

Integrated Quality & Performance Report

March 2026

Summary - Performance

Performance

KPI	Latest month	Performance	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
AE Attendances per day	Feb 26	992.2	-			950.6	827.0	1074.2
Ambulance Handovers <15mins LGI	Feb 26	00:15:24	00:15:00			00:15:18	00:14:26	00:16:10
Ambulance Handovers <15mins SJUH	Feb 26	00:18:15	00:15:00			00:17:31	00:14:37	00:20:26
Last Minute Cancelled Ops	Feb 26	87	-			90	37	143
Cancelled Ops 28days	Feb 26	33	-			21	2	41
Cancer 28day FSD	Jan 26	75.3%	75.0%			75.0%	67.1%	82.8%
Cancer 31day	Jan 26	96.1%	96.0%			89.6%	84.6%	94.6%
Cancer 62 day	Jan 26	64.9%	85.0%			58.8%	47.6%	70.0%
Diagnostics	Feb 26	94.3%	95.0%			91.7%	88.1%	95.4%
DNA Rate	Feb 26	6.44%	-			6.94%	6.24%	7.63%
Outpatient DNA Volumes	Feb 26	7413	-			8526	6441	10611
ECS Monthly	Feb 26	74.8%	78.0%			75.0%	70.6%	79.4%
Elective LoS	Feb 26	3.6	-			4.1	3.1	5.1
Elective Readmissions	Feb 26	2.84%	-			3.24%	2.86%	3.62%
Non-Elective LoS	Feb 26	9.9	-			7.4	6.3	8.5
Non- Elective Readmissions	Feb 26	9.90%	-			11.15%	9.69%	12.60%
OPFU3months	Feb 26	42035	-			36685	34637	38733
RTT Performance	Feb 26	65.9%	92.0%			64.1%	62.4%	65.8%
RTT Total Waiting list	Feb 26	85760	-			89586	87236	91935
RTT 52 Week Breach Backlog	Feb 26	1305	0			2205	1717	2693
RTT 78Week Breach Backlog	Feb 26	17	0			44	-5	94



Summary

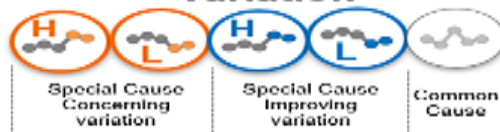
KPI	Latest month	Performance	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
VTE	Feb 26	96.1%	95.0%			96.5%	95.3%	97.8%
CDI	Feb 26	15	-			14	6	22
MRSA	Feb 26	1	-			1	-2	3
E. Coli	Feb 26	17	-			25	9	40
Pseudomonas	Feb 26	2	-			4	-2	10
Klebsiella spp	Feb 26	8	-			11	0	22
Patient Level Metrics Score	Feb 26	93.8%	90.0%			94.8%	92.9%	96.7%
Environment Level Metrics Score	Feb 26	90.1%	90.0%			93.1%	89.6%	96.5%
Falls	Feb 26	199	-			197	165	230
Falls Rate per 1000 Bed Days	Feb 26	3.63	-			3.49	3.01	3.98
Developed Pressure Ulcers	Feb 26	64	-			47	26	69
Developed Pressure Ulcer Rate	Feb 26	1.17	-			0.75	0.23	1.26
Admitted with Pressure Ulcers	Feb 26	304	-			308	249	366
Admitted with Pressure Ulcers Rate	Feb 26	5.54	-			5.48	4.31	6.65
2222 Calls	Nov 25	59	-			59	38	81
Cardiac Arrest Calls	Nov 25	18	-			17	5	29
SHMI	Jan 26	112.3	100.0			112.3	110.8	113.9
Still Births	Jan 26	4.70	5.20			3.86	3.03	4.69
Rolling Extended Perinatal mortality rate (all NND)	Jan 26	8.80	-			9.14	8.42	9.87
Number of MNSI Referrals	Jan 26	0	-			1	-2	4
% Complaint Responses Sent Within Target Times (LR1 let	Feb 26	28%	80%			33%	14%	53%
% CSU Draft Comments Received Within Target Times (LR	Feb 26	47%	80%			49%	32%	67%
Median Response Lead Time (Days)	Feb 26	56	-			49	37	62
Defect Rate	Jan 26	1%	15%			8%	#N/A	#N/A
PALS Concerns - % Patients contacted in 2 w/days	Feb 26	78%	80%			79%	73%	85%



Core Metrics

Measure	Reporting Period	Performance	Target	Variance	Assurance
Rolling Overall Sickness Rate	Feb-26	5.26%	4.90%		
Rolling Voluntary Turnover Rate	Feb-26	5.38%	5.93%		
In-Month Agency Spend (as % of total pay bill)	Feb-26	0.62%	0.53%		
In-Month Bank Spend (as % of total pay bill)	Feb-26	5.48%	2.83%		
In-Month Vacancy Percentage	Feb-26	6.05%	N/A		
In-Month Mandatory Training Compliance Rate	Feb-26	88.98%	85.00%		
YTD Number of concerns raised to FTSU Guardian	Feb-26	221	N/A		
Quarterly Pulse Survey					
PS Engagement Score	Jan-26	6.41	6.5		
PS Team Working Score	Jan-26	6.36	TBC		
PS Line Management Score	Jan-26	6.74	TBC		
Annual Staff Survey					
SS Engagement Score	25/26	6.71	6.9		
SS Response Rate	25/26	47%	47.6%		
SS Team Working Score	25/26	6.54	>6.8		
SS Line Management Score	25/26	6.74	>6.9		

Variation



Assurance



Core Metrics

Ambulance Handover

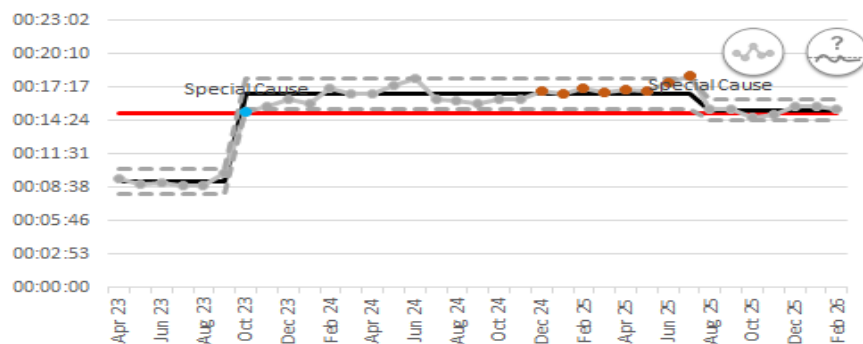
February 2026

Target: <15mins
Performance – LGI : 00:15:24
Performance – SJUH : 00:18:15

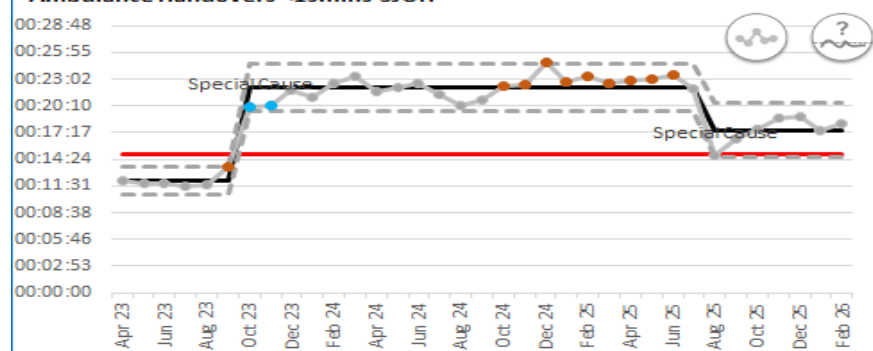
Executive Owner: Tim Hiles (Chief Operating Officer)

Variance: Special cause variation.

