

Integrated Quality & Performance Report

May 2026

Summary - Performance

Performance

KPI	Latest month	Performance	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
AE Attendances per day	Apr 26	990.3	-			975.6	862.2	1088.9
Ambulance Handovers <15mins LGI	Apr 26	00:13:59	00:15:00			00:15:00	00:13:49	00:16:10
Ambulance Handovers <15mins SJUH	Apr 26	00:16:21	00:15:00			00:17:12	00:14:03	00:20:22
Last Minute Cancelled Ops	Apr 26	103	-			91	36	146
Cancelled Ops 28days	Apr 26	36	-			22	1	43
Cancer 28day FSD	Mar 26	83.7%	75.0%			75.4%	67.1%	83.6%
Cancer 31day	Mar 26	96.2%	96.0%			90.1%	85.3%	94.8%
Cancer 62 day	Mar 26	71.2%	85.0%			59.3%	48.5%	70.1%
Diagnostics	Mar 26	93.1%	95.0%			91.6%	88.0%	95.2%
DNA Rate	Apr 26	6.73%	-			6.90%	6.18%	7.63%
Outpatient DNA Volumes	Apr 26	7904	-			8177	6234	10120
ECS Monthly	Apr 26	78.8%	78.0%			75.3%	70.9%	79.7%
Elective LoS	Apr 26	3.7	-			4.1	3.2	5.0
Elective Readmissions	Apr 26	3.00%	-			3.25%	2.89%	3.61%
Non- Elective LoS	Apr 26	7.7	-			7.4	6.6	8.2
Non- Elective Readmissions	Apr 26	10.59%	-			11.28%	9.92%	12.64%
OPFU3months	Apr 26	42657	-			37479	35438	39520
RTT Performance	Apr 26	67.5%	92.0%			64.5%	62.9%	66.1%
RTT Total Waiting list	Apr 26	86725	-			89388	87004	91772
RTT 52 Week Breach Backlog	Apr 26	1304	0			2119	1677	2561
RTT 78Week Breach Backlog	Apr 26	14	0			36	-1	73









Summary

KPI	Latest month	Performance	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
VTE	Apr 26	96.1%	95.0%			96.5%	95.2%	97.8%
CDI	Apr 26	8	-			14	5	23
MRSA	Apr 26	2	-			1	-2	3
E. Coli	Apr 26	13	-			25	9	40
Pseudomonas	Apr 26	1	-			4	-2	10
Klebsiella spp	Apr 26	6	-			11	0	22
Patient Level Metrics Score	Apr 26	94.8%	90.0%			94.4%	93.6%	95.1%
Environment Level Metrics Score	Apr 26	92.8%	90.0%			93.1%	89.5%	96.7%
Falls	Apr 26	230	-			198	165	231
Falls Rate per 1000 Bed Days	Apr 26	4.09	-			3.51	2.99	4.03
Developed Pressure Ulcers	Apr 26	34	-			46	25	66
Developed Pressure Ulcer Rate	Apr 26	0.60	-			0.69	0.22	1.16
Admitted with Pressure Ulcers	Apr 26	307	-			308	244	372
Admitted with Pressure Ulcers Rate	Apr 26	5.46	-			5.47	4.34	6.60
2222 Calls	Apr 26	90	-			61	35	87
Cardiac Arrest Calls	Apr 26	20	-			17	5	30
SHMI	Apr 26	112.3	100.0			112.3	110.8	113.8
Still Births	Mar 26	4.30	5.20			3.90	3.07	4.73
Rolling Extended Perinatal mortality rate (all NND)	Mar 26	8.00	-			9.01	8.03	9.98
Number of MNSI Referrals	Mar 26	1	-			1	-2	4
% Complaint Responses Sent Within Target Times (LR1 let	Apr 26	23%	80%			33%	14%	53%
% CSU Draft Comments Received Within Target Times (LR	Apr 26	36%	80%			49%	31%	67%
Median Response Lead Time (Days)	Apr 26	54	-			50	38	62
Defect Rate	Jan 26	1%	15%			8%	#N/A	#N/A
PALS Concerns - % Patients contacted in 2 w/days	Apr 26	83%	80%			79%	72%	85%



Core Metrics

Measure	Reporting Period	Performance	Target	Variance	Assurance
Staff Engagement	Apr-26	6.37	6.5		
Local Induction	Apr-26	79.81%	85%		
Afc Appraisal Rate *	Apr-26	18.06%	95%		
Mandatory Training Compliance Rate	Apr-26	89.98%	85.00%		
Voluntary Turnover	Apr-26	5.15%	5.45%		
Rolling Sickness Absence Rate	Apr-26	5.25%	4.90%		
In-Month Vacancy Percentage	Apr-26	3.44%	N/A		
Worked FTE as % of Establishment +	Apr-26	100.98%	< 100%		



- *LTHT annual appraisal season runs from April to June each year, current appraisal data is low due to appraisal season only just commencing. Our appraisal rate for 2025/26 was 91%.*
- + *Worked FTE as % of Establishment is a new developing metric for 2025/26.*

Core Metrics

Ambulance Handover

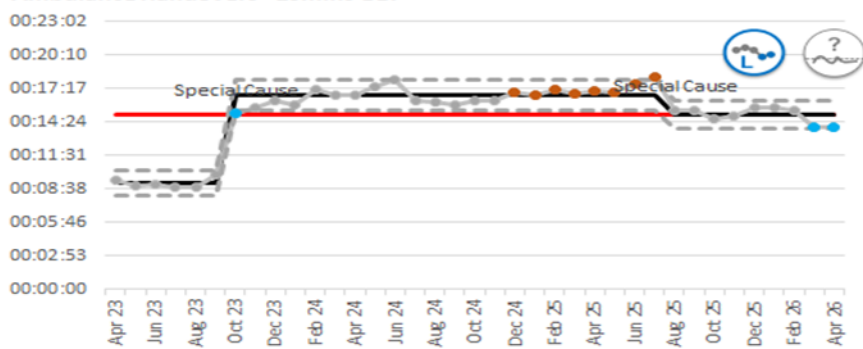
April 2026

Target: <15mins
Performance – LGI : 00:13:59
Performance – SJUH : 00:16:21

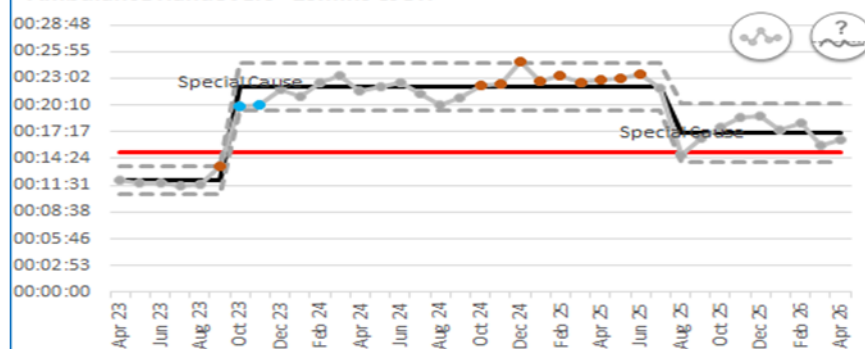
Executive Owner: Tim Hiles (Chief Operating Officer)

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

Ambulance Handovers <15mins LGI



Ambulance Handovers <15mins SJUH



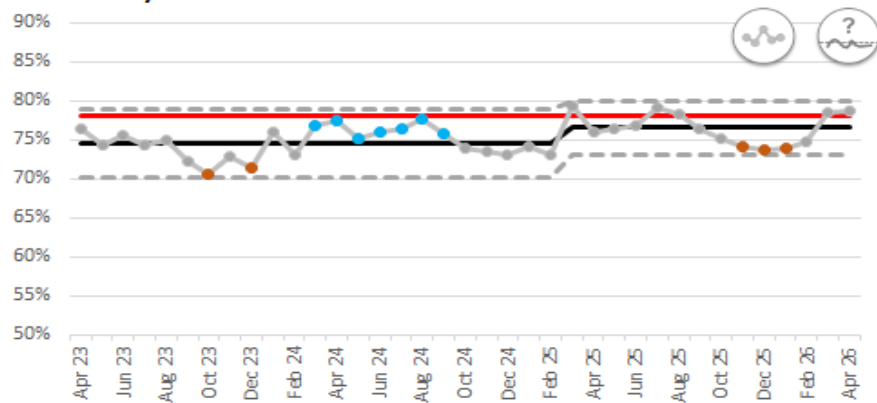
Background	Performance	Key Issues	Current Actions
<ul style="list-style-type: none"> 95% of all handovers should take place within 15 minutes On average the first 7 minutes of the 15-minute allocation for ambulance handover is taken by the ambulance crew parking the vehicle and "off loading" (YAS term) the patient. This leaves 8 minutes for booking-in and clinical handover to the A&E nurse 	<ul style="list-style-type: none"> LGI – April 2026 average handover time was 13:59, improved from our February position of 15:24 SJUH – April 2026 average handover time was 16:21, improved from February position of 18:15 Overall, the average handover for the Trust was 15:16 against a trajectory of 20:19 0 handovers were over 45 minutes in April 2026 LGI placed 11th and SJUH placed 39th out of 183 hospitals for ambulance handovers for April 2026 	<ul style="list-style-type: none"> The clock start for the ambulance handover remains at 25 metres away from the A&E front door The handover data is unvalidated and submitted as a live feed via YAS to NHSE 	<ul style="list-style-type: none"> Daily retrospective validation of all ambulance handovers recorded as exceeding 45 minutes is now embedded. Corrections can be applied to the YAS data submission where appropriate. LTHT and YAS continue to work to identify common themes and explore opportunities relating to staff training, automated system corrections, and further improvement actions As part of ongoing pathway development, the Trust will also assess the implications and potential operational benefits of streaming suitable patients directly to EEMAC once implemented in July 2026 The request to YAS in November 2025 to reduce the GPS trigger point from 25 metres to 10 metres from the Emergency Department entrance remains delayed due to technical issues within YAS systems; a technical upgrade is required

Emergency Care Standard

April 2026

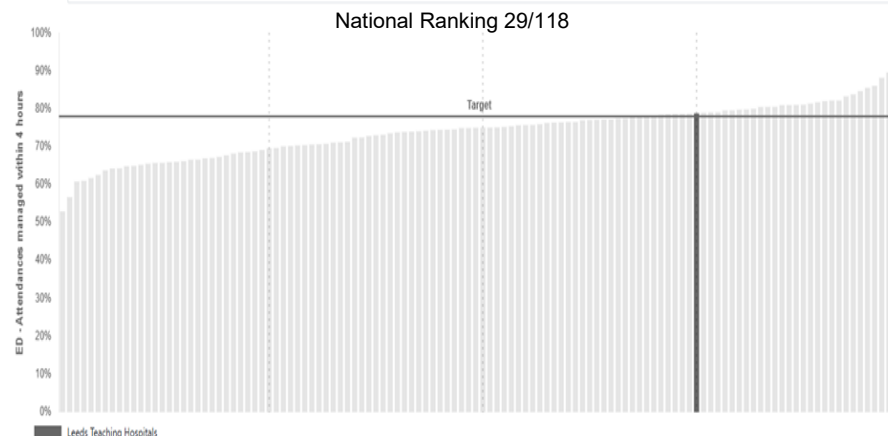
National Planning Priority Target April 2026: 79.8%
Performance: 78.8%

ECS Monthly



Executive Owner: Tim Hiles (Chief Operating Officer)

Variance: Common cause variation. Hit and Miss variation indicated



Background	Performance	Key Issues	Current Actions
<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 82% in March 2027 	<ul style="list-style-type: none"> ECS delivery for April 2026 was 78.8% against NHSE trajectory of 79.8%. This was 2.7% above April 2025's performance National average ECS 74.8% for April 2026 Ranked 29th out of 118 Trusts for ECS performance in April 2026 and 3rd out of 10 peers 2nd highest volume of attendances amongst peers 	<ul style="list-style-type: none"> A&E congestion: slow patient movement and delays in arranging onward care in the community or across the city remain the biggest challenges Ongoing delays in mental health assessment and bed availability, leading to prolonged stays in A&E while patients wait for specialist input or appropriate placement Planned extended hour GP model delay in start date 	<ul style="list-style-type: none"> Development and implementation of Extended Emergency Medicine Ambulatory Care (EEMAC) across both sites, aligned to national guidance, with test-of-change commencing in June 2026 ahead of full operational implementation in July 2026 ECS recovery plan, including internal improvement trajectories to support 2026/27 performance target of 82% by March 2027. Daily monitoring, weekly reporting to Director Tri team for assurance, escalation and support Development of Urgent Care Community Forum to strengthen system-wide collaboration with community partners and support development of associated capital investment proposals

