0
Retained foreign object post-procedure	0	0	0	0	1	0
Overdose of insulin due to abbreviation or incorrect device	1	0	0	0	1	0
Total	2	2	1	2	2	0

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>

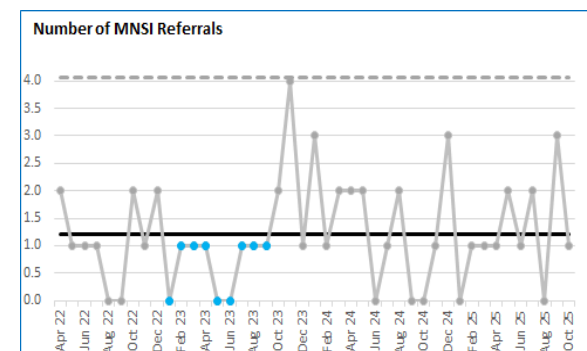
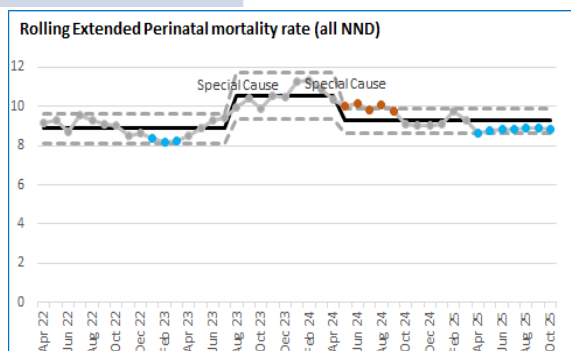
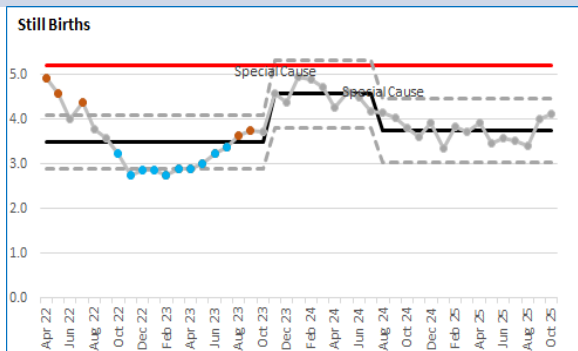


October 2025

Still Birth Rate: 4.1
Extended Perinatal Mortality Rate: 8.84
Number of MNSI Referrals: 1

Executive Owner: Rabina Tindal (Chief Nurse)

Variance: – Common Cause Variation.



Background	Context	Action
<ul style="list-style-type: none"> 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 example, on perinatal abnormalities come 	<p>There was 2 stillborn babies during October 2025</p> <ul style="list-style-type: none"> Antepartum Stillbirth at SJUH – aged 20, BMI 30, booked for care in her 2nd pregnancy (previous 14 week loss Ethnicity was White British, she was a non smoker, and was booked for midwifery led care. She did not attend some appointments and these were appropriately followed up. The dating and anomaly scan findings were normal, and combined 1st trimester screening was low risk. A glucose tolerance test was also normal. At 29+1 weeks she attended Antenatal Day Unit with a 2nd episode of reduced baby movements, and sadly it was confirmed that the baby had died in utero. Baby was born, following induction, 820g (1st centile). The Duty of Candour process is being followed. The case will be reviewed at Maternity Services Risk Meeting, and will be for PMRT review in due course. The parents have been provided with information around the PMRT process, and encouraged to provide feedback. An early debrief meeting has been offered. Antepartum Stillbirth at SJUH – First pregnancy, BMI 24, Country of birth Philippines (English preferred language) Entered the UK in 2022. Midwifery led care. Normal dating and anomaly scans, low risk combined screening. Glucose tolerance test normal. Mother attended hospital with a 1st episode of reduced baby movements at 34+1 weeks gestation, and sadly it was confirmed that the baby had died in utero. Baby was born following induction, weighing 2260g (50th centile). The Duty of Candour process is being followed. The case will be reviewed at Maternity Services Risk Meeting, and will be for PMRT review in due course. 	<ul style="list-style-type: none"> 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

Oct 2025

Target: 4.9 %

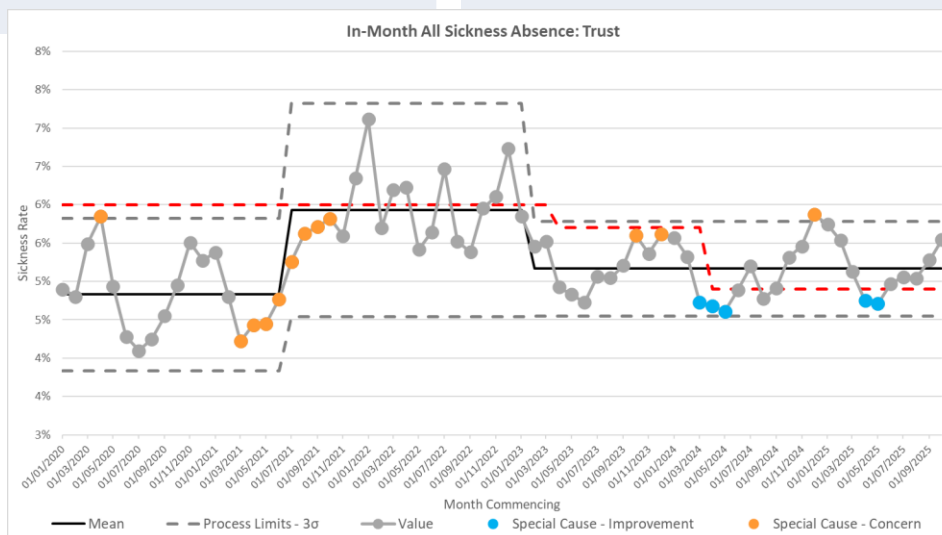
Performance (Rolling Sickness Absence Rate): 5.26%

Variance: Common cause variation in month.