Ambulance Handovers <15mins LGI



Ambulance Handovers <15mins SJUH

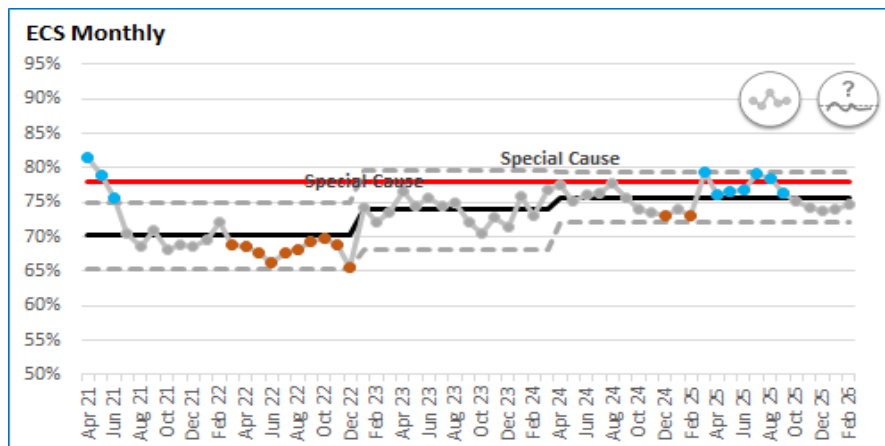


Background	Performance	Key Issues	Current Actions
95% of all handovers should take place within 15 minutes - On average the first 7 minutes of the 15-minute allocation for ambulance handover is taken by the ambulance crew parking the vehicle and "off loading" (YAS term) the patient. This leaves 8 minutes for booking-in and clinical handover to the A&E nurse	- We have met our national submitted trajectory for ambulance handover for the last 7 months - LGI – Feb 2026 average handover time was 15:24 - SJUH – Feb 2026 average handover time was 18:15 0.8% of handovers were over 45 minutes in February 2026 - LGI placed 14th and SJUH placed 47th out of 183 hospitals for ambulance handovers for February 2026	- 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	- A request, submitted to YAS in November 2025, for the GPS trigger point to move to 10 metres from 25 metres from the A&E entrance to support more accurate recording of when the ambulance vehicle becomes stationary has been accepted - planned to be implemented by YAS in February 2026 - due to YAS technical issues this has been delayed until April 2026 - Daily validation of all ambulance handovers recorded as over 45 minutes are now retrospectively corrected on the YAS data submission. LTHT are now working with the ambulance service to theme the 45- minute handover breaches that have been incorrect and consider training, automated corrections and required actions

Emergency Care Standard

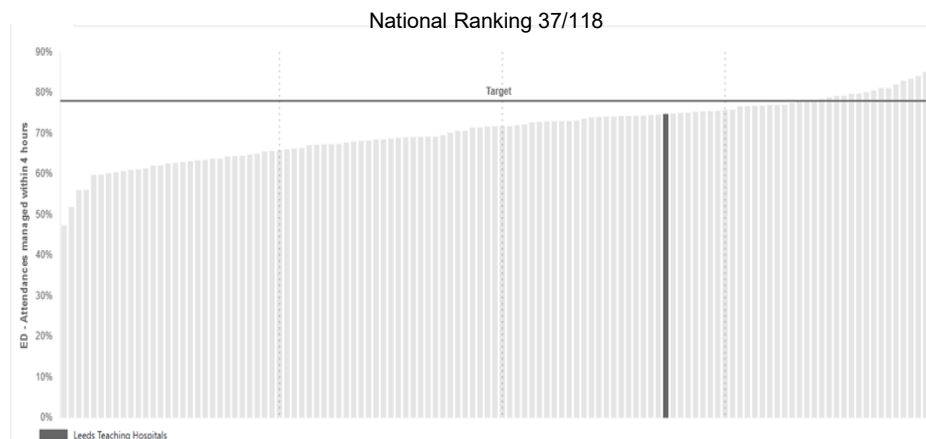
February 2026

National Planning Priority Target 2025/26: 78% by March 2026
Performance: 74.8% against national trajectory



Executive Owner: Tim Hiles (Chief Operating Officer)

Variance: Common cause variation. Hit and Miss variation indicated



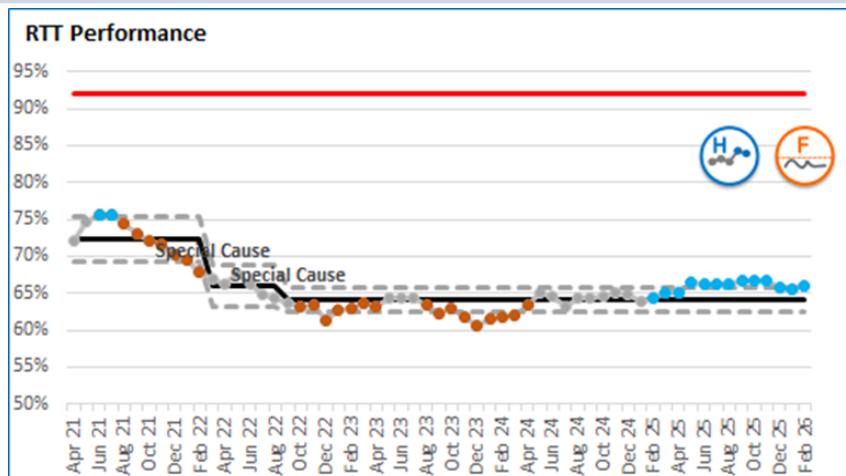
Background	Performance	Key Issues	Current Actions
- The constitutional standard is that 95% of attendees to A&E will be admitted, transferred or discharged in 4 hours - The 2025/26 national planning requirement is to deliver 78% in March 2026	- ECS delivery for February 2026 was 74.8% against NHSE trajectory of 73.6% - National average ECS 71.5% for Feb 2026 - Ranked 37th out of 118 Trusts for ECS performance in Feb 2026 and 3rd out of 10 peers 2nd highest volume of attendances amongst peers	- A&E crowding high; limited patient outflow from A&E to ward capacity and city/community placements - Delays in access to mental health assessment / availability of appropriate mental health beds. Patients remaining in A&E for extended periods while awaiting specialist review or placement	- JEOU trial commenced on 4th March, aimed at improving patient streaming, observation capacity and supporting improved flow from A&E - LGI assessment footprint remodelled and implemented on 5th March to improve front-door assessment processes and timeliness of patient flow through the emergency department - LTHT selected as an NHSE pilot site for ECS validation sprint supporting strengthened data quality and exploring any data quality opportunities for the month of March