RTT

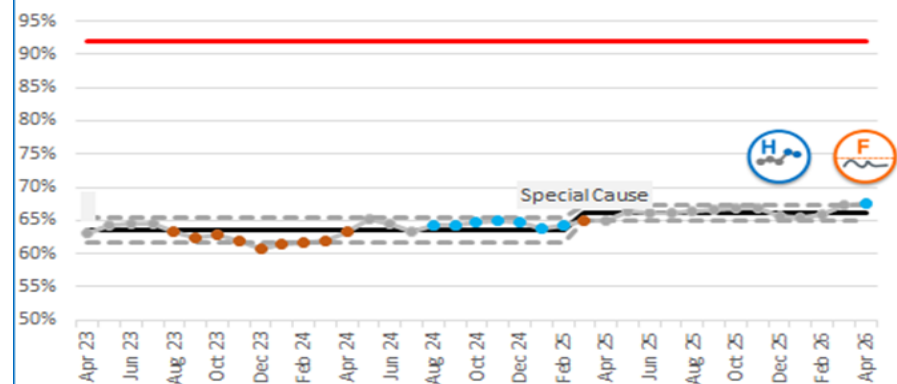
April 2026

Executive Owner: Tim Hiles (Chief Operating Officer)

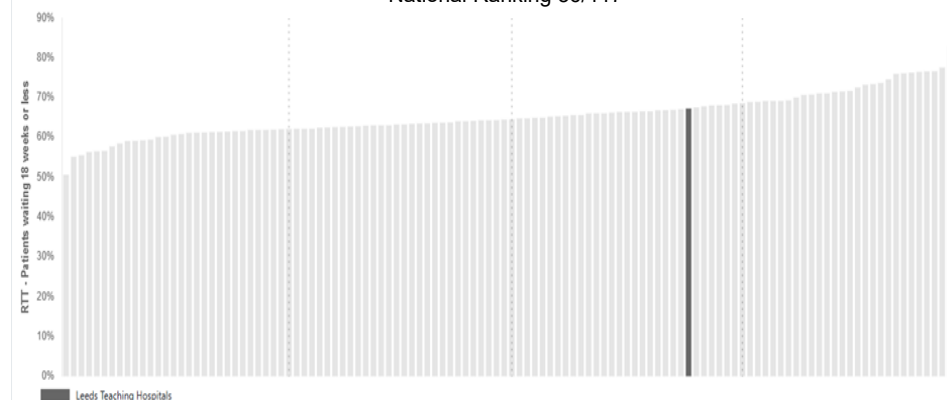
Target: 92%
Performance: 67.5%

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

RTT Performance



National Ranking 36/117



Background	Performance	Key Issues	Current Actions
<ul style="list-style-type: none"> The constitutional standard is 92% of patients are treated within 18 weeks of referral The 2026/27 national planning guidance required an improvement of 7% by March 2027 with the Trust agreed target set at 73.4% 	<ul style="list-style-type: none"> 18-week RTT was 67.5% in April 2026 a 0.27% improvement on March 2026 TWL size grew by 1,600 to 86,725 at the end of April 2026 Number of patients over 18 weeks increased to 28,183 in April 2026. 285 patients more than March 2026 Time to 1st OPA was 74.01% in April 2026, up from 73.06% in March 2026 LTHT ranked 36th amongst 117 Trusts 	<ul style="list-style-type: none"> Impact of Easter, the Bank Holidays and IA on capacity 	<ul style="list-style-type: none"> Review of theatre list allocation across all sites and specialities to reduce the gap between capacity and demand FDP and the Outpatient Transformation Workstream continue to drive CSU validation to reduce unnecessary appointments and utilise capacity more efficiently RTT training materials revised and updating of RTT Handbook to ensure pathways are recorded correctly CAH and WGH Hub Optimisation weeks, looking at new ways of working, how we can prevent delays and treat more patients to support elective theatre throughput

RTT 52 Weeks

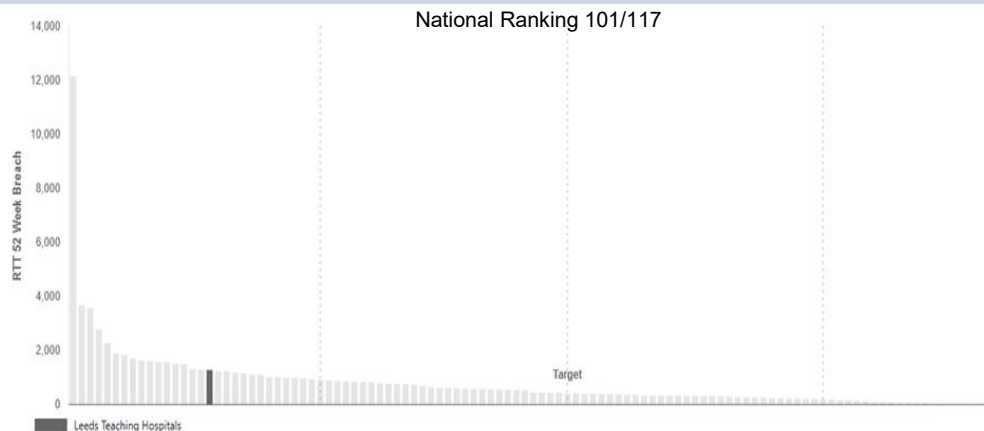
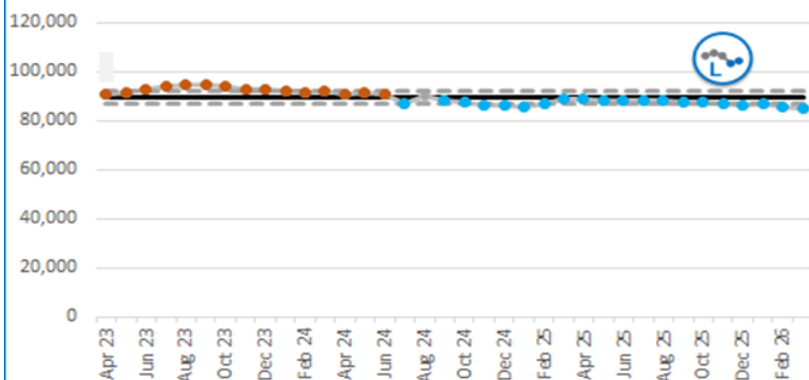
April 2026

Executive Owner: Tim Hiles (Chief Operating Officer)

National Planning Priority Target 2026/27: 1% of TWL (c750)

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

RTT Total Waiting list



Background	Performance	Key Issues	Current Actions
<ul style="list-style-type: none"> Planning guidance for 2026/27 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"> LTHT had 1304 patients who waited over 52-weeks by the end of April 2026 52-week waits accounted for 1.5% of total waiting list in April 2026 LTHT ranked 101st amongst 117 Trusts LTHT had 110 patients who waited over 65-weeks by the end of April 2026 	<ul style="list-style-type: none"> Operational site pressures have led to elective cancellations to ensure the most clinically urgent patients take priority High demand on HDU and HOBs beds has also led to long waiting elective cancellations 	<ul style="list-style-type: none"> Ongoing targeted work to reduce 52-week waits for patients Theatre lists continued to be reallocated to support CSU's with over 52 week wait Use of Independent Sector to treat long waiting patients Revision of the Integrated Accountability Framework to support monitoring and operational delivery across the organisation

Cancer 28 Day Faster Diagnostic

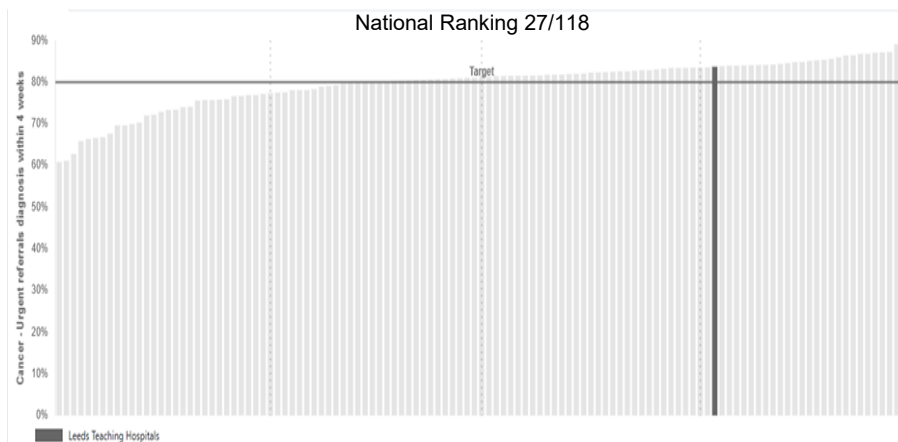
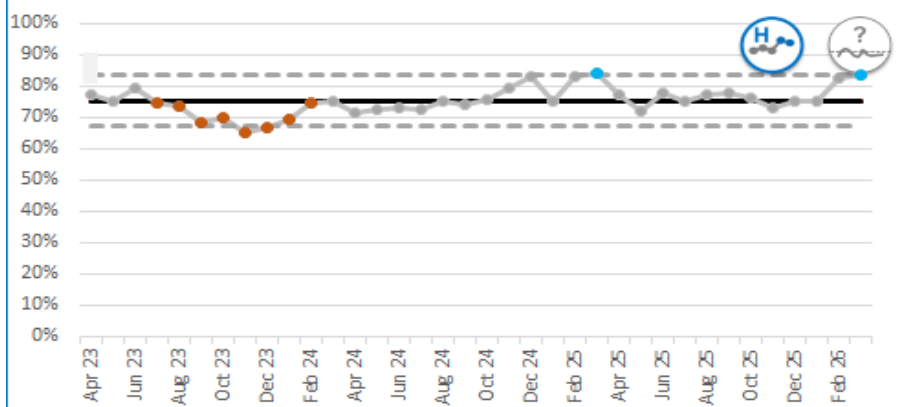
March 2026

Target: 75%
Performance: 83.7%

Executive Owner: Tim Hiles (Chief Operating Officer)

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

Cancer 28day FSD



Background	Performance	Key Issues	Current Actions
<ul style="list-style-type: none"> Patients should not wait more than 28 days from referral to finding out if they have cancer The NHSE expectation is that by March 2026, 75% of patients will be notified of their cancer status by day 28 This metric will increase to 80% from April 2026. 	<ul style="list-style-type: none"> 28-day FDS performance was 83.7% in March 2026 Ranked 27th of 118 Trusts for March 2026 Delivering against plan 4060 out of 4854 patients were informed of their diagnosis within 28 days 	<ul style="list-style-type: none"> Significant workforce challenges in Breast pathway. Risk identified in H&N and Gynae pathways (impacting 2ww) - both in a recovering position 	<ul style="list-style-type: none"> Additional imaging capacity being identified at weekends to minimise patient waiting times for screening and symptomatic Breast patients VO in place to support locum bank radiologists and consultant radiologist from around region to assist with film reading and Breast screening assessment clinics Reducing STT waiting time across key pathways (Gynae, LGI, UGI) to increase opportunity for 28 days. Working with IS providers to ensure efficient access to care