Executive Owner: Kate Sims (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 however remain slightly above target. 	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 approved by Staff Side. Final edits being made to the accompanying guidance, and then it will go for Exec approval. Updated comms and training materials have been prepared to support the launch of the new policy. 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

Oct 2025

Target: 5.93%

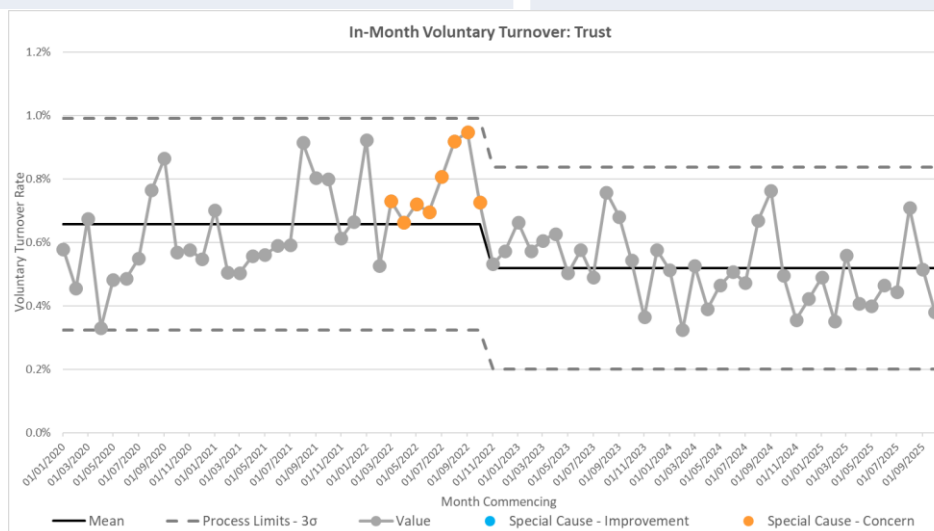
Performance (Rolling Voluntary Turnover Rate): 5.50%

Variance: Common cause variation.

Executive Owner: Kate Sims (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"> The in-month rates remain within the wide control limits. The rolling rate is below target as of October 2025. 	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 as 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

Oct 2025

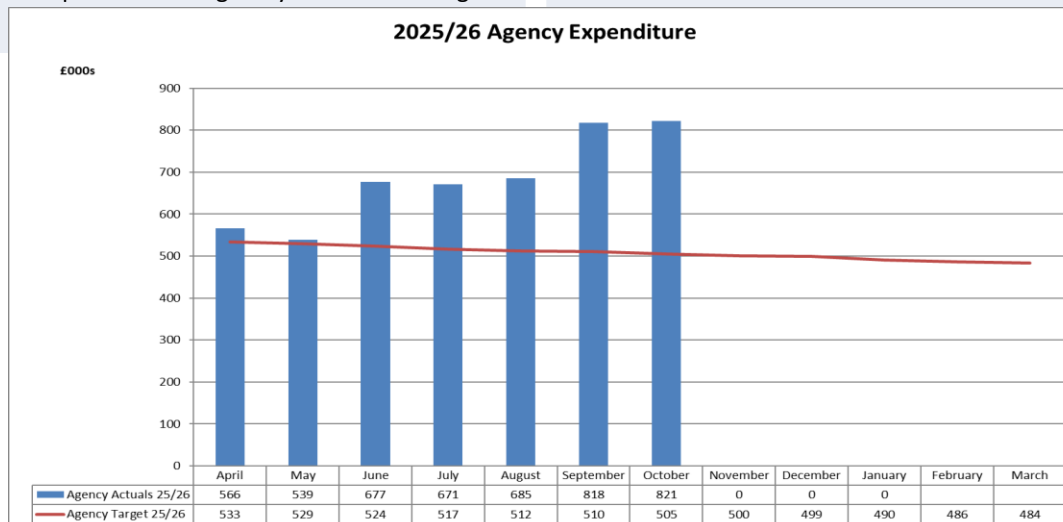
Target: 0.53% **Performance:** 0.79%

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

Executive Owner: Kate Sims (Director of HR & OD)

Management/Clinical Owner: Chris Ellison

Sub-Groups: Resource Management Group and Workforce Management Group



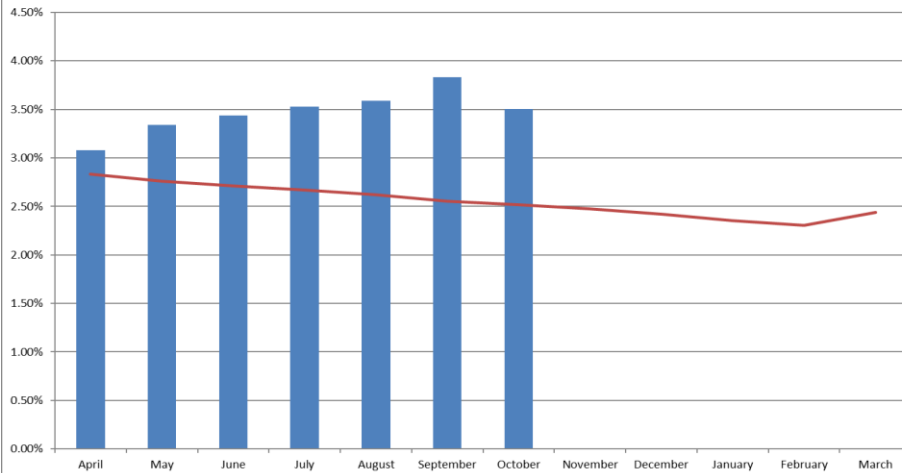
Background	What the chart tells us	Issues	Actions	Context
<ul style="list-style-type: none"> This was an area of strong performance for the Trust in 2024/25. The agency cap for 2025/26 is set as a 5% reduction on agency spend against 2024/25 with a decreasing spend target per month phased across the year. This target is being 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 continued to increase since June onwards. Agency has been due to both nursing (Women's & Children's) and medical (SIM and Neurosciences). 	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 were 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 reductions required on temporary workforce spend. Deep dives continue to happen into Agency spend across specific CSUs where agency spend had been higher than anticipated. We continue to monitor CSU agency spend throughout 2025/26 and put actions in place where appropriate. A Workforce Availability Task & Finish Group is targeting specific CSUs where spend is high in order to understand the reason for workforce unavailability driving the spend. Additional supportive action is being provided to these CSUs such as additional support with managing attendance. 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