February 2026

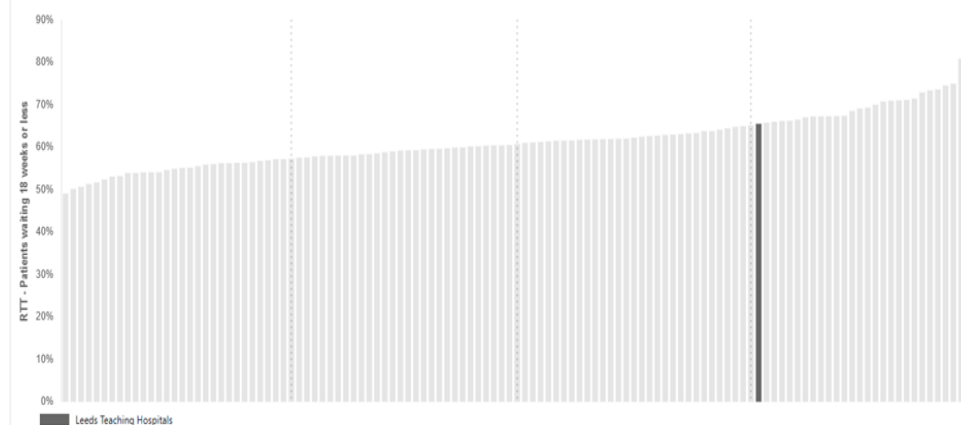
Target: 92%
Performance: 65.9%

Executive Owner: Tim Hiles (Chief Operating Officer)

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



National Ranking 28/118



Background	Performance	Key Issues	Current Actions
- The constitutional standard is to ensure 92% of patients are treated within 18 weeks of referral (Outpatient waiting times) - The 2025/26 national planning guidance required an improvement of 5% by March 2026 (from 65% in Nov 24 to 70% by Mar 2026)	18-week RTT was 65.9% in Feb 2026 - TWL size fell to 85,760 at the end of Feb 2026 from 86,915 in Jan 2026 18-week ranking: RTT is 28th out of 118 Trusts - Number of patients over 18 weeks decreased to 29,241 in Feb 2026 compared to 29,986 in Jan 2026 - Time to first OP appointment improved to 71.14%	- Winter pressures resulting in some admitted cancellations - In February numbers on total waiting list, under 18, over 18 weeks, long waiters, (52, 78 & 104 weeks) all decreased on previous month - Referral rates from GPs continue to be above plan: circa 3% growth between Q3 - Q4	- National Q4 Validation Sprint: external partner delivering administrative validation exercise delivering a 12% removal rate. - Q4 Elective Sprint (first OP) is underway: deliver additional activity and RTT clock stops. Some services using the independent sector to deliver more activity - CSUs auditing outpatient follow-up waiting list: confirm opportunity to reduce unnecessary follow-up activity (H&N trial identified a removal rate of 15%)

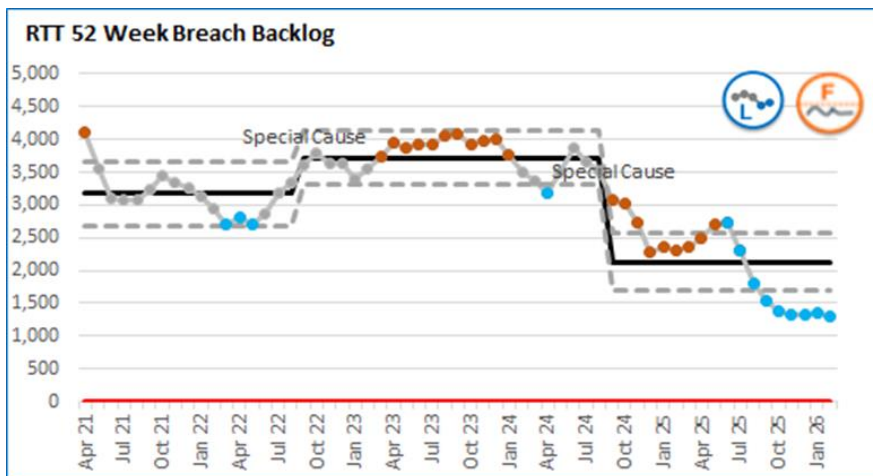
RTT 52 Weeks

February 2026

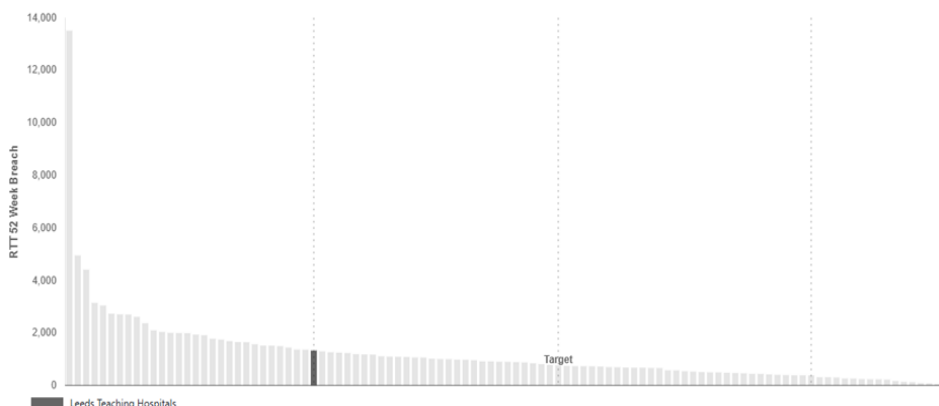
National Planning Priority Target 2025/26: 1% of TWL (c750)
Performance: 1,305

Executive Owner: Tim Hiles (Chief Operating Officer)