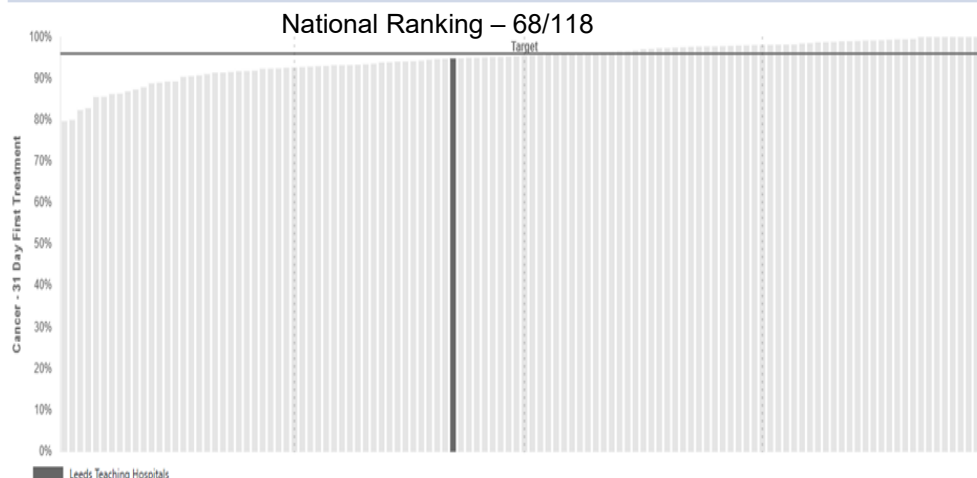
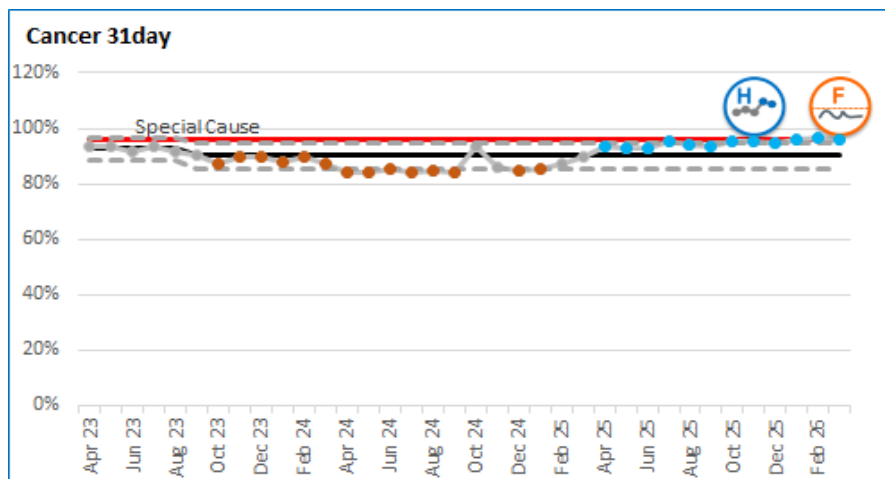
Cancer 31 day

March 2026

Target: 96%
Performance: 96.21%

Executive Owner: Tim Hiles (Chief Operating Officer)

Variance: Special cause of improving nature. The process will fail to achieve the target more often that it achieves it.



Background	Performance	Key Issues	Current Actions
<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"> The reported position for March was 96.2% Ranked 68th of 118 Trusts for March 2026 	<ul style="list-style-type: none"> Surgical capacity is the main constraint 	<ul style="list-style-type: none"> Identifying further opportunities to reallocate theatres at WGH, where possible, to TRS to increase capacity. Access to surgical robot remains a key constraint – flexing lists to respond to peaks in demand. Identifying opportunities to increase GA capacity for RFA to reduce waiting time.

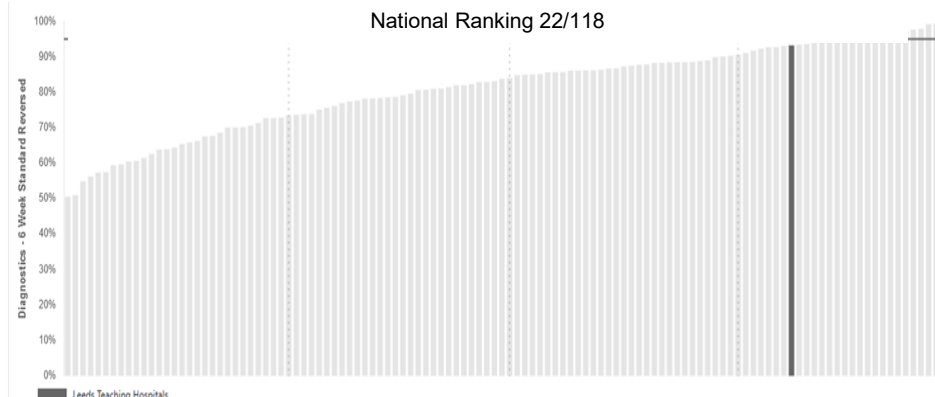
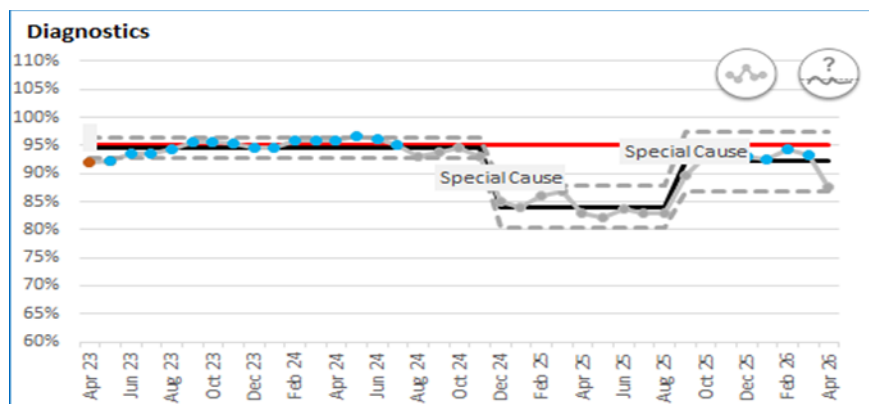
Diagnostic Waits

April 2026

Target: 95%
Performance: 87.68%

Executive Owner: Tim Hiles (Chief Operating Officer)

Variance: Common cause variation. Fail variation indicated

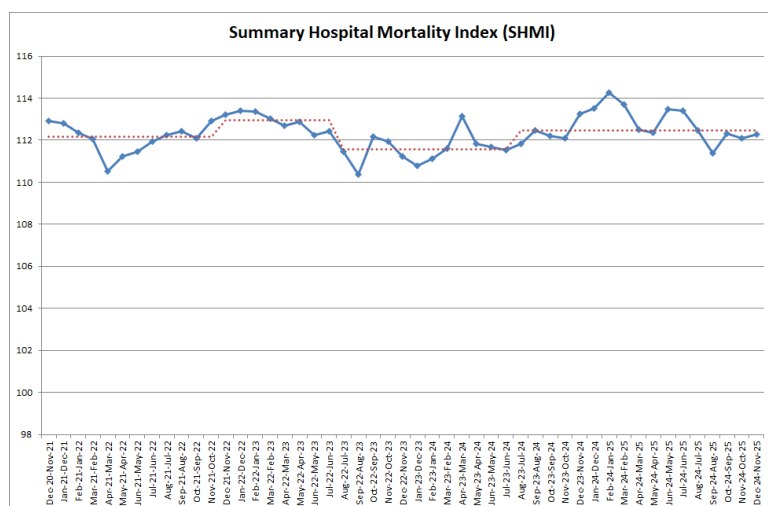


Background	Performance	Key Issues	Current Actions
<ul style="list-style-type: none"> Constitutional standard is that 99% of patients wait no more than 6 weeks for a routine diagnostic test 2024/25 National Planning priority was to deliver 95% by March 2025 	<ul style="list-style-type: none"> Ranked 22nd of 118 Trusts (acute and combined) for March 2026 Diagnostic waiting list at March month end was 18,130 2223 patients breached 6 weeks at April month end 	<ul style="list-style-type: none"> Ultrasound have had significant capacity challenges over March and April which risks an increase in breach numbers over coming months MRI delays for Paediatric GA due to anaesthetist & theatre capacity. Reduced capacity due to scanner replacement Children's endoscopy and cystoscopy have long waiters due to capacity challenges Audiology overdue waits for paediatric follow-up reviews will be included as 6ww from April onwards 	<ul style="list-style-type: none"> Ultrasound: accessing additional insourcing capacity in process and active discussions with staff to encourage increased uptake of additional sessions Variation Order in Place for anaesthetists to provide additional weekend LHTT lists. Requests for numerous dates submitted to T&A CSU, awaiting confirmation of which additional dates can be covered with theatre and anaesthetic staff MRI van in place to mitigate lost capacity from scanner replacement, however unable to accommodate all patients due to accessibility Audiology breach numbers to increase from April due to the move of overdue planned patients into 6ww reporting. These will continue to be higher until August 2026, but will reduce each month in line with recovery plan

Mortality

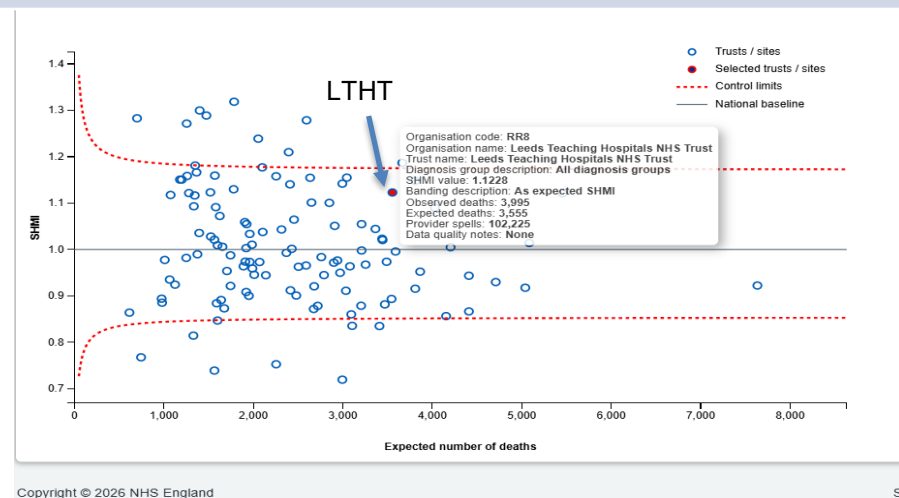
December 2024 – November 2025

Target: 100
Performance – SHMI: 112.3 “As Expected”



Executive Owner: Dr Magnus Harrison (Chief Medical Officer)

Variance: Common cause variation.



Background	Context	Action
<ul style="list-style-type: none"> There are two national Trust-level risk adjusted measures of mortality; the Summary Hospital Mortality Indicator (SHMI) and the Hospital Standard Mortality Rate (HSMR). These are used by NHSi and the CQC to inform the mortality alert process, and are calculated using a twelve month rolling average. 	<ul style="list-style-type: none"> The Trust SHMI for December 2024 – November 2025 was 112.3 and “As Expected”. The Upper Control Limit was 117.5 	<ul style="list-style-type: none"> The Mortality Improvement Group will continue to monitor SHMI in terms of both absolute value, comparison with peer organisations and changes in the diagnostic group breakdown. We continue to seek assurance through statistical analysis, coding reviews, and case note analysis. The Trust have strengthened the learning from deaths framework and have a robust screening process in place, the Structured Judgement Review (SJR) methodology is used to identify learning and provide assurance on quality of care.

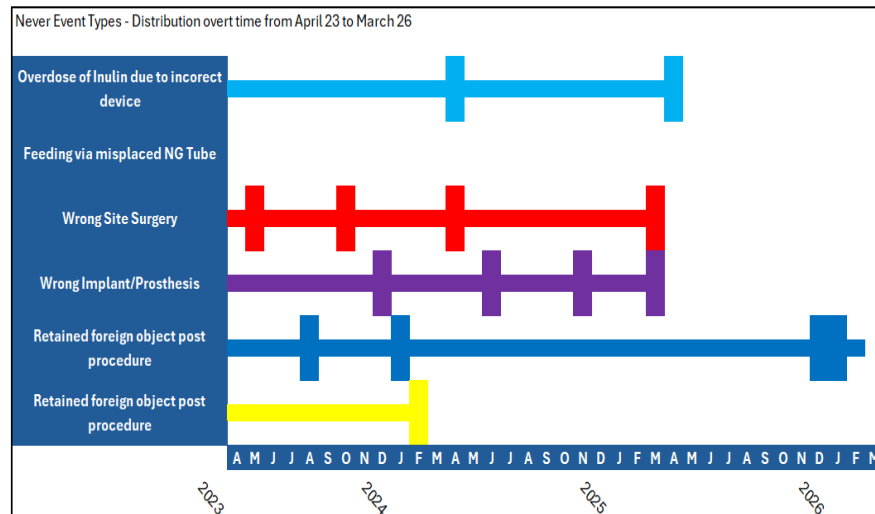
Never Events

Q4 (2025/26)

Target: 0
Performance : 4 (YTD)

Executive Owner: Dr Magnus Harrison (Chief Medical Officer)

Variance: Common cause variation.