Oct 2025

Target for Bank Spend: 2.71% (bank only)
Performance: 4.62% (bank only)

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

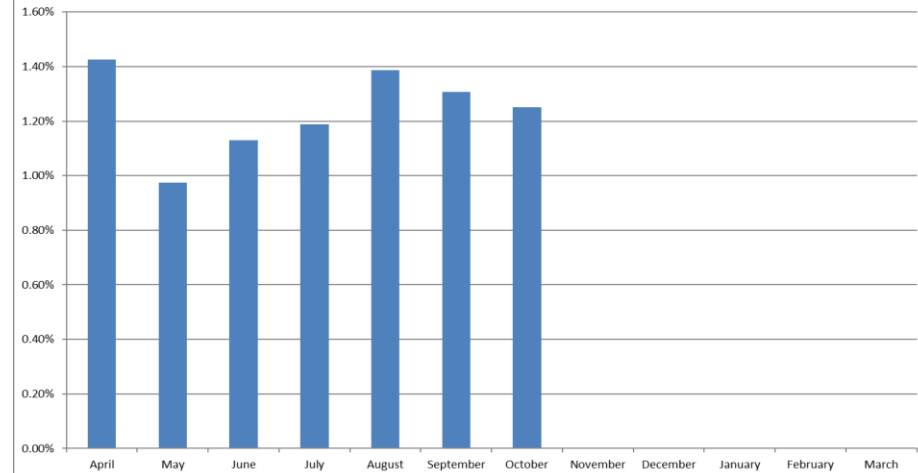


Executive Owner: Kate Sims (Director of HR & OD)

Management/Clinical Owner: Chris Ellison

Sub-Groups: Resource Management Group and Workforce Management Group

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 is being 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 October 2025 is 3.5% of total staff spend against an October target of 2.5%. Bank costs are higher than anticipated partly driven by L12 and J32 winter wards remaining open longer than planned, along with the costs associated with covering the resident doctors' industrial action. 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 have been undertaken into bank and overtime spend to identify appropriate actions and monthly KPIs are being monitored. A Workforce Availability Task & Finish Group is targeting specific CSUs where spend is high in order to understand the reason for workforce unavailability driving the spend. Additional supportive action is being provided to these CSUs such as additional support with managing attendance. A Medical & Dental Optimisation Group is progressing work to support the reduction in medical temporary spend. HR and Finance Business Partners continue to work with CSUs to develop workforce action plans to address the situation. 	N/A

Vacancy Rate

Oct 2025

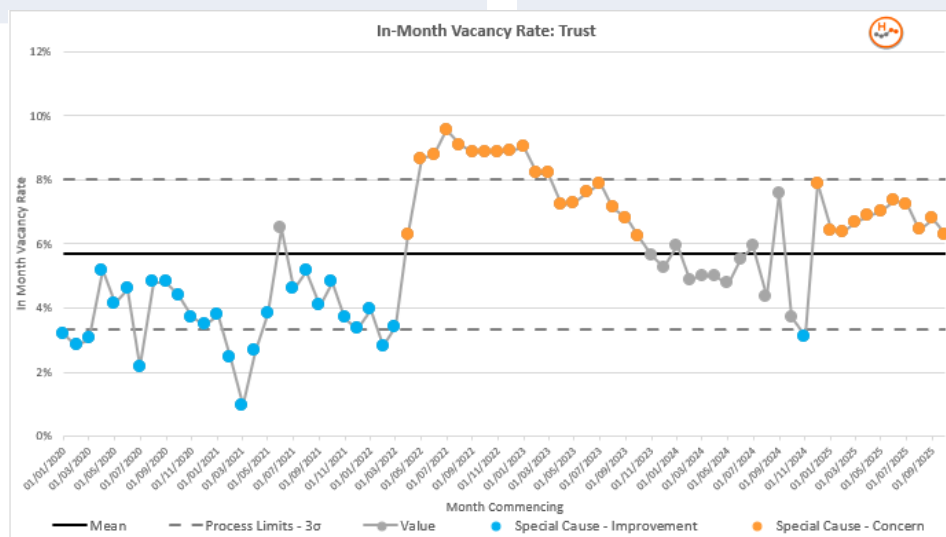
Target: N/A
Performance: 6.29%

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

Executive Owner: Kate Sims (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 and 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

Jul 2025

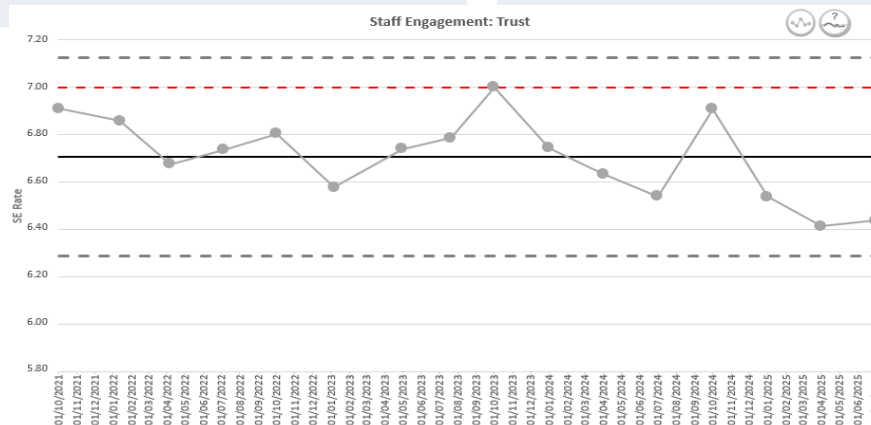
Target: 7
Performance: 6.4

Variance: Common cause variation.