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



National Ranking 88/118

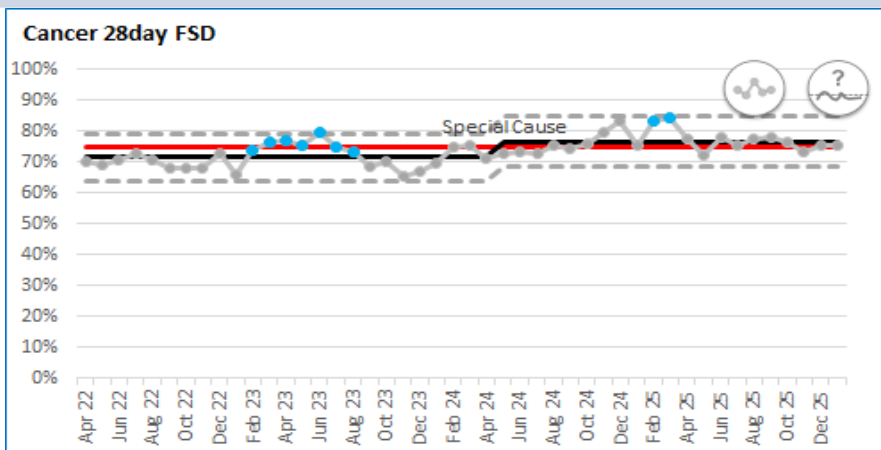


Background	Performance	Key Issues	Current Actions
Planning guidance for 2025/26 requires Trusts to ensure that fewer than 1% of patients on an RTT clock have waited over 52 weeks	- LTHT had 1,305 patients who waited over 52-weeks by the end of Feb 2026 - For February 2026, the number of patients waiting over 65-weeks was 109 - Ranked 88th of 118 trusts at January month end 52-week waits accounted for 1.52% of total waiting list in February 2026	- The number of over 52-week waits plateaued from October to February although 1305 is the lowest number this financial year - CSU's issues: high volume of P2 patients, paed anaesthetic cover, HOBs beds 52-week growth: increase is predominantly across ENT and Clinical Genetics and Immunology 52-week decrease (143): is predominantly across Gynae, Hip & Knee, Adult Spines, Vascular and Colorectal	- Focus on non-admitted 52-week breaches - Gynae working to eliminate 52-week waits for patients - Neurosciences: Q4 2025/26: additional OP clinics and requested additional weekend operating being worked through - Chapel Allerton theatre lists have been reallocated to Neurosciences - H&N: increased use of Gilbert Scott theatres in Q4

Cancer 28 Day Faster Diagnostic

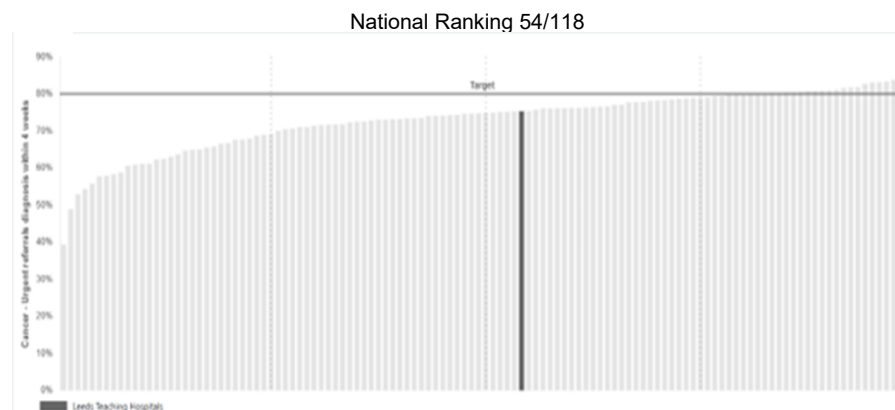
January 2026

Target: 75%
Performance: 75.3%



Executive Owner: Tim Hiles (Chief Operating Officer)

Variance: Common cause variation. Hit and Miss variation indicated



Background	Performance	Key Issues	Current Actions
- 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	28-day FDS performance was 75.3% in January 2026 - Ranked 54th of 118 Trusts for January 2026 (improved from 92nd in December) - Delivering against plan 3284 out of 4365 patients were informed of their diagnosis within 28 days	- Capacity in breast imaging does not meet demand - Variation in pathology turnaround times	- Additional imaging capacity in Breast to increase the % of patients who have imaging at first assessment including outsourcing on a weekend - Longer-term OD input into breast imaging services to improve recruitment and retention - Agreement in place for appropriate recording of lower GI patients with polyp post scope (not cancer) - Revised IDA pathway agreed and expected to commence from April 2026.

Cancer 31 day

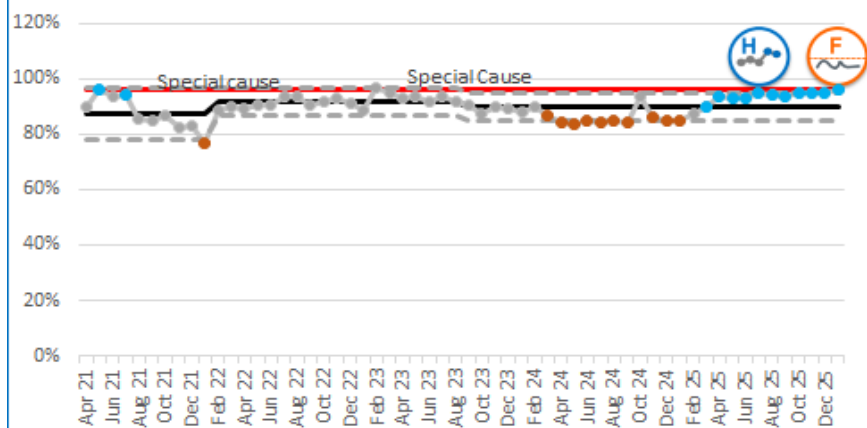
January 2026

Target: 96%
Performance: 94.9%

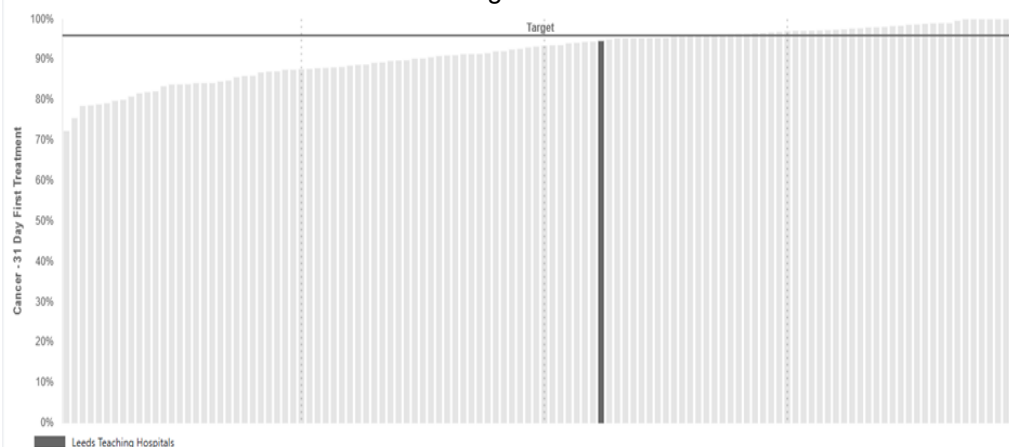
Executive Owner: Tim Hiles (Chief Operating Officer)