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

Background	Context	Action
<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>4 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). Retained Surgical item (Interventional Radiology/ENT) Retained Surgical item (gynaecology theatres SHU) 	<p>Never Events are a national PSIRP priority. Previously these were always investigated as a PSII. In late 2025, NHS England advised alternative review methodologies could be used where appropriate. Following this advice, the retained item incident reported in December 2025 was reviewed using the after action review methodology, as it was determined that the learning was already identified, and established practice from Theatres and Anaesthesia CSU could be implemented rapidly, reducing risk of further incidents and harm.</p> <p>Learning and actions from Never Events are subject to review at the WYAAT shared learning group chaired by LTIT</p>

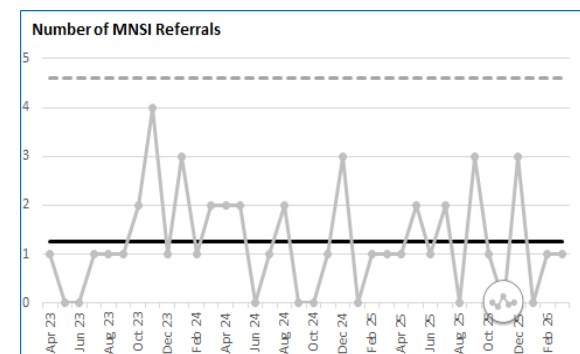
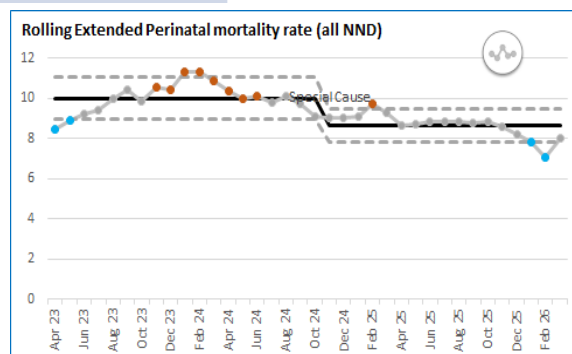
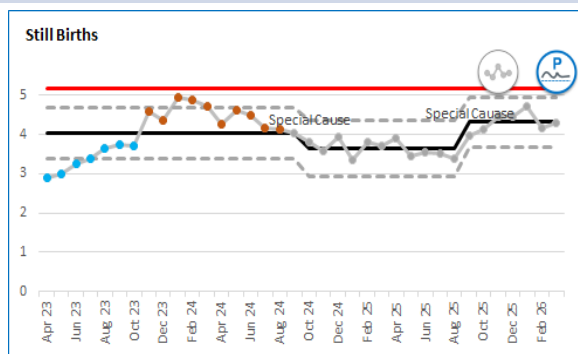
Maternity

March 2026

Still Birth Rate: 4.3
Extended Perinatal Mortality Rate: 8.0
Number of MNSI Referrals: 1

Executive Owner: Beverley Geary (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 complex congenital abnormalities some of which have an impact on 	<ul style="list-style-type: none"> There were 3 still births in the reporting period that will be reviewed through the PMRT process. There were 6 neonatal deaths, causes of death were primarily associated with severe congenital anomalies and extreme prematurity. Referrals from other providers had been made for antenatal specialist fetal medicine services, neonatal intensive care support following birth with antenatal/intrapartum care at LGI or for postnatal neonatal intensive care following birth with another provider. There was 1 referral to MNSI in March. 	<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

April 2026

Target: 4.9 %

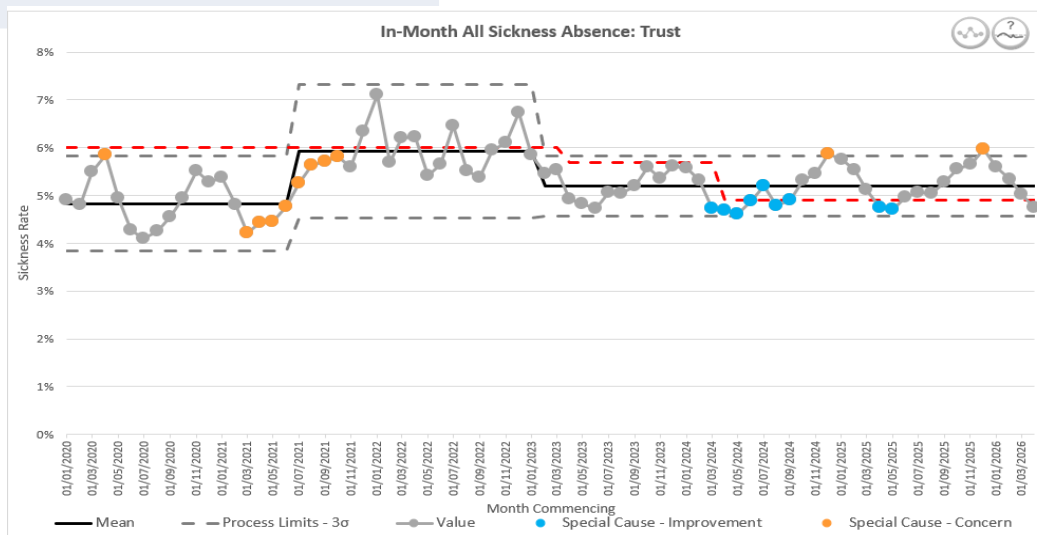
Performance (Rolling Sickness Absence Rate): 5.25% (Avg Calendar Days Lost Per Person – 20.1)

Variance: Common cause variation in month.

Executive Owner: Suzanne Dunkley, Chief People Officer

Management/Clinical Owner: Chris Jones

Sub-Groups: People Assurance Group



Issues	Actions	Context
N/A	<ul style="list-style-type: none"> The Supporting Attendance Policy is being refined following feedback from Trade Unions, managers and colleagues. Changes emphasise simplification and enhanced support for managers and colleagues in applying the policy. This sits within a broader cross-cutting Trust programme to improve attendance and workforce availability, supporting delivery of the workforce plan, service delivery, quality and the financial plan. The new People Improvement Framework process is providing a structure to review additional absence and wellbeing data. Analysis of this data for the CSUs with the highest absence rates is helping us identify bespoke interventions for those CSUs from relevant teams in the People Function. Thrive at Work pilot to help reduce/prevent long-term sickness absence concluded in March 2026, learning from the project will be shared at an event in May. Absence management will be a cross-cutting theme to support workforce availability and therefore help achieve our workforce plan. 	<ul style="list-style-type: none"> LTHT is ranked 86th out of 205 trusts nationally for sickness absence (source Model Hospital NOF Score) and 4th out of 33 in North-East and Yorkshire region reflecting a positive position (in the best performing quartile). Areas within the trust with the highest sickness absence rates include Outpatients, Theatres & Anaesthesia and Adult Critical Care CSUs.

Voluntary Turnover

April 2026

Target: 5.45%

Performance (Rolling Voluntary Turnover Rate): 5.15%

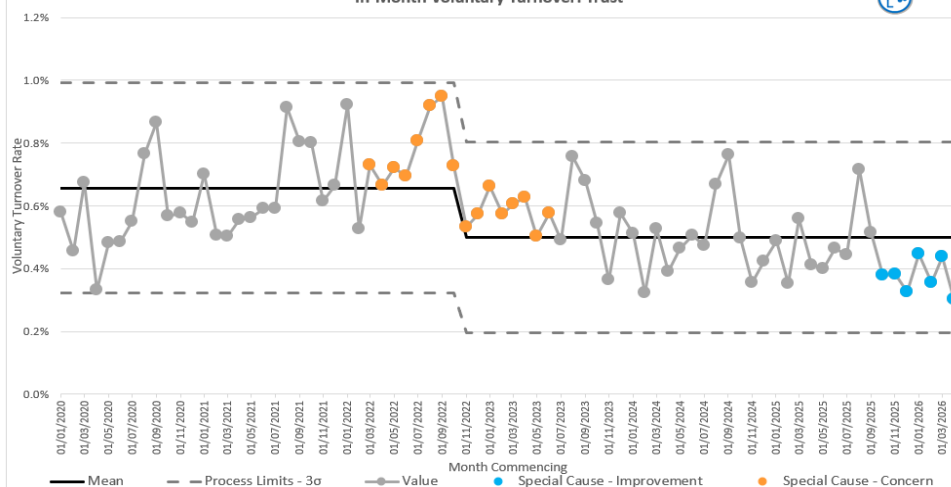
Variance: Common cause variation.

Executive Owner: Suzanne Dunkley, Chief People Officer

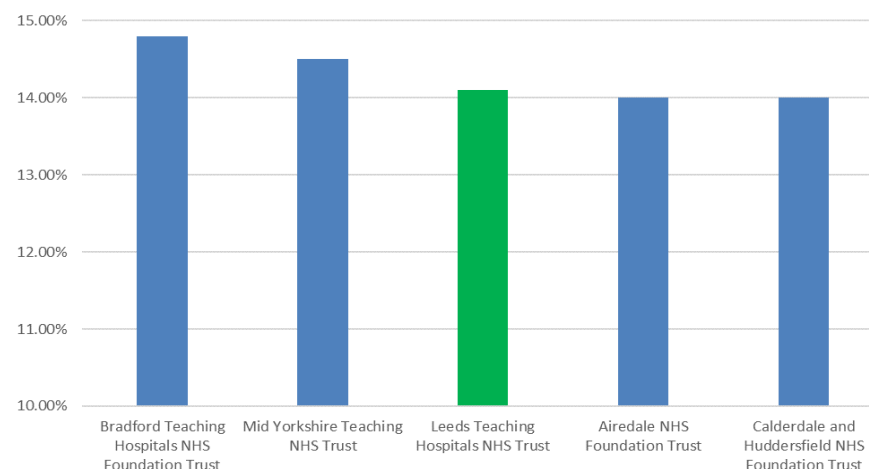
Management/Clinical Owner: Jo Buck

Sub-Groups: People Assurance Group

In-Month Voluntary Turnover: Trust



Overall Turnover - WY ICB Trusts



Background	Issues	What the chart tells us	Actions	Context
<ul style="list-style-type: none"> Voluntary turnover removes fixed term (including rotating resident doctors), contract expiries, dismissals etc. Overall turnover includes all leavers. The data source for the comparison is NHS Model Hospital who use a different methodology, their data includes all leavers and is dated as of December 2025. 	N/A	<ul style="list-style-type: none"> The in-month rates are showing a special cause improvement. 	<ul style="list-style-type: none"> The 3 most common reasons for Voluntary Turnover are (in order): Relocation; Work/Life Balance; Promotion. The Clinical CSUs with the highest levels of Voluntary Turnover are Adult Therapies CSU and Head & Neck CSU. The lowest turnover in clinical CSUs is in Theatres & Anaesthetics and Adult Critical Care. Our People Improvement Framework process is supporting deep-dives into these areas to identify additional supportive action from the People Function this will include action to address unwanted high-turnover and understand any correlation between turnover and sickness absence. HR Business Partners are working with CSUs to understand any pinch-points/pockets of high voluntary turnover that may impact on patient care. Retention plans are incorporated into all CSU Operational Workforce Plans and are part of their 'business and usual' e.g. stay conversations, health and wellbeing conversations, staff survey discussions, regular 1:1 meetings. 	<ul style="list-style-type: none"> Total Trust turnover is 10.58% compared to voluntary turnover being 5.38%. Leeds has a positive position of being 3rd out of 5 trusts in WY ICB for overall turnover (as of December 2025 – source NHS Model Hospital). The methodology used in model hospital means that the benchmarking is not 100% comparable to local measures.