Executive Owner: Kate Sims (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



October 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 October the Trust reported an in-month deficit of £1.0m, which was £1.0m adverse to the planned deficit. For the financial year to date the deficit is £26.8m, which is £11.6m adverse to the NHSE plan. The biggest drivers of the adverse position are pay expenditure being higher than planned and the Maternity Incentive Scheme rebate clawback.

Income to date is £1,221.1m which is £9.0m favourable to plan and expenditure to date is £1,247.8m, £20.6m adverse to plan. Year to date income includes additional Education & Training funding mainly associated with the tariff uplift and additional Genomics income which are offset with costs.

Pay expenditure to date is £722.7m, £12.1m 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, Building the Leeds way costs transferred from capital to revenue and bank reduction plans not yet delivering as expected. Non-pay expenditure to date is £525.1m (including depreciation and finance costs), £8.4m adverse to the plan. The non pay adverse variance relates mainly to the Maternity Incentive Scheme Year 5 & 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 NHS oversight Framework the latest published segmentation and league table gives the Trust a combined finance score of 2, based on Q1 financial performance. The M7 YTD adverse variance to plan of £11.6m (0.96% of turnover) would result in a NOF score of 3.

Capital & Cash Position



October 2025

Executive Owner: Jenny Ehrhardt (Director of Finance)

Capital

The Trust's capital expenditure forecast for 2025/26 has been increased from £89.1m to £101m due to additional PDC capital of £8m from the Community Diagnostics Centre funding, £3m to support the Maternity and Neonates, £0.7m for SUSTAIN and £0.2m for Cyber - Logging and Monitoring. The programme is broken down as follows:

Programme	Forecast 2025/26 £000
Medical Equipment	14,018
Informatics	7,366
Building & Engineering	70,349
Building the Leeds Way	1,000
Contingency	5,261
Leases	<u>3,000</u>
Total	100,994

The Expenditure to 31st October 2025 was £21.9m which was £1.2m behind forecast. M&SE YTD spend is £3.1m, which was in line with forecast. Informatics YTD spend was £3.9m, which was in line with forecast. B&E YTD spend was £13.5m, which was behind forecast by £1.2m. Most of the underspend was on the Steam Heated Calorifier Replacements Block and Replacement of distribution board in multiple blocks, switchgear & transformers projects because of the Pre-construction Services Agreements still ongoing and the contract not yet in place. The rest of the underspend was on a number of project that are experiencing work delays. The B&E forecast will be reprofiled. BtLW YTD spend was £0.3m, which was in line with forecast. Leases expenditure in October was £0.5m due to the inception of the Quantum Surgical Epione system and the Breast Screening property lease. The YTD expenditure is now at £1.1m.

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 October 2025 closing cash balance is £83.8m, an increase of £24.4m from the previous month. This is £5m better than the latest fundamental review (£78.8m), mainly due to the pace of the Capital Programme 2025/26, offset by other payables variances.

Total receipts for the month amounted to £212m which included £37m for Education Funding, covering the four months October 2025 to January 2025, and £2.5m for the August VAT return. The September VAT return was submitted to HMRC during the first week of October and payment received in November.

Total payments in month were £188m, comprising £103m for payroll and £85m for accounts payable. The accounts payable spend included £4.5m of capital invoices.

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, which fluctuates from 0.07% to 0.1% above the interest offered by the standard GBS account currently at 3.89%. A total of £19.5k 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



October 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	107.2	107.5	0.3	747.4	752.0	4.5
	Non-PbR Drugs, Blood and Devices	395.9	33.0	35.7	2.7	230.9	225.2	(5.7)
	Sub-Total Commissioner Income	1,685.5	140.2	143.2	3.0	978.4	977.2	(1.2)
	Other Clinical Income	11.8	1.0	1.1	0.2	6.9	8.4	1.5
	Total Clinical Income	1,697.2	141.2	144.3	3.2	985.2	985.6	0.3
	Other Income (non Covid)	305.3	25.1	29.0	3.8	173.5	182.3	8.9
	Other Income (Covid Top Up; Testing; Vaccination)	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Total Income	2,002.5	166.3	173.3	7.0	1,158.7	1,167.9	9.2
EXPENDITURE	Pay Costs	(1,207.0)	(100.4)	(104.1)	(3.6)	(710.7)	(722.8)	(12.1)
	Sub-Total Pay	(1,207.0)	(100.4)	(104.1)	(3.6)	(710.7)	(722.8)	(12.1)
	Non Pay Costs (excl Non-PbR Drugs, Blood and Devices)	(389.0)	(32.2)	(35.1)	(2.9)	(231.1)	(247.9)	(16.8)
	Non-PbR Drugs, Blood and Devices	(396.4)	(33.0)	(35.5)	(2.5)	(231.2)	(223.7)	7.5
	Sub-Total Non Pay	(785.4)	(65.2)	(70.6)	(5.4)	(462.3)	(471.6)	(9.3)
	Total Expenditure	(1,992.4)	(165.7)	(174.7)	(9.1)	(1,173.0)	(1,194.4)	(21.4)
	EBITDA	10.2	0.6	(1.4)	(2.1)	(14.3)	(26.5)	(12.2)
	EBITDA%			-0.8%			-2.3%	
OTHER	Depreciation	(54.3)	(4.6)	(3.8)	0.8	(29.6)	(29.6)	0.0
	Amortisation	(4.5)	(0.4)	(0.3)	0.0	(2.7)	(2.7)	(0.0)
	Impairments	(10.5)	0.0	0.0	0.0	(10.5)	0.0	10.5
	Investment Revenue	4.1	0.3	0.4	0.1	2.4	3.6	1.2
	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	(8.4)	(19.7)	(11.3)
	Dividends payable on Public Dividend Capital (PDC)	(10.8)	(0.9)	(0.9)	0.0	(6.3)	(6.3)	0.0
	Retained Surplus/(Deficit) BEFORE ERF/TIF	(89.9)	(6.1)	(7.2)	(1.1)	(69.4)	(81.1)	(11.7)
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)	(0.2)	(0.1)	(0.4)	(2.0)	(1.6)
	Impairments	10.5	0.0	0.0	0.0	10.5	0.0	(10.5)
	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)	(6.2)	(7.4)	(1.2)	(59.2)	(83.0)	(23.8)
	Elective Recovery Fund (ERF)	97.7	8.1	8.2	0.1	56.4	57.3	0.9
	Adjusted Surplus/(Deficit) INCLUDING ERF	11.0	1.8	0.8	(1.0)	(2.8)	(25.7)	(22.9)
	Adjust PFI revenue costs to UK GAAP basis	(11.0)	(1.8)	(1.8)	(0.0)	(12.4)	(1.1)	11.3
	Adjusted financial performance surplus/(deficit)	0.0	0.1	(1.0)	(1.0)	(15.2)	(26.8)	(11.6)