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

Cancer 31day



National Ranking – 52/118



Background	Performance	Key Issues	Current Actions
96% of patients should receive treatment within 31 days - This includes patients receiving both first and subsequent Cancer treatments	- The reported position for January was 94.9% - Ranked 52nd of 118 Trusts for January 2026	Surgical capacity is the main constraint	- Re-allocation of WGH list from AMS to TRS to increase melanoma capacity - Access to surgical robot is a key constraint – flexing lists to respond to peaks in demand

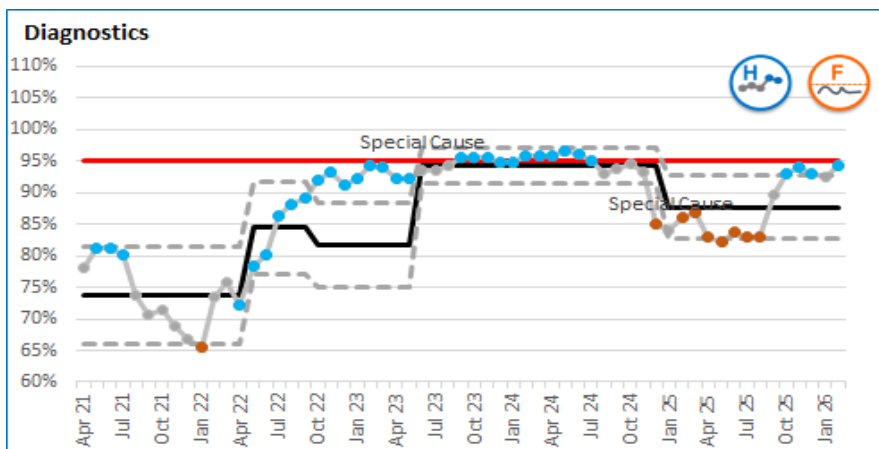
Diagnostic Waits

February 2026

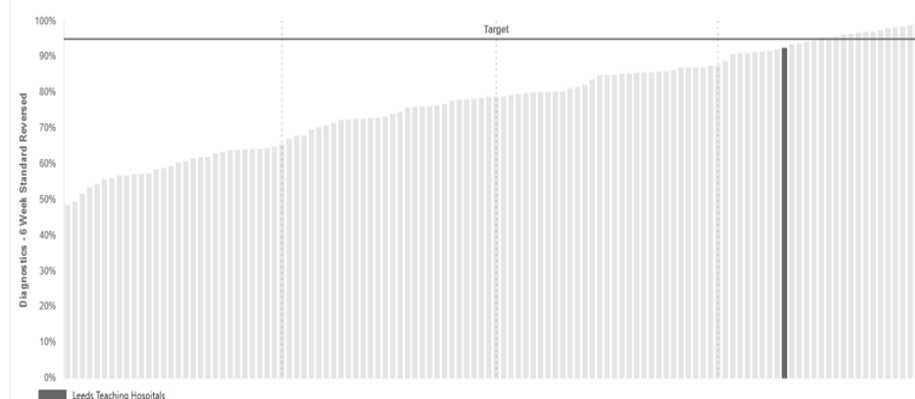
Target: 95%
Performance: 94.28%

Executive Owner: Tim Hiles (Chief Operating Officer)

Variance: Special Cause of improving nature. Fail variation indicated



National Ranking 20/118



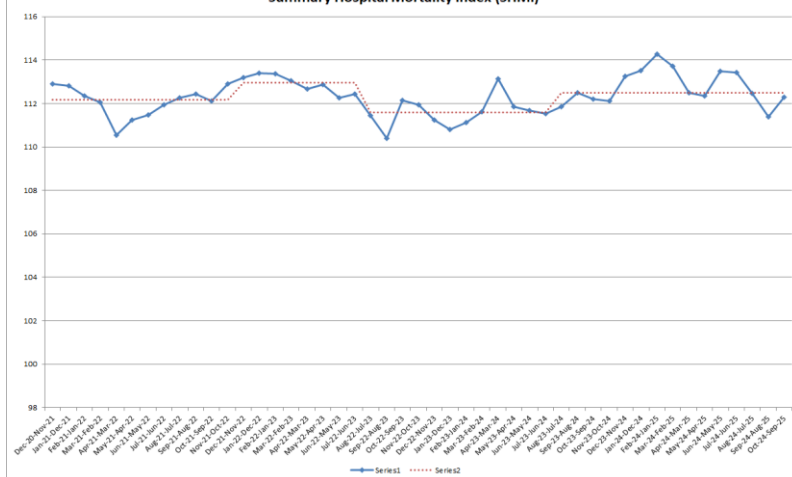
Background	Performance	Key Issues	Current Actions
- Constitutional standard is that 99% of patients wait no more than 6 weeks for a routine diagnostic test 2024/25 National Planning priority was to deliver 95% by March 2025	- Ranked 20th of 118 Trusts (acute and combined) for January 2026 - Diagnostic waiting list at February month end was 16,495 944 patients breached 6 weeks at February month end	- MRI delays for Paediatric GA due to anaesthetist & theatre capacity - Children's endoscopy and cystoscopy have long waiters - Audiology overdue waits for paediatric follow-up reviews will be included as 6ww from April onwards.	- Ultrasound: Backlogs reducing in line with recovery plan. Underlying workforce challenges remain - MRI rocket simulator for children has been delayed and is now expected to be delivered by October 26 - CT 6ww: Cardiac CT radiographer led lists delayed and should now start April 26 - Outsourcing and insourcing options for children's Endoscopy and Cystoscopy presented and agreed at TERG. Four additional lists planned for March with LTHT staff. Unable to accommodate one provider in LTHT theatres so other options are being explored - Additional sessions (with payment) are running to reduce backlog of overdue paediatric audiology follow-up. Lists started 28th February

Mortality

October 2024 – September 2025

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

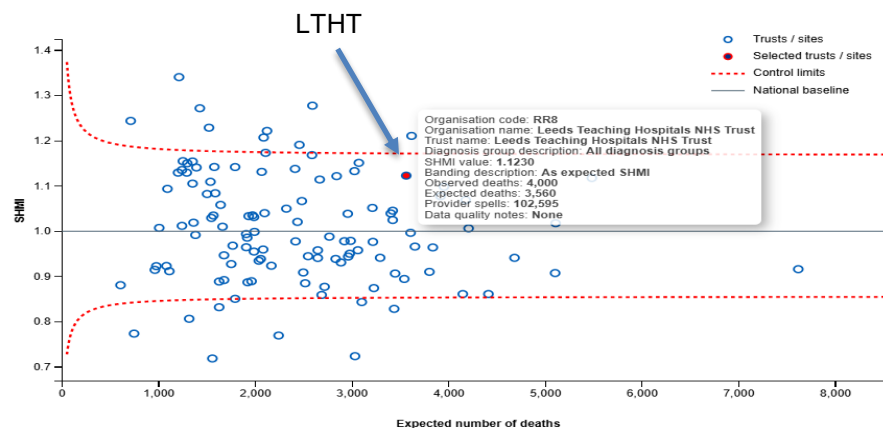
Summary Hospital Mortality Index (SHMI)



Executive Owner: Dr Magnus Harrison (Chief Medical Officer)

Variance: Common cause variation.