Agency FTE

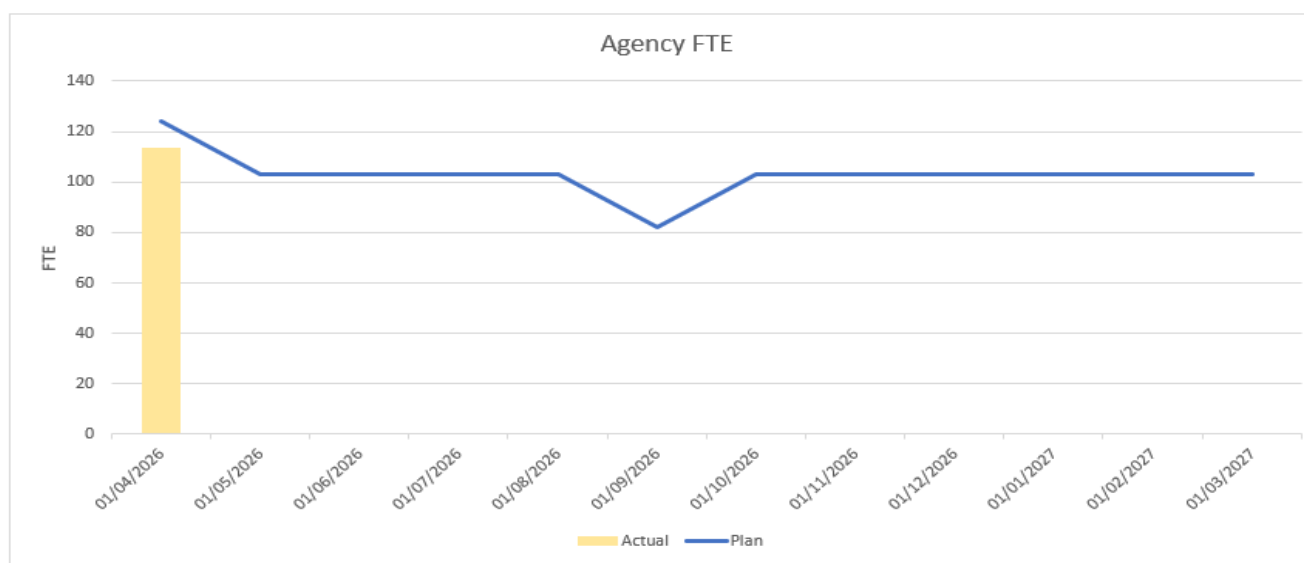
April 2026

Executive Owner: Suzanne Dunkley, Chief People Officer

Management/Clinical Owner: Jo Buck/Chris Ellison

Sub-Groups: People Assurance Group

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



Background	What the chart tells us	Issues	Actions	Context
<ul style="list-style-type: none"> The agency WTE worked plan takes into account the agency expenditure plan required and takes into account historical fluctuations in usage across August and September. This target will be monitored as we progress through 2026/27. 	<ul style="list-style-type: none"> We are currently below target for agency usage. Agency costs reduced mainly due to the end of agency support on L40 (Children's) from 1st April and a reduction of agency usage in Women's. 	N/A	<ul style="list-style-type: none"> LTHT is currently in Model Hospital quartile 2 (second lowest quartile) for agency spend when compared against other Trusts. A Workforce Availability Task & Finish Group is working with red CSUs on reasons behind workforce unavailability and agency spend. There is focus on Medical & Dental workforce through the Medical & Dental Optimisation Programme - supporting CSUs to reduce temporary spend. We are continuing to monitor CSU agency spend and putting action in place where appropriate. HR and Finance Business Partners continue to work with CSUs to develop workforce action plans to address the situation. 	<ul style="list-style-type: none"> N/A

Bank FTE

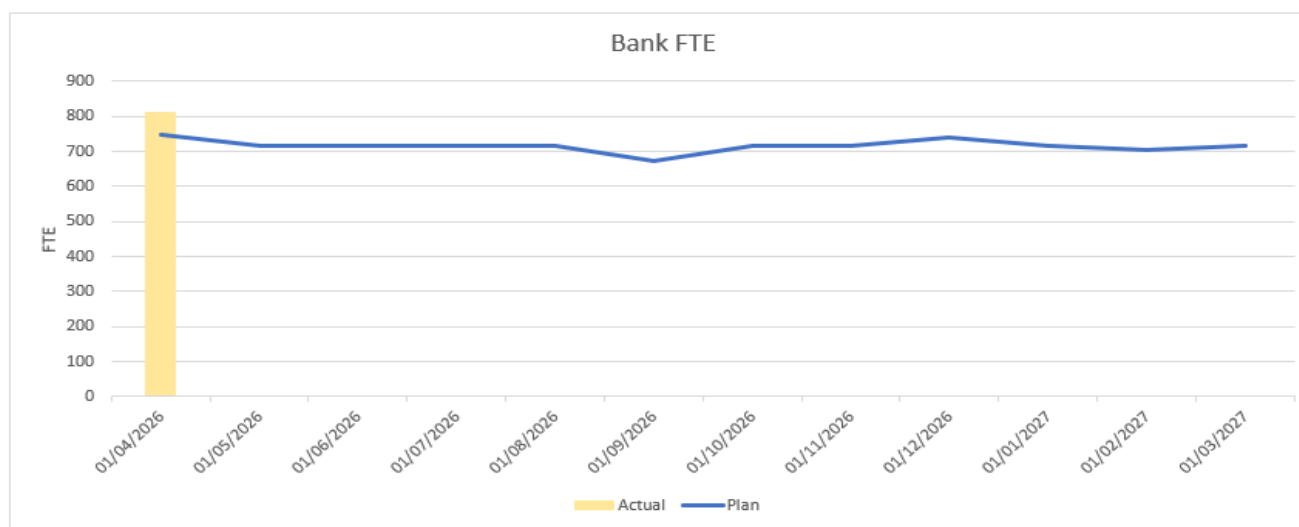
April 2026

Executive Owner: Suzanne Dunkley, Chief People Officer

Management/Clinical Owner: Jo Buck/Chris Ellison

Sub-Groups: People Assurance Group

	01/04/2026	01/05/2026	01/06/2026	01/07/2026	01/08/2026	01/09/2026	01/10/2026	01/11/2026	01/12/2026	01/01/2027	01/02/2027	01/03/2027
Plan	749.5	715	715	715	715	674.5	715	715	738	715	704	715
Actual	813.01											



Background	What the chart tells us	Issues	Actions	Context
<ul style="list-style-type: none"> The bank WTE worked plan takes account of the bank expenditure plan required. The Plan takes into account historical fluctuations in usage across the year. 	<ul style="list-style-type: none"> We are currently operating above plan for our bank FTE. In April we saw bank cost increases due to medical bank usage across SIM, AMS and TRS. This was due to a mixture of vacancies, high acuity, enhanced care and sickness. 	N/A	<ul style="list-style-type: none"> LTHT is currently in Model Hospital quartile 1 (lowest quartile) for bank spend when compared against other Trusts. A Workforce Availability Task & Finish Group is working with red CSUs on reasons behind workforce unavailability and bank spend. There is focus on Medical & Dental workforce through the Medical & Dental Optimisation Programme - supporting CSUs to reduce temporary spend. The Trust has an internal Executive Turnaround Committee in place with one action being to progress with a recent PwC recommendation of moving overtime to bank to reduce overtime which can cost more than bank. We are continuing to monitor CSU bank spend and putting action in place where appropriate. HR and Finance Business Partners continue to work with CSUs to develop workforce action plans to address the situation. 	<ul style="list-style-type: none"> N/A

Contracted Substantive FTE

April 2026

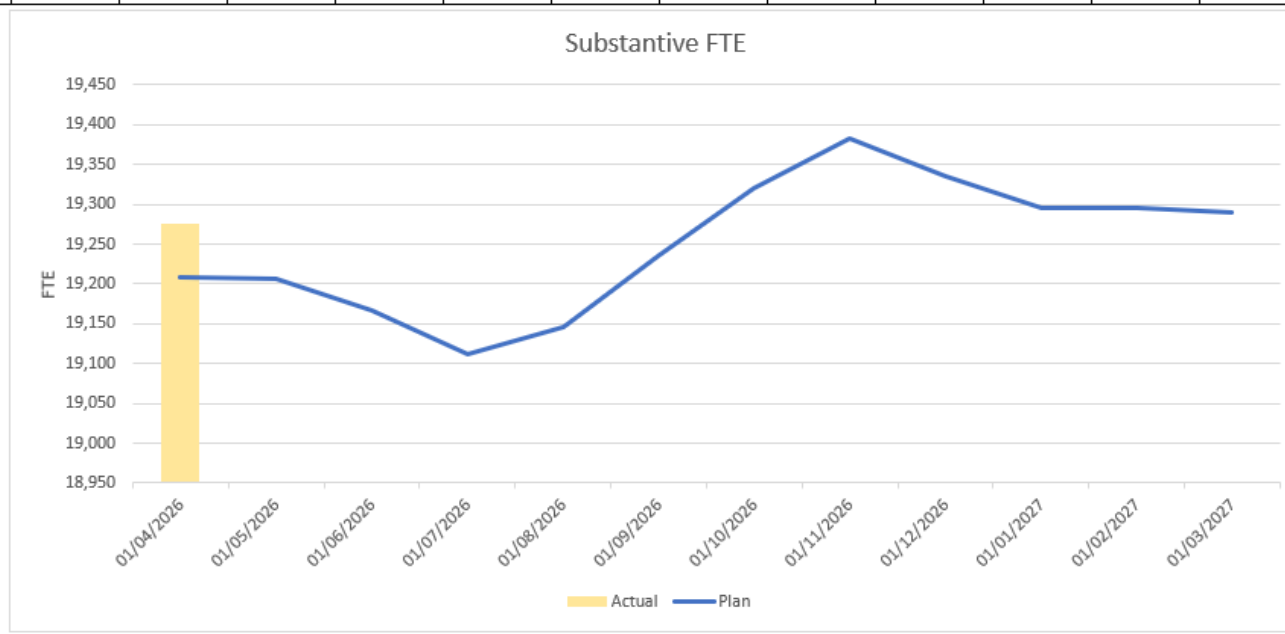
Executive Owner: Suzanne Dunkley, Chief People Officer

Target: Performance:

Management/Clinical Owner: Jo Buck/Chris Ellison

Sub-Groups: People Assurance Group

	01/04/2026	01/05/2026	01/06/2026	01/07/2026	01/08/2026	01/09/2026	01/10/2026	01/11/2026	01/12/2026	01/01/2027	01/02/2027	01/03/2027
Plan	19207.74	19206.836	19167.503	19112.348	19146.346	19235.682	19320.021	19383.17	19336.24	19295.363	19295.896	19290.398
Actual	19276.088											



Background	What the chart tells us	Issues	Actions	Context
<ul style="list-style-type: none"> Our workforce plan submitted as part of the Medium-Term Planning process for 2026/27 is shown by the blue line. The Plan takes account of seasonality of our annual recruitment cycles. 	<ul style="list-style-type: none"> <i>To note: Further work is being undertaken to support alignment.</i> The chart shows our contracted FTE against plan (blue line). We are currently 68 FTE above plan for Month 1. 	N/A	<ul style="list-style-type: none"> The Trust has an internal Executive Turnaround Committee in place with one action being a review and reduction of FTE. The actions being undertaken to achieve this are: <ul style="list-style-type: none"> Address over-establishments to ensure CSUs are operating within funded establishments Reduce bank and agency spend Disestablish vacancies where appropriate Focus on absence reduction 	N/A