Statement of Financial Position



October 2025

Executive Owner: Jenny Ehrhardt (Director of Finance)

	Year to date movement			In Month	
	Closing 31st March 2025 £m	As at 31st October 2025 £m	Year to date movement £m	Prior Month £m	In-month movement £m
Non-Current Assets:					
Property, Plant And Equipment	804.1	796.4	(7.7)	796.2	0.2
Intangible Assets	10.8	8.2	(2.7)	8.5	(0.3)
Trade And Other Receivables	12.5	15.0	2.5	14.6	0.4
Total Non-Current Assets	827.5	819.6	(7.9)	819.3	0.3
Current Assets:					
Inventories	29.4	28.6	(0.8)	30.7	(2.1)
Trade And Other Receivables	72.3	76.8	4.5	82.3	(5.5)
Cash and Cash Equivalents	82.2	83.8	1.6	59.4	24.4
Non-Current Assets Held for Sale	0.0	0.0	0.0	0.0	0.0
Total Current Assets	183.8	189.1	5.3	172.3	16.8
Total Assets	1,011.3	1,008.7	(2.6)	991.6	17.1
Current Liabilities:					
NHS Trade Payables	(4.4)	(1.6)	2.8	(2.6)	1.0
Trade and Other Payables	(211.0)	(236.0)	(25.0)	(217.1)	(18.9)
Borrowing / DH Loans	(2.1)	(2.1)	(0.0)	(2.1)	(0.0)
Other Financial Liabilities - PFI	(21.8)	(22.7)	(0.9)	(22.6)	(0.1)
Provisions For Liabilities And Charges	(7.9)	(7.8)	0.0	(7.9)	0.0
Total Current Liabilities:	(247.2)	(270.3)	(23.1)	(252.3)	(18.1)
Net Current Assets/ (Liabilities)	(63.4)	(81.2)	(17.8)	(79.9)	(1.3)
Total Assets Less Current Liabilities	764.1	738.4	(25.7)	739.4	(1.0)
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)	(8.2)	1.0	(8.2)	0.0
Other Financial Liabilities - PFI	(278.7)	(277.2)	1.5	(278.6)	1.4
Provisions For Liabilities And Charges	(10.0)	(9.2)	0.8	(9.8)	0.6
Total Non-Current Liabilities	(297.9)	(294.5)	3.3	(296.5)	2.0
Total Assets Employed	466.2	443.8	(22.4)	442.8	1.0
Financed By Taxpayers Equity					
Public Dividend Capital	641.8	643.1	1.4	643.1	0.0
Retained Earnings	(175.6)	(199.3)	(23.7)	(200.3)	1.0
Revaluation Reserve	0.0	0.0	0.0	0.0	0.0
Total Taxpayers Equity	466.2	443.8	(22.4)	442.8	1.0

Cash Flow Statement



October 2025

Executive Owner: Jenny Ehrhardt (Director of Finance)

Cash Flow	Closing 31st March 2025 £m	As at 31st October 2025 £m	Previous Month £m
<u>Operating Activities</u>			
EBITDA	112.1	30.8	24.1
Donated assets received credited to revenue but non cash	(7.3)	(4.2)	(3.7)
Interest paid	(14.6)	(8.3)	(7.2)
Dividend paid	(7.0)	(5.1)	(5.1)
Decrease/(increase) in inventories	(0.8)	0.8	(1.3)
Decrease/(increase) in trade and other receivables	13.9	(3.8)	(9.4)
(Decrease)/Increase in trade and other payables	(9.8)	35.3	16.5
(Decrease)/Increase in provisions	1.6	(0.8)	(0.2)
Net cash inflow/(outflow) from Operating Activities	88.2	44.8	13.7
<u>Cash Flows from Investing Activities</u>			
Interest received	4.6	3.6	3.2
(Payments) for property, plant and equipment	(79.4)	(35.5)	(29.8)
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	4.2	3.7
PFI lifecycle prepayments (cash outflow)	(6.2)	(3.9)	(3.4)
Net cash outflow from Investing Activities	(75.9)	(31.6)	(26.2)
Net cash inflow before Financing	12.3	13.2	(12.5)
<u>Cash Flows from Financing Activities</u>			
Public dividend capital received	44.3	1.4	1.4
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)	(1.0)	(1.0)
Capital element of finance lease and PFI	(20.6)	(12.0)	(10.6)
Net cash inflow/(outflow) from Financing Activities	21.7	(11.6)	(10.3)
Increase/(decrease) in cash	34.0	1.6	(22.8)
Cash at the beginning of the year	48.2	82.2	82.2
Cash at the end of the financial period	82.2	83.8	59.4