SHMI funnel plot



Background

Context

Action

- 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.

- The Trust SHMI for October 2024 – September 2025 was 112.3 and “As Expected”.
- The Upper Control Limit was 117.2

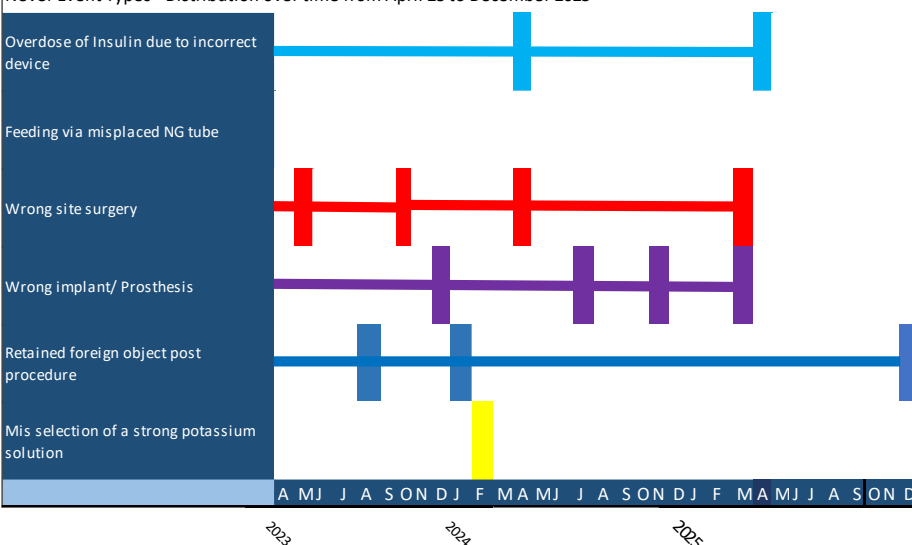
- The Mortality Improvement Group will continue to monitor SHMI in terms of both absolute value, comparison with peer organisations and changes in the diagnostic group breakdown.
- We continue to seek assurance through statistical analysis, coding reviews, and case note analysis. The Trust have strengthened 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

Q3 (2025/26)

Target: 0
Performance : 3 (YTD)

Never Event Types - Distribution over time from April 23 to December 2025



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	Q3 25-26	Total
Wrong site surgery	1	0	0	1	0	0	0	2
Wrong implant/ Prosthesis	0	2	1	1	0	0	0	4
Retained foreign object post-procedure	0	0	0	0	1	0	1	2
Insulin overdose due to abbreviation or incorrect device	1	0	0	0	1	0	0	2
Total	2	2	1	2	2	0	1	10

Background	Context	Action
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 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.	The number of Never Event incidents are reported to our commissioners each quarter via the national Strategic Information System (StEIS). There have were 7 Never Events reported in 2024/25. 3 Never Events have been reported in 25/26: - Overdose of Insulin due to wrong device (ACC). - Retained surgical item (ENT Theatres WGH). - Retained Surgical item (Interventional Radiology/ENT)	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. Learning and actions from Never Events are subject to review at the WYAAT shared learning group chaired by LTUT.

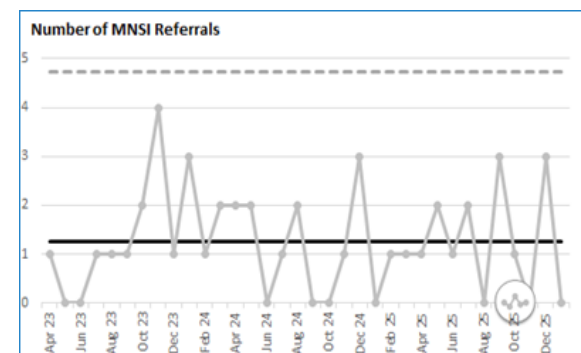
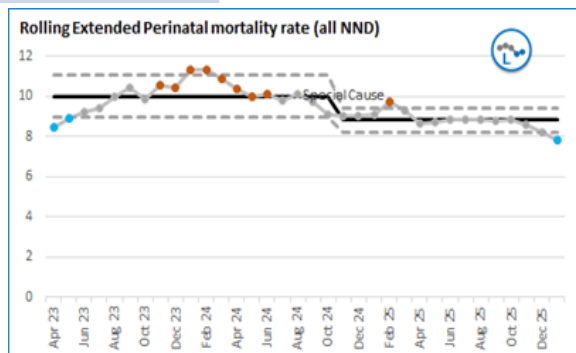
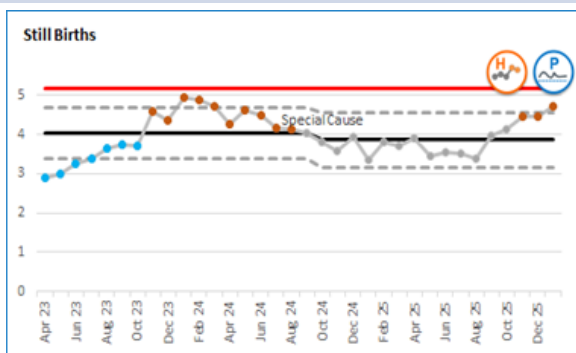
Maternity

January 2026

Still Birth Rate: 4.7
Extended Perinatal Mortality Rate: 8.8
Number of MNSI Referrals: 0

Executive Owner: Beverley Geary (Chief Nurse)

Variance: – Common Cause Variation.