Combined Contract/Bank/Agency FTE

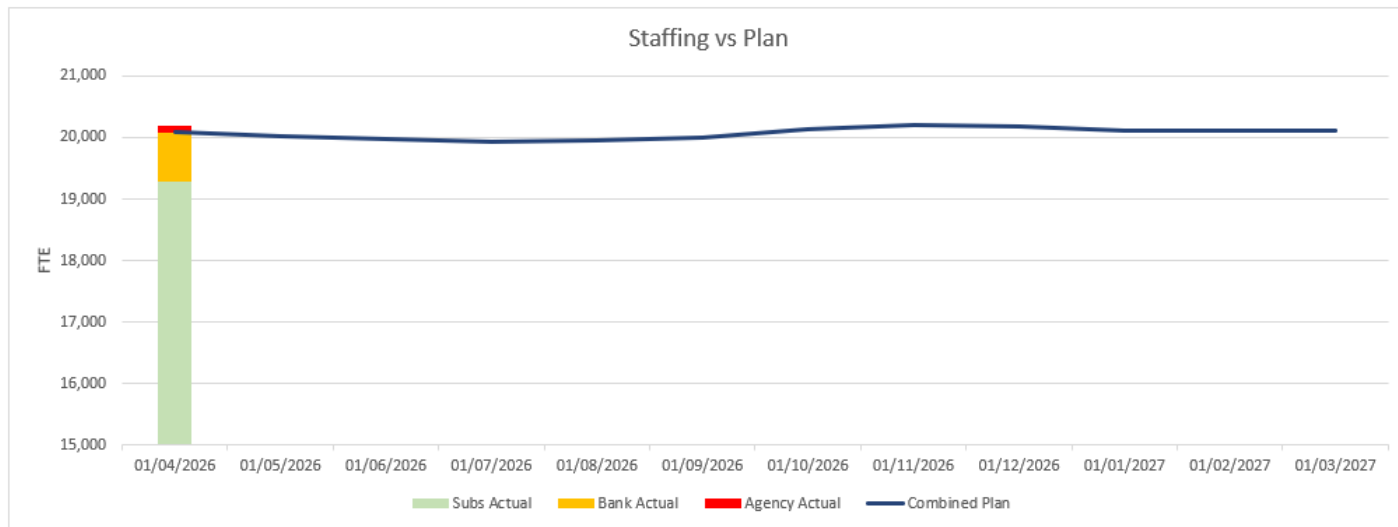
April 2026

Executive Owner: Suzanne Dunkley, Chief People Officer

Management/Clinical Owner: Jo Buck/Chris Ellison

Sub-Groups: People Assurance Group

	01/04/2026	01/05/2026	01/06/2026	01/07/2026	01/08/2026	01/09/2026	01/10/2026	01/11/2026	01/12/2026	01/01/2027	01/02/2027	01/03/2027
Subs Plan	19207.73984	19206.83642	19167.50297	19112.34823	19146.34637	19235.68243	19320.02051	19383.17043	19336.23994	19295.3632	19295.89615	19290.39792
Subs Actual	19276.08784											
Bank Plan	749.5	715	715	715	715	674.5	715	715	738	715	704	715
Bank Actual	813.01											
Agency Plan	124.00	103.00	103.00	103.00	103.00	82.00	103.00	103.00	103.00	103.00	103.00	103.00
Agency Actual	113.51											
Combined Plan	20081.23984	20024.83642	19985.50297	19930.34823	19964.34637	19992.18243	20138.02051	20201.17043	20177.23994	20113.3632	20102.89615	20108.39792



Background	What the chart tells us	Issues	Actions	Context
<ul style="list-style-type: none"> This chart combines the Bank, Agency and Substantive FTE charts from the previous three slides against the workforce plan submitted to NHSE for the 2026/27 Medium-Term Planning 	<ul style="list-style-type: none"> <i>To note: Further work is being undertaken to support alignment between Finance and WTE data.</i> This shows that the combined bank/agency/substantive workforce is 122 WTE above plan for month 1. 	N/A	<ul style="list-style-type: none"> The Trust has an internal Executive Turnaround Committee in place with one action being a review and reduction of FTE. A Workforce Availability Task & Finish Group is working with red CSUs on reasons behind workforce unavailability and agency spend. There is focus on Medical & Dental workforce through the Medical & Dental Optimisation Programme - supporting CSUs to reduce temporary spend. HR and Finance Business Partners continue to work with CSUs to develop workforce action plans. 	N/A

Vacancy Rate

April 2026

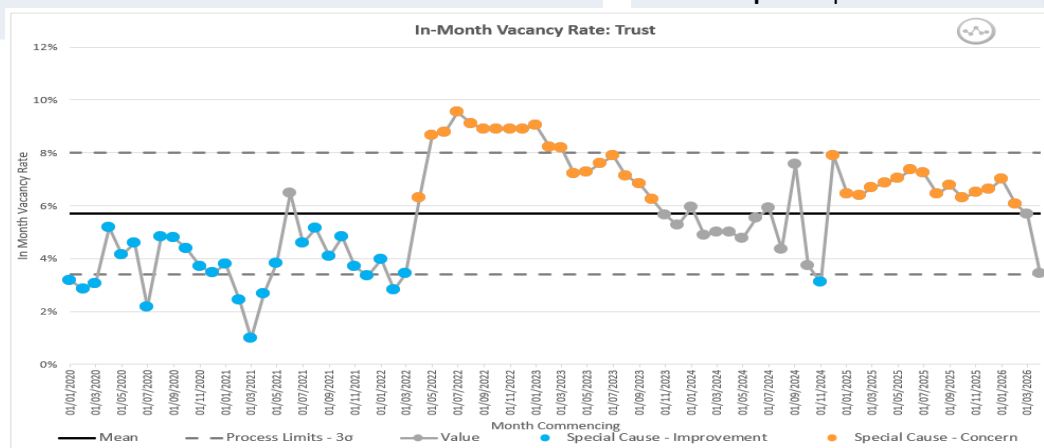
Target: N/A
Performance: 3.44%

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

Executive Owner: Suzanne Dunkley, Chief People Officer

Management/Clinical Owner: Jo Buck

Sub-Groups: People Assurance Group



Background	Issues	What the chart tells us	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. 	N/A	<ul style="list-style-type: none"> The gap between establishment and substantive staff in post is currently being utilised by Bank and Agency usage. 	<ul style="list-style-type: none"> During 2025/26, the Trust has had a vacancy control process in place. This remains in place for 2026/27. The process involves a 13-week lead in time for adverts for some CSUs to support them achieving financial balance meaning vacancies are not being filled as quickly as in previous years. There are, however, exceptions to the 13-week lead in time where there are specific service requirements these exceptions are agreed by Tier 2 and TERG. Our higher vacancies are in SIM and Women's CSUs. Women's are focusing on midwife recruitment to achieve Birthrate+ numbers. In Children's CSU a Neonatal business case has recently been approved which will support an increase in cot capacity and bring workforce requirements in line with BAPM (British Association of Prenatal Medicine). Reducing the vacancy rate in clinical patient facing roles will reduce our agency and bank and help us to achieve our workforce plan. CSUs continue to identify ways of retaining and developing our workforce through apprenticeships and growing our own into registered and non-registered roles across the Trust. SHRBPs continue to work closely with CSUs and corporate teams to ensure operational workforce plans include actions to address vacancy hotspots and exploring alternative options e.g. alternative roles (ACP, PA, Nursing Associates) along with apprenticeship options. 	N/A

Staff Engagement Rate

April 2026

Target: 6.9
Performance: 6.7

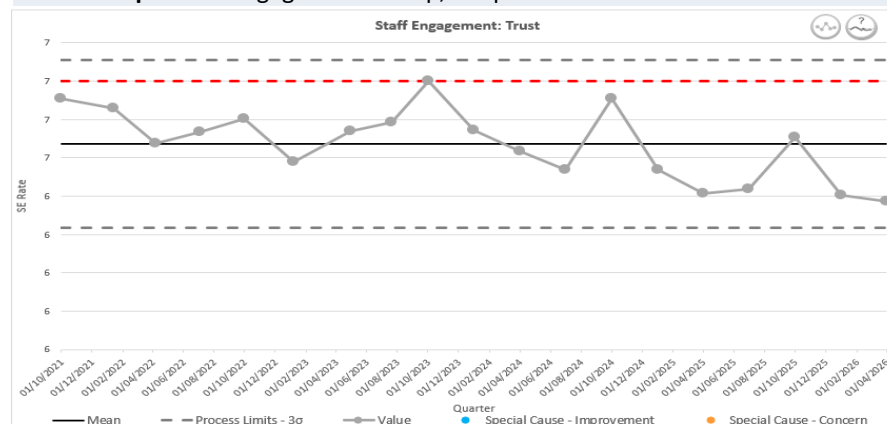
Variance: Common cause variation.

Background	What the chart tells us
<ul style="list-style-type: none"> Results deteriorated nationally across several People Promise themes Inc. staff engagement, advocacy and team working showing a decline since 2023. LTHT was not an exception, although no longer holds an above average position, falling in line for all People Promise Themes. 2025 was expected to be another challenging year and the target was therefore to maintain staff engagement, which has not been achieved. 	<ul style="list-style-type: none"> Score remains within control limits albeit showing a consistent downward trend for the last 3 year (skewed by the variation between quarterly and annual surveys).

Executive Owner: Suzanne Dunkley, Chief People Officer

Management/Clinical Owner: Chris Jones

Sub-Groups: Staff Engagement Group, People and Culture Committee



Issues	Actions	Context
<p>Annual Staff Survey:</p> <ul style="list-style-type: none"> Participation in 2025 is 47%, in line with the national average, but a deterioration from 2024 of 1%. Over 10,000 colleagues responded (equating to more than in 2024), which is a statistically representative sample. Staff Engagement Score is 6.7 (from 6.9). LTHT has seen a deterioration across all People Promise Themes, which has been the trend nationally. However, LTHT are now broadly in line, rather than above the national average. 	<ul style="list-style-type: none"> Progress being made against the newly identified NHS Staff Survey High Impact Actions, with a surrounding project management infrastructure now established, and being communicated Trust-wide: <ul style="list-style-type: none"> <i>Act on concerns & tackle poor behaviour</i> <i>Keep colleagues well and reduce absence</i> <i>Equip leaders to involve colleagues & balance wellbeing with service need</i> <i>Improve appraisal value & everyday conversations</i> <i>Embed refreshed LTHT Values</i> <i>Focused support for key colleague groups & sites</i> <i>Intensive support to lowest-engagement CSUs</i> CSUs have identified local high impact actions, and informed Operational Workforce Action Plans, supported by the HR Business Partners. New Performance Improvement Framework (PIF) enabling holistic, and targeted People Function CSU support. CSU learning, best practice, and support provided via the newly refreshed Colleague Engagement Forum (previously Staff Engagement Group). New results dashboard and pilot enabling local deep dive analysis of results and therefore targeted support. Noteworthy progress being made against the new Inclusion & Belonging Improvement Plan actions. Noteworthy progress being made against the Trust values refresh, enabling cultural and behavioural change. 	<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



March 2026

Executive Owner: Jenny Ehrhardt (Director of Finance)

Financial Performance: For the financial year 2025/26 the Trust achieved the financial plan, delivering a small surplus of £39k against the breakeven plan, subject to audit, which is the ninth consecutive year of a surplus.

Waste Reduction Programme (WRP): To achieve its financial plan the Trust ended the year delivering the planned waste reduction target of £89m.

I&E Position 2026/27

April 2026

Executive Owner: Jenny Ehrhardt (Director of Finance)

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

In April, the Trust reported a year-to-date deficit of £6.6m which is £3.5m adverse to the NHSE plan. The biggest drivers of the month 1 deficit are costs associated with the resident doctor's industrial action in April and pay expenditure being higher than planned, partially mitigated by reduced non-pay expenditure and additional bank interest received.

Income to date is £181.4m which is £1.3m favourable to plan and expenditure to date is £188m, £4.8m adverse to plan. The income variances are due to additional funding to cover the agenda for change and medical pay awards above the values included in the plan and various other increases in income including education and training and research and innovation which are offset with expenditure. Pass through drugs and devices income was lower than plan and is offset with a decrease in expenditure.

Pay expenditure to date is £111.6m, £6.9m adverse to the NHSE plan and as mentioned above £1.3m of the adverse variance is due to costs associated with pay awards that weren't included in the plan which are offset with additional funding. Other main reasons for the adverse variance are the costs incurred to cover the resident doctor's industrial action in April and under delivery of efficiencies mainly due to not reducing substantive and bank spend as planned. Non-pay expenditure to date is £76.4m (including depreciation and non operating items), £2.1m favourable to the plan due to decreased spend on passthrough drugs and devices which is offset by income, reduced spend on other non-pay including clinical supplies and building and engineering contracts and materials and an increase in bank interest received.

The Trust is forecasting a breakeven position, there are a number of risks within this and work is continuing to mitigate these risks in order to deliver the plan.

Under the NHS oversight Framework the latest published segmentation and league table gives the Trust a combined finance score of 3, based on Q3 financial performance. The M1 YTD adverse variance to plan of £3.5m (1.92% of turnover) would result in a NOF score of 4.