Supplementary Metrics Produced by Exception



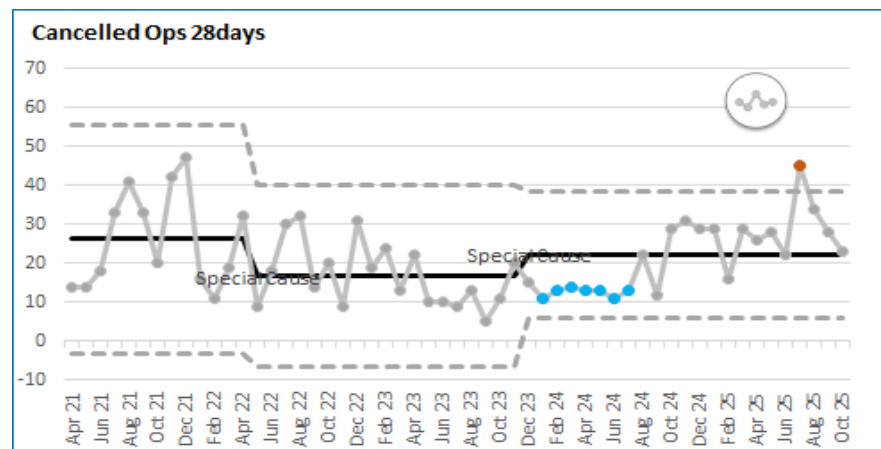
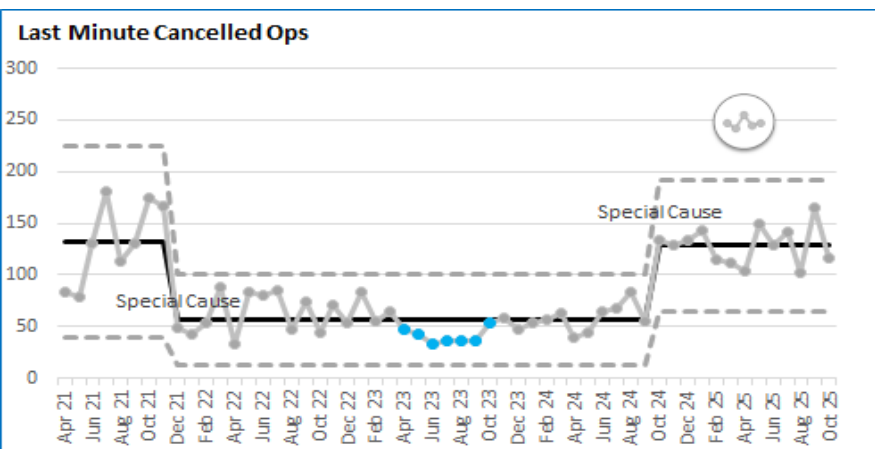
Cancelled Ops

October 2025

Target-28-day breaches: 0
Performance – LMCO: 116
Performance – 28-day Standard: 23

Executive Owner: Tim Hiles (Chief Operating Officer)

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



Background	Context	Action
Ensure all patients who have operations cancelled on the day of surgery, for non-clinical reasons are offered another binding date to be treated within a maximum of 28 days (zero tolerance standard)	<p>Cancelled Operations</p> <ul style="list-style-type: none"> There were 116 LMCO in October 2025 a reduction from September when it was 165. The main reasons for LMCO continue to be 'ran out of theatre time' and 'ward bed capacity' <p>28 Day Breaches</p> <ul style="list-style-type: none"> There were 23 breaches of the 28-day standard in October 2025 a reduction from September when it was 28 	<ul style="list-style-type: none"> Audits of cancellation reasons completed by 8/9 surgical CSUs. Themes have been discussed in Specialty Theatre Improvement Groups and actions to reduce on-day cancellations agreed On-day cancellation escalation process reiterated at Strategic Theatre Utilisation Group (12/11/25) to prompt increased compliance with SOP Neurosciences and pre-assessment have met to discuss optimising POA pathway to prevent avoidable on-day cancellations for unfit patients Strategic Theatre Utilisation Group oversight of productivity metrics and HVLC list delivery 28-day breach numbers monitored in Service Delivery Accountability Meetings (SDAM)

Supplementary Metrics NHS Oversight Framework

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

Reduce waits
for patients

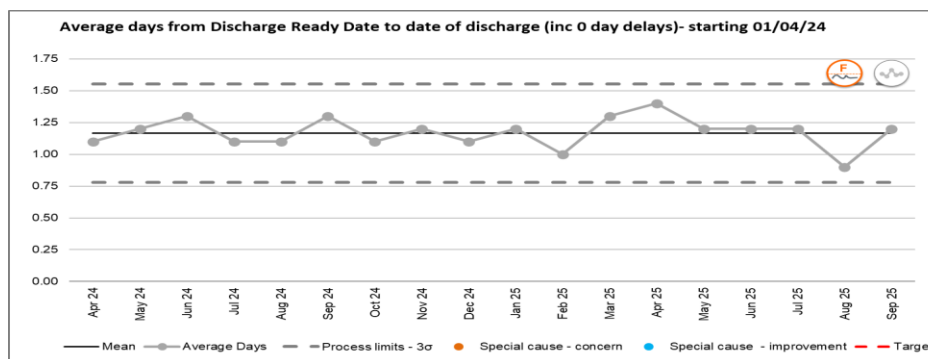


September 2025

Performance: 1.2 days

Executive Owner: Tim Hiles (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"> The discharge ready date records the date the patient no longer meets the 'Criteria to Reside' in a hospital bed 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 	<ul style="list-style-type: none"> This is a new metric displayed on the NHSE Oversight Framework dashboard for Q1 for this year For September 2025 (latest data available), the average number of days between discharge ready date and actual date of discharge was 1.2 days National average is 0.9 days 	<ul style="list-style-type: none"> Monitoring of internal and external delays daily based on the midnight snapshot data. Outstanding actions relating to transport/eDans/Therapies are escalated daily to the relevant CSU Making Every Day Count (MEDC) structured peer Gemba walks by CSU and Director tri teams in Dec 2025. CSU Tri teams notified and provided with MEDC packs and bundles 6-weeks in advance. LTHT Ops centre providing training & education on coding to ensure any delays are accurate and known. Specific work on submission of relevant discharge referral (eDIDS) underway. Update report due Dec 2025 City action plan developed for patients requiring ongoing system support that are over 21 day past their DRD. Patients reviewed through multi-agency LLOS meetings weekly and issues escalated. Strategic approach to themes being addressed through Pathway 3 and ASL meeting.