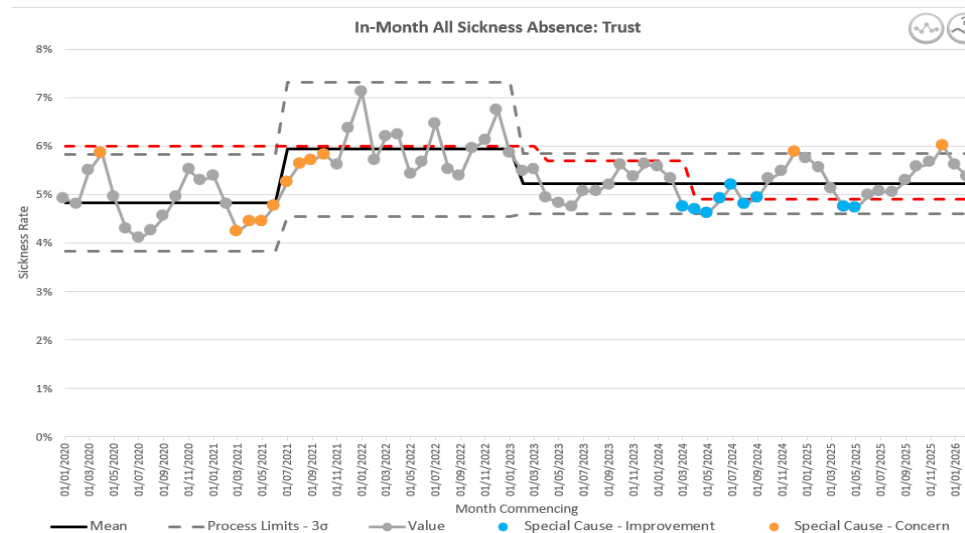


Background	Context	Action
- The MBRRACE definition of a stillbirth is: A baby delivered at or after 24 completed weeks' gestational age showing no signs of life, irrespective of when the death occurred. - The MBRRACE definition of a early neonatal death is: A liveborn baby (born at 20 completed weeks' gestational age or later, or with a birthweight of 400g or more where an accurate estimate of gestation is not available) who died before 7 completed days after birth. - The MBRRACE definition of a neonatal death is: A liveborn baby (born at 20 completed weeks' gestational age or later, or with a birthweight of 400g or more where an accurate estimate of gestation is not available), who died before 28 completed days after birth. - MBRRACE define perinatal death as: A stillbirth or early neonatal death. - MBRRACE define extended perinatal death as: A stillbirth or neonatal death. - LTHT is a tertiary unit and receives referrals for complex congenital abnormalities some of which have an impact on	- During the reporting period there were 4 stillbirths that will be reviewed through the perinatal mortality review process. - There were 3 inborn neonatal deaths and 1 outborn neonatal deaths - There were 0 referrals to MNSI.	- 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

Feb 2026	Executive Owner: Suzanne Dunkley, Chief People Officer
Target: 4.9 % Performance (Rolling Sickness Absence Rate): 5.26% (Avg Calendar Days Lost Per Person – 20.1)	Management/Clinical Owner: Chris Jones
Variance: Common cause variation in month.	Sub-Groups: Health and Wellbeing Group and Workforce Management Group

Background	What the chart tells us
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.	In-month sickness absence rates has returned to within control limits since exceeding in December.



Issues	Actions	Context
N/A	- Revised Supporting Attendance Policy has not been approved by Executives. Therefore, the revisions are currently being re-reviewed alongside additional feedback from CSUs about the policy and process. These will be mapped out in early April, and a timeline developed for revising the policy, amending the guidance and associated documents, consultation with Staff Side, approval, and implementation. - The new PIF 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.	- 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. - Areas within the trust with the highest sickness absence rates include Outpatients, Theatres & Anaesthesia and Adult Critical Care CSUs

Voluntary Turnover

Feb 2026

Target: 5.45%

Performance (Rolling Voluntary Turnover Rate): 5.38%

Variance: Common cause variation.

Executive Owner: Suzanne Dunkley, Chief People Officer

Management/Clinical Owner: Jo Buck

Sub-Groups: Resource Management Group, Workforce Management Group

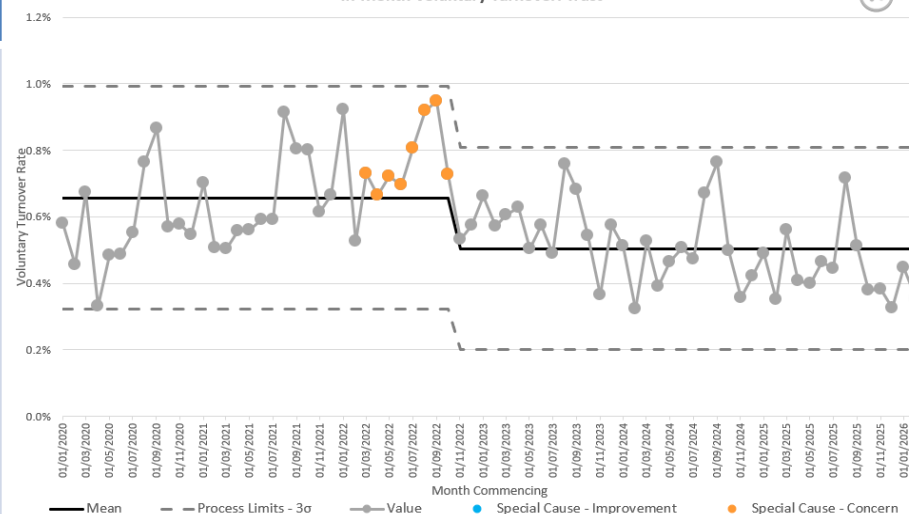
Background

- Following the Trust Commitment in 2024/25, we have set the target at maintaining current performance in relation to turnover.

What the chart tells us

- The in-month rates remain within the wide control limits.

In-Month Voluntary Turnover: Trust



Issues

Actions

N/A

- 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, Pathology and Head & Neck CSU. The lowest turnover in clinical CSUs is in Theatres & Anaesthetics and Adult Critical Care.
- A new Performance 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.
- Annual self-assessment process embedded into Staff Engagement Group's Forward Plan, informed by the NHS Staff Survey Results and aligning to In-Year Commitments.
- Retention plans are incorporated into all CSU Operational Workforce Plans and are part of their 'business and usual' e.g. stay conversations, health and wellbeing conversations, staff survey discussions, regular 1:1 meetings.

Context

- Total Trust turnover is 10.58% compared to voluntary turnover being 5.38%.
- 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

Feb 2026

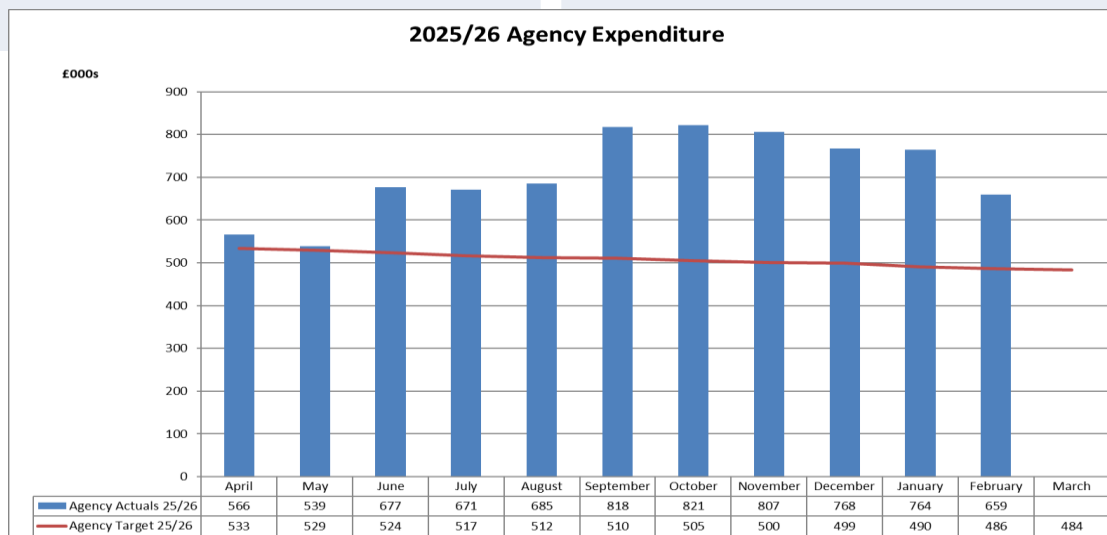
Executive Owner: Suzanne Dunkley, Chief People Officer