Capital & Cash Position



April 2026

Executive Owner: Jenny Ehrhardt (Director of Finance)

Capital

2025/26

Capital expenditure was finalised at £104.8m for the financial year 2025/26.

2026/27

The Trust's capital expenditure forecast for 2026/27 is £109.2m which is based on the latest NHSE plan, which is pending the actual capital allocation further to May's CPG meeting. The plan submitted originally to NHSE had indicative allocations which are broken down as follows

Programme	Forecast 2026/27 £000
Medical Equipment	10,311
Informatics	5,091
Building & Engineering	87,676
Building the Leeds Way	500
5% overplanning	2,631
Leases	2,990
Total	109,199

The expenditure to 30th April 2026 was £2.3m which was behind plan by £2.5m when compared against the M1 NHSE plan. The Capital Programme funding allocation is being prioritised in terms of risk scoring and deliverability within the financial year.

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

Cash

The April month end cash balance is £139.6m, an increase of £5.6m from March. This is £23m more than the fundamental review M11 best case (£116.6m) which is due to year end capital creditors, plus the additional Surge and PFI funding received in March 2026.

Total receipts for the month amounted to £205m which included £29m for quarter 1 of the Education Funding Agreement and £5.1m for the March 2026 VAT return.

Total payments in the month were £200m, comprising £105m for payroll and £95m for accounts payable. The accounts payable spend included £6.8m of capital invoices which were included in capital creditors at the year end following high levels of expenditure in March 2026.

Bank interest of £0.5m was received in the month. A total of £0.006m additional interest income has been received from the investments made with the National Loans Fund this month, where marginally higher interest rates were offered.

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



April 2026

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
Commissioner Income (excluding Non-PbR Drugs, Blood and Devices)	1,335.1	111.3	112.7	1.4	111.3	112.7	1.4
Non-PbR Drugs, Blood and Devices	394.8	32.9	31.3	(1.6)	32.9	31.3	(1.6)
Sub-Total Commissioner Income	1,729.9	144.2	144.0	(0.1)	144.2	144.0	(0.1)
Other Clinical Income	15.2	1.3	1.3	0.0	1.3	1.3	0.0
Total Clinical Income	1,745.1	145.4	145.3	(0.1)	145.4	145.3	(0.1)
Other Income (non Covid)	313.1	25.6	26.5	0.9	25.6	26.5	0.9
Other Income (Covid Top Up; Testing; Vaccination)	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Income	2,058.2	171.0	171.8	0.8	171.0	171.8	0.8
Pay Costs	(1,250.8)	(104.7)	(111.6)	(6.9)	(104.7)	(111.6)	(6.9)
Sub-Total Pay	(1,250.8)	(104.7)	(111.6)	(6.9)	(104.7)	(111.6)	(6.9)
Non Pay Costs (excl Non-PbR Drugs, Blood and Devices)	(418.5)	(37.0)	(36.6)	0.4	(37.0)	(36.6)	0.4
Non-PbR Drugs, Blood and Devices	(394.0)	(32.8)	(31.4)	1.5	(32.8)	(31.4)	1.5
Sub-Total Non Pay	(812.5)	(69.8)	(67.9)	1.9	(69.8)	(67.9)	1.9
Total Expenditure	(2,063.3)	(174.5)	(179.6)	(5.1)	(174.5)	(179.6)	(5.1)
EBITDA	(5.1)	(3.5)	(7.8)	(4.3)	(3.5)	(7.8)	(4.3)
EBITDA %			-4.5%			-4.5%	
Depreciation	(58.2)	(4.9)	(4.6)	0.2	(4.9)	(4.6)	0.2
Amortisation	(4.5)	(0.4)	(0.4)	(0.1)	(0.4)	(0.4)	(0.1)
Impairments	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Investment Revenue	3.9	0.3	0.5	0.2	0.3	0.5	0.2
Other Gains and (Losses)	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Finance Costs	(24.6)	(2.1)	(1.6)	0.5	(2.1)	(1.6)	0.5
Dividends payable on Public Dividend Capital (PDC)	(13.9)	(1.2)	(1.2)	0.0	(1.2)	(1.2)	0.0
Retained Surplus/(Deficit) BEFORE ERF/TIF	(102.4)	(11.6)	(15.0)	(3.4)	(11.6)	(15.0)	(3.4)
Allowed Technical Adjustments							
IFRIC 12 Adjustment	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Donated Asset Adjustment/ Peppercorn Lease	(2.5)	(0.2)	0.3	0.5	(0.2)	0.3	0.5
Impairments	0.0	0.0	0.0	0.0	0.0	0.0	0.0
NHP Redundancy Provision	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Impact of consumables donated from other DHSC bodies	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Adjusted Surplus/(Deficit) BEFORE ERF	(104.9)	(11.8)	(14.7)	(2.9)	(11.8)	(14.7)	(2.9)
Elective Recovery Fund (ERF)	115.3	9.6	9.6	0.0	9.6	9.6	0.0
Adjusted Surplus/(Deficit) INCLUDING ERF	10.3	(2.2)	(5.1)	(2.9)	(2.2)	(5.1)	(2.9)
Adjust PFI revenue costs to UK GAAP basis	(10.3)	(0.9)	(1.4)	(0.6)	(0.9)	(1.4)	(0.6)
Adjusted financial performance surplus/(deficit)	(0.0)	(3.1)	(6.6)	(3.5)	(3.1)	(6.6)	(3.5)

Statement of Financial Position



April 2026

Executive Owner: Jenny Ehrhardt (Director of Finance)

	Year to date movement			In Month	
	Closing 31st March 2026 £m	As at 30th April 2026 £m	Year to date movement £m	Prior Month £m	In-month movement £m
Non-Current Assets:					
Property, Plant And Equipment	784.0	781.3	(2.7)	784.0	(2.7)
Intangible Assets	24.2	24.2	(0.0)	24.2	(0.0)
Trade And Other Receivables	14.5	8.6	(5.9)	14.5	(5.9)
Total Non-Current Assets	822.8	814.1	(8.7)	822.8	(8.7)
Current Assets:					
Inventories	29.9	29.2	(0.7)	29.9	(0.7)
Trade And Other Receivables	94.0	95.3	1.3	94.0	1.3
Cash and Cash Equivalents	134.0	139.6	5.6	134.0	5.6
Non-Current Assets Held for Sale	0.0	0.0	0.0	0.0	0.0
Total Current Assets	257.9	264.1	6.2	257.9	6.2
Total Assets	1,080.7	1,078.2	(2.5)	1,080.7	(2.5)
Current Liabilities:					
NHS Trade Payables	(3.0)	(3.4)	(0.4)	(3.0)	(0.4)
Trade and Other Payables	(278.0)	(281.9)	(3.8)	(278.0)	(3.8)
Borrowing / DH Loans	(2.1)	(2.1)	(0.0)	(2.1)	(0.0)
Other Financial Liabilities - PFI	(23.4)	(23.6)	(0.2)	(23.4)	(0.2)
Provisions For Liabilities And Charges	(3.3)	(4.2)	(0.8)	(3.3)	(0.8)
Total Current Liabilities:	(309.8)	(315.1)	(5.3)	(309.8)	(5.3)
Net Current Assets/ (Liabilities)	(51.9)	(51.0)	0.9	(51.9)	0.9
Total Assets Less Current Liabilities	770.9	763.1	(7.8)	770.9	(7.8)
Non-Current Liabilities:					
NHS Trade Payables	0.0	0.0	0.0	0.0	0.0
Trade and Other Payables	0.0	0.0	0.0	0.0	0.0
Borrowings / DH Loans	(7.2)	(7.2)	0.0	(7.2)	0.0
Other Financial Liabilities - PFI	(270.3)	(268.9)	1.4	(270.3)	1.4
Provisions For Liabilities And Charges	(8.5)	(7.6)	0.9	(8.5)	0.9
Total Non-Current Liabilities	(286.0)	(283.7)	2.3	(286.0)	2.3
Total Assets Employed	484.9	479.4	(5.4)	484.9	(5.4)
Financed By Taxpayers Equity					
Public Dividend Capital	702.3	702.3	0.0	702.3	0.0
Retained Earnings	(222.0)	(227.4)	(5.4)	(222.0)	(5.4)
Revaluation Reserve	4.5	4.5	0.0	4.5	0.0
Total Taxpayers Equity	484.9	479.4	(5.4)	484.9	(5.4)

Cash Flow Statement



April 2026

Executive Owner: Jenny Ehrhardt (Director of Finance)

Cash Flow	Closing 31st March 2026 £m	As at 30th April 2026 £m	Previous Month £m
<u>Operating Activities</u>			
EBITDA	99.4	1.8	99.4
Donated assets received credited to revenue but non cash	(7.0)	(0.0)	(7.0)
Interest paid	(14.2)	(1.1)	(14.2)
Dividend paid	(9.1)	0.0	(9.1)
Decrease/(increase) in inventories	(0.5)	0.7	(0.5)
Decrease/(increase) in trade and other receivables	(22.0)	4.8	(22.0)
(Decrease)/Increase in trade and other payables	65.7	16.5	65.7
(Decrease)/Increase in provisions	(6.2)	(0.1)	(6.2)
Net cash inflow/(outflow) from Operating Activities	106.0	22.6	106.0
<u>Cash Flows from Investing Activities</u>			
Interest received	5.8	0.5	5.8
(Payments) for property, plant and equipment	(95.1)	(14.9)	(95.1)
Proceeds from disposal of property, plant and equipment	0.2	0.0	0.2
(Payments) for intangible assets	(1.2)	(0.4)	(1.2)
Proceeds from disposal of intangible assets	0.0	0.0	0.0
Receipt of cash donations to purchase capital assets	7.0	0.0	7.0
PFI lifecycle prepayments (cash outflow)	(6.8)	(0.6)	(6.8)
Net cash outflow from Investing Activities	(90.1)	(15.3)	(90.1)
Net cash inflow before Financing	15.9	7.3	15.9
<u>Cash Flows from Financing Activities</u>			
Public dividend capital received	60.5	0.0	60.5
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	(2.1)
Capital element of finance lease and PFI	(22.6)	(1.7)	(22.6)
Net cash inflow/(outflow) from Financing Activities	35.9	(1.7)	35.9
Increase/(decrease) in cash	51.8	5.6	51.8
Cash at the beginning of the year	82.2	134.0	82.2
Cash at the end of the financial period	134.0	139.6	134.0

Supplementary Metrics Produced by Exception

Cancelled Ops

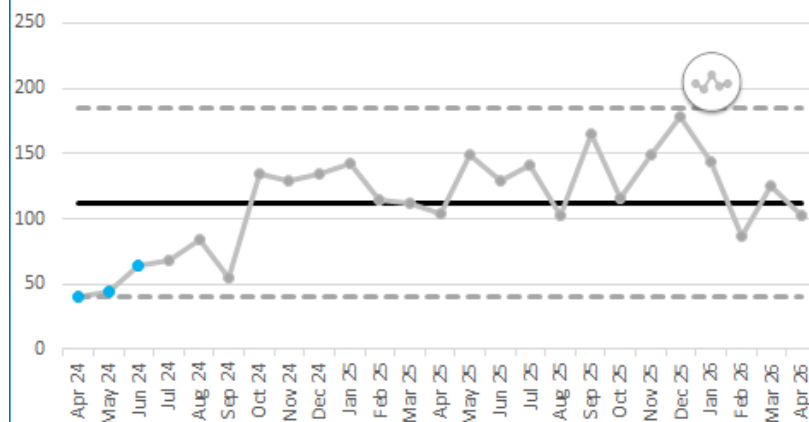
April 2026

Target-28-day breaches: 0
Performance – LMCO: 103
Performance – 28-day Standard: 36