Tier 1 Recovery Trajectory

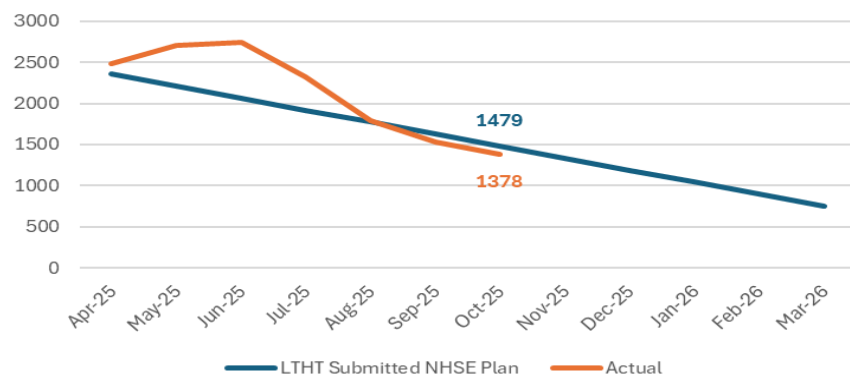
Reduce waits
for patients



August 2025

Executive Owner: Tim Hiles (Chief Operating Officer)

Tier 1 52 week waiters



Background	Context	Action
<ul style="list-style-type: none"> LTHT was placed into Tier 1 at the end of quarter 1 of 2025/26 	<p>NHSE have confirmed that a recommendation has been made to the tiering review group that LTHT be removed from Tiering for elective activity and stepped down to tier 2 for cancer.</p>	<p>Overview of Actions:</p> <p>Focus remains on reducing total waiting list volumes and patients above 65 weeks.</p> <p>Admitted waiting lists continue to grow in volume while non-admitted lists are slowly reducing.</p> <p>Key area of risk is ENT where capacity to deliver for cancer surgery and long waits is limited. Additional capacity has been developed through use of Gilbert Scott theatres and D&C exercise commenced</p>

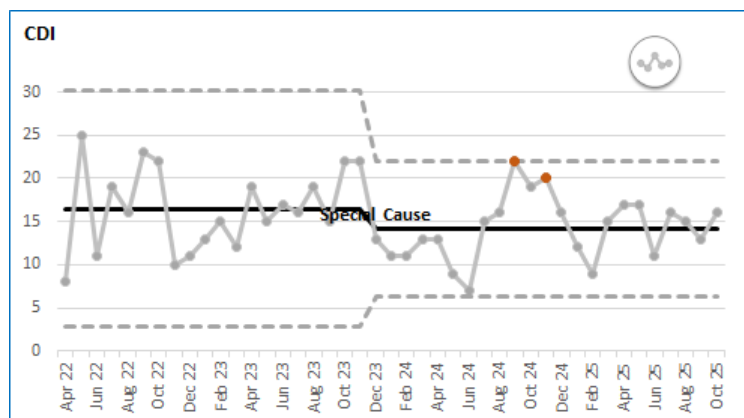


Recognise and act upon moments that matter to our patients

CDI

October 2025

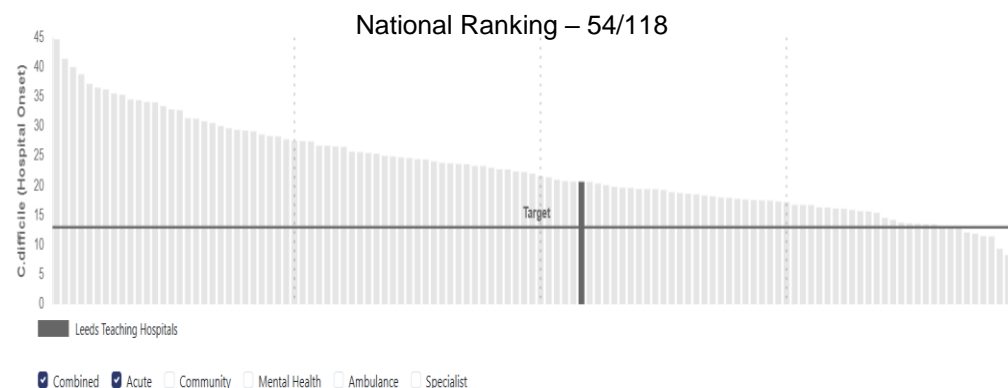
Target: 13
Performance: 16
YTD vs Threshold: 115%



Data as at 18/11/25

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: August 2025

Background	Context	Action
<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> The SPC chart demonstrates fluctuation around the mean. The number of cases for October 2025 is 16. National comparator Hospital Onset data from July shows LHT position remaining in the third quartile ranked 49 out of 118 NHS Trusts 	<ul style="list-style-type: none"> Renewed focus on decluttering the bed space and clinical area to promote effective cleaning. CDI MDT ward round recommenced June 2025 following microbiology laboratory move. Facilitates identifying practice gaps and development of bespoke actions to influence change . Hands Ready is a key area of focus Impact of AMR focus within the annual plan will support the work to reduce CDI infection through antimicrobial stewardship and learning from PSIRF reviews. Renewed focus on #CAPES