Target: 0.50% **Performance:** 0.64%

Management/Clinical Owner: Chris Ellison

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

Sub-Groups: Resource Management Group and Workforce Management Group



Background	What the chart tells us	Issues	Actions	Context
- 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.	- The Trust's current agency performance is 0.71% against a peer average of 1.1% for 25/26. - To support achievement of the target it has been phased across the financial year. - Agency spend has been significantly above plan since June. Key drivers of the overspend against the plan relate to additional support in Maternity and Neonatal and specialist staff supporting CAMHS patients in the Children's CSU. The Trust has an agreement with WY ICB to fund the costs supporting one specific patient and we are in discussions about funding for the other patients.	N/A	- 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 2026 LTH is ranked in the 2nd best Quintile for agency with Model Hospital. - There is a Workforce Availability Group in place meeting fortnightly specifically focusing on support required for CSUs to reduce workforce unavailability and agency spend. - There is a Medical and Dental Optimisation Group undertaking deep dives into the medical workforce with the aim of reducing temporary spend. - We are continuing to monitor CSU agency spend and putting actions in place where appropriate. - HR and Finance Business Partners continue to work with CSUs to develop workforce action plans to address the situation.	N/A

Feb 2026

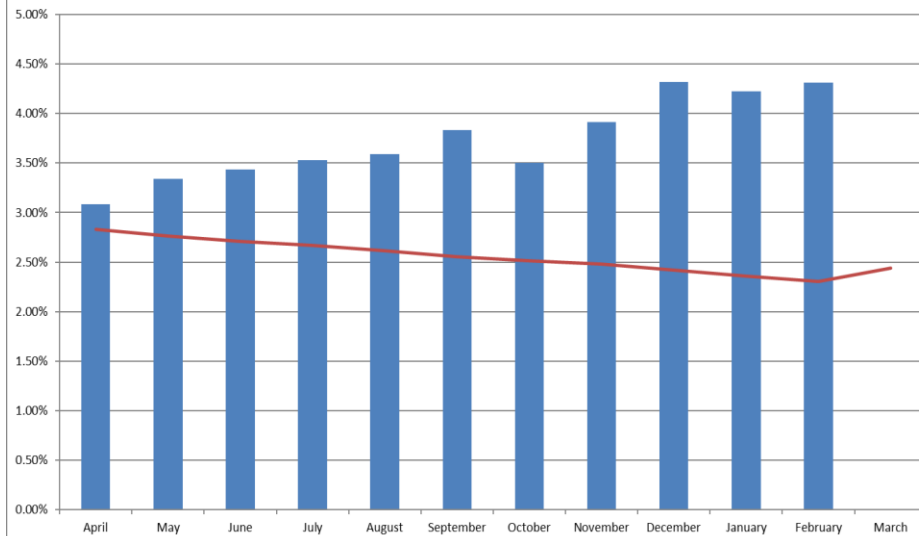
Target for Bank Spend: 2.31% (bank only)
Performance: 4.31% (bank only)

Executive Owner: Suzanne Dunkley, Chief People Officer

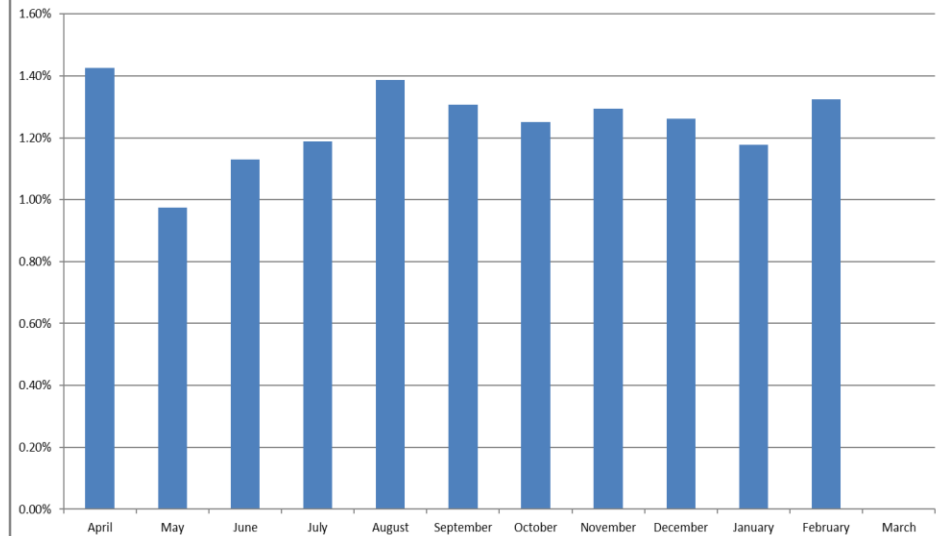
Management/Clinical Owner: Chris Ellison

Sub-Groups: Resource Management Group and Workforce Management Group

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



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



Background	What the chart tells us	Issues	Actions	Context
- 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	- The red line on the bank graph shows our target across the year. - Bank spend for February 2026 is 4.31% of total staff spend against a February target of 2.31%. Bank costs are £2.2m higher than anticipated. The adverse variance is mainly due to winter pressures, measures to increase roster fill rate in Maternity and Neonates, surge rates in Urgent Care, costs associated with covering the resident doctors industrial action and bank reduction plans not delivering as expected. There is no target against which to measure overtime spend.	N/A	- During 2025/26 the Leeds Improvement Method (LIM) principles of daily management supported reductions in the use of bank spend and other variable pay. As at March 2026 LTH is placed in the top 1st quintile for bank spend on Model Hospital. - There is a Workforce Availability Group in place meeting fortnightly specifically focusing on support required for CSUs to reduce workforce unavailability and bank and overtime 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 costs. - There is a Medical and Dental Optimisation Group undertaking deep dives into the medical workforce with the aim of reducing 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

Feb 2026

Target: N/A
Performance: 6.05%

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: Resource Management Group and Workforce Management Group

Background

- 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.

What the chart tells us

- The gap between establishment and substantive staff in post is currently being utilised by Bank and Agency usage.

In-Month Vacancy Rate: Trust