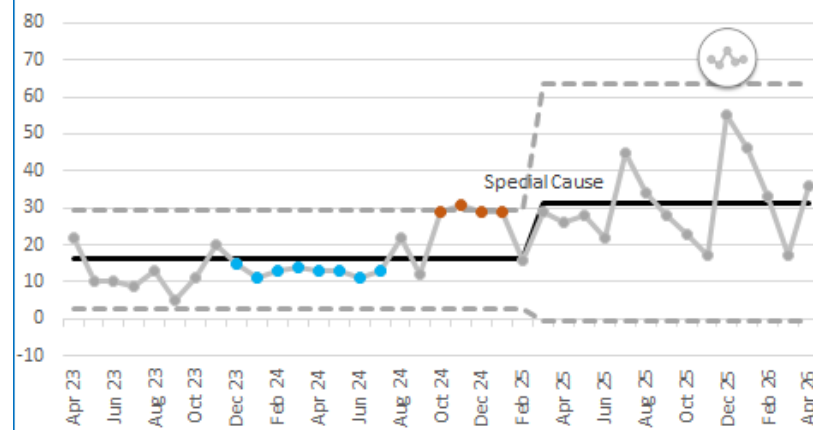
Executive Owner: Tim Hiles (Chief Operating Officer)

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

Last Minute Cancelled Ops



Cancelled Ops 28days



Background	Performance	Key Issues	Current Actions
<p>Ensure all patients who have operations cancelled on the day of surgery, for non-clinical reasons are offered another binding date to be treated within a maximum of 28 days (zero tolerance standard)</p>	<p>Cancelled Operations</p> <ul style="list-style-type: none"> 103 LMCO in April 2026 which is a decrease from March. Cancellation reason 'Ran out of theatre time' was 44% of the total non-clinical LMCO on-the-day in April which is an increase on March <p>28 Day Breaches</p> <ul style="list-style-type: none"> There were 36 breaches of the 28-day standard in April 2026 which is an increase from the 17 in March Ranked 78th out of 118 Trusts for Q4 	<p>Risks of increased numbers of LMCO and 28-day breaches due to:</p> <ul style="list-style-type: none"> bed pressures Increased NC2R patients in the bed base Higher utilisation rates Increasing attendances and TCIs in ED Industrial action 	<ul style="list-style-type: none"> Improving bed occupancy positions are resulting in fewer recent cancellations for no bed COO and CMO writing to surgeons with greatest under-utilisation including those affected by cancelled operations Trials of Golden patient and standby patient lists to minimise and replace last minute cancelled ops as part of Hub optimisation weeks. 28-day breach numbers monitored in Service Delivery meetings Reinforcement of 'first-start' principles with particular focus in adult cardiac surgery and critical care given recent spike in on day cancellations

Supplementary Metrics NHS Oversight Framework

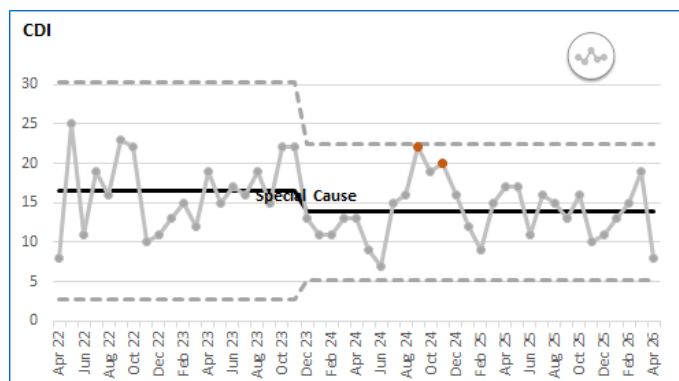
CDI

April 2026

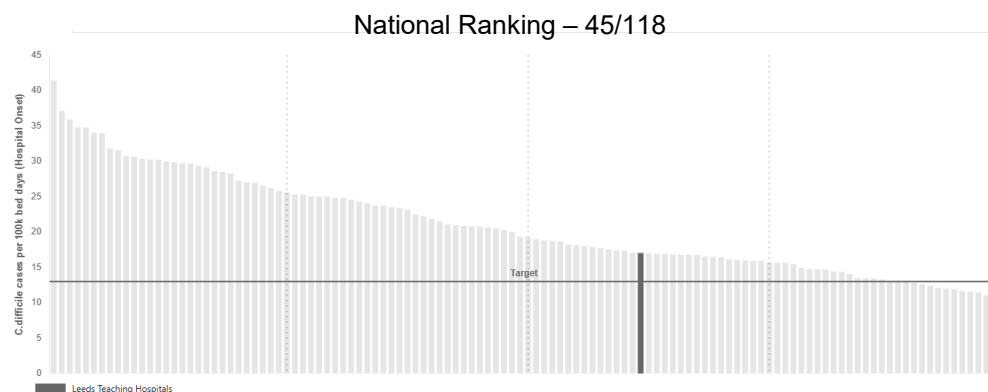
Target:
Performance: 8

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 as at 11/05/26



Data Source: Fingertips

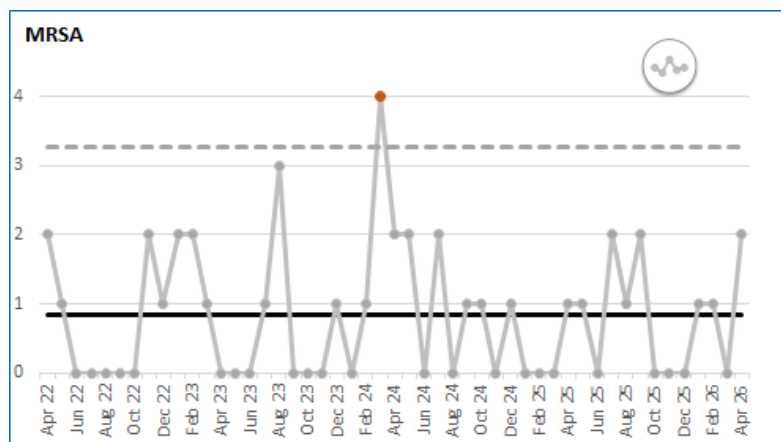
Data Period: February 2026

Background	Context	Action
<ul style="list-style-type: none"> The Trust HCAI thresholds for <i>Clostridioides</i> difficile infection (CDI), Meticillin Resistant <i>Staphylococcus</i> aureus (MRSA) and Gram-negative bloodstream infections (GNBSI) are determined nationally from NHSE and form part of the NHS Standard Contract. Thresholds for 2026/27 are awaited. 	<ul style="list-style-type: none"> The SPC chart demonstrates a sharp drop below the mean from previously increasing numbers towards the latter end of 2025/26; the number of cases for April 2026 is 8. National comparator Hospital Onset data from February shows LTH's position remaining in the third quartile ranked 45 out of 118 NHS Trusts, which is a deterioration from our previous position of 41. 	<ul style="list-style-type: none"> Focus on decluttering and equipment storage to facilitate cleaning Weekly ward rounds continue with audit and feedback to clinical teams. Good practice and areas for improvement tasks are feedback to ward teams by email and action plans followed up by IPC Antimicrobial stewardship – continued

MRSA

April 2026

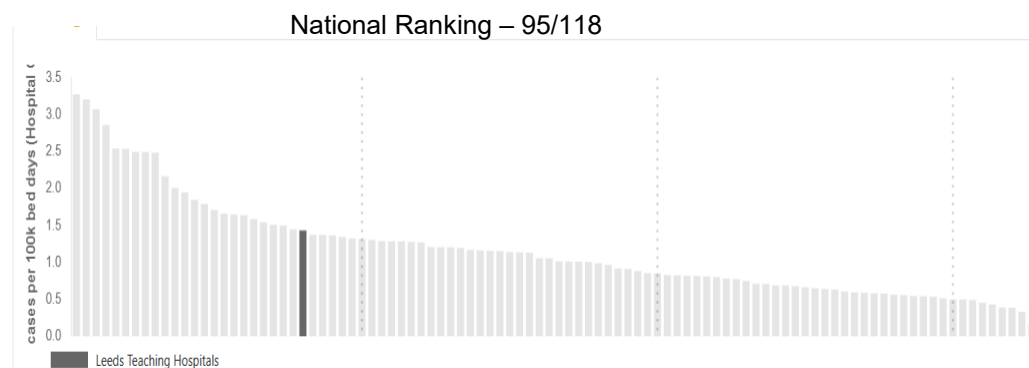
Target:
Performance: 2



Data as at 06/05/26

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: January 2026

Background	Context	Action
<ul style="list-style-type: none"> There is a National 'zero tolerance' approach to MRSA bloodstream infections National MRSA bacteraemia incidence has increased year on year since 2020 (lowest rates were seen during the COVID-19 pandemic), this is accounted for by increases in both healthcare-associated and community cases. 	<ul style="list-style-type: none"> The SPC chart shows LTHT has recorded 2 cases in April 2026 against a zero-tolerance approach. National comparator Hospital Onset data from January shows LTHT's position has moved to within the first quartile of the table and is ranked 95 out of 118 NHS Trusts. This is a deterioration from the previous position of 88. 	<ul style="list-style-type: none"> Trust Vascular Access Device Safety (VADS) group prioritising support for introduction of: <ul style="list-style-type: none"> Criteria led removal Digitalised Peripheral Cannula Document Standardised ANTT training package Standardised CVAD documentation MRSA source isolation data review leading to consultation on new side-room prioritisation tool.

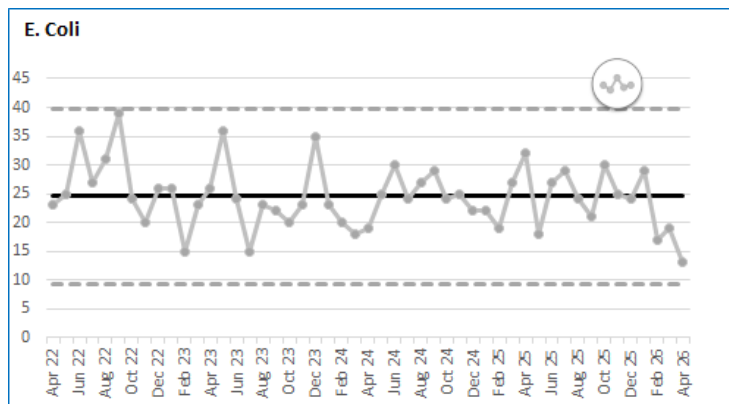
E. Coli

April 2026

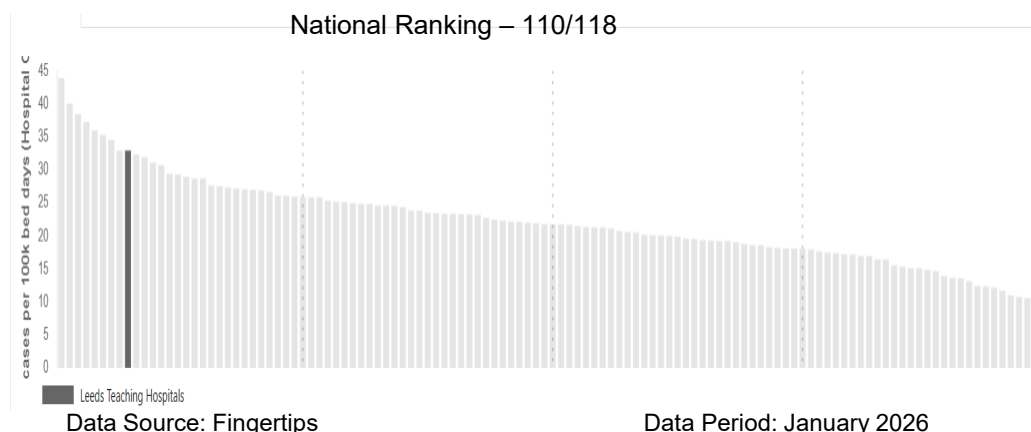
Target:
Performance: 13

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 as at 06/05/26










Background	Context	Action
<ul style="list-style-type: none"> The Trust HCAI thresholds for <i>Clostridioides difficile</i> infection (CDI), Metcillin 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. Thresholds for 2026/27 are awaited. 	<ul style="list-style-type: none"> The SPC chart shows a decrease in cases below the mean. The number of E. coli cases for April 2026 is 13. National comparator Hospital onset data from January shows LTH's position remaining within the first quartile of the table and is ranked 110th out of 118 NHS Trusts, with no change to the previously recorded position. 	<ul style="list-style-type: none"> Key areas of focus include enhanced device management by ensuring good ANTT knowledge, daily check that the device is still needed, robust device monitoring and criteria led device removal. Work on pre-procedure and pre-device insertion prophylaxis has been completed, including updating trust-wide antimicrobial guidance in response to findings from HCAI reviews

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