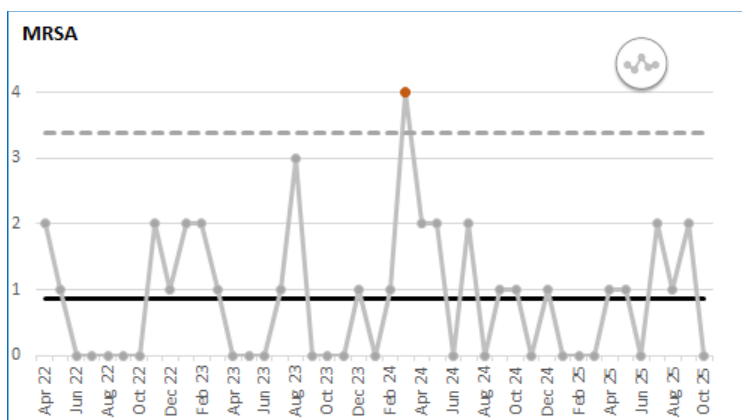


Recognise and act
upon moments that
matter to our patients

MRSA

October 2025

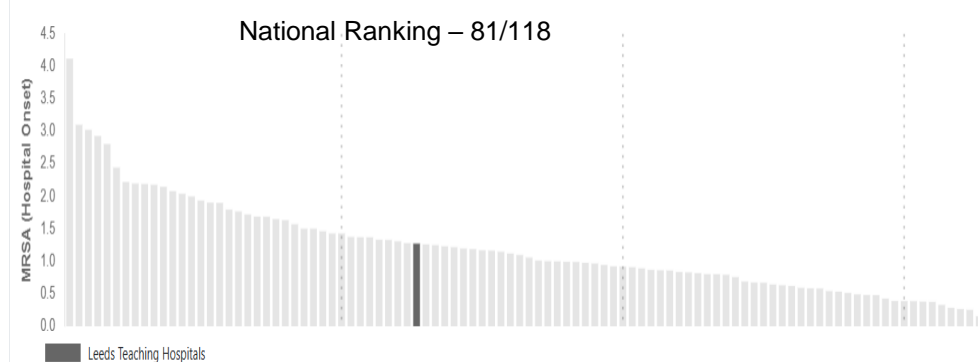
Target: 0
Performance: 0



Data as at 18/11/25

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: August 2025

Background	Context	Action
<ul style="list-style-type: none"> There is a National 'zero tolerance' approach to MRSA bloodstream infections. 	<ul style="list-style-type: none"> The SPC chart shows LTHT has recorded 0 cases in October 2025 against a zero-tolerance approach. National comparator Hospital Onset data from August shows LTHT position remaining within the second quartile of the table and is ranked 81 out of 118 NHS Trusts. Recurring themes around decolonisation and device care(including difficult device insertion) identified. 	<ul style="list-style-type: none"> Trust Vascular Access Device Safety (VADS) group growing, five key workstreams identified, prioritisation underway. Trust review of Aseptic Non-Touch Technique training and implementation completed. Proposal to procure national product agreed in principle. October focus month for MRSA prevention including, risk assessment, decolonisation application, video and guidance 'at a glance'



Recognise and act
upon moments that
matter to our patients

E. Coli

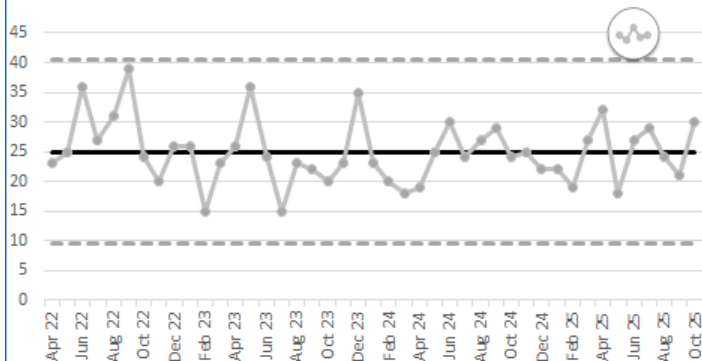
October 2025

Target: 22
Performance: 30
YTD vs Threshold: 118%

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

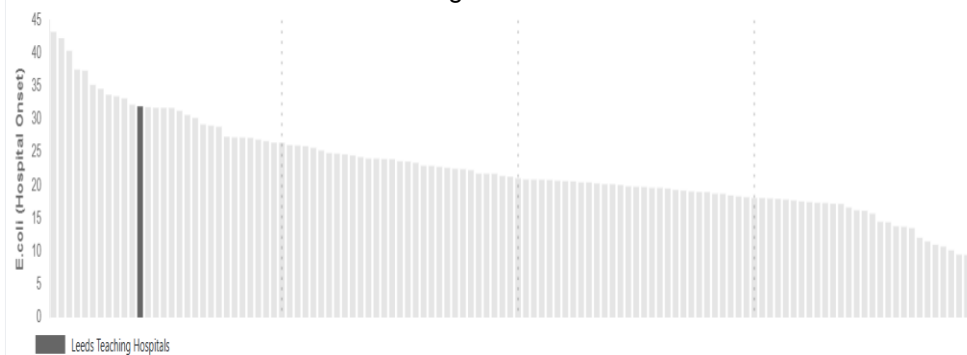
Variance: Common cause variation. The process will regularly achieve the target

E. Coli



Data as at 18/11/25

National Ranking – 107/118



Data Source: Fingertips

Data Period: August 2025








Background	Context	Action
<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> The SPC chart demonstrates fluctuation of cases around the mean. The number of E. coli cases for October 2025 is 22. National comparator Hospital onset data from July shows LTHT position remaining within the first quartile of the table and is ranked 107 out of 118 NHS Trusts. 	<ul style="list-style-type: none"> Key areas of focus include enhance device management by ensuring good ANTT knowledge , daily check that the device is still needed, robust device monitoring and criteria led device removal. 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. System Wide GNBSI Improvement group in place –Workshop planned for October to review the key themes identified so far and to work collaboratively on developing a citywide plan for GNBSI

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	LHT

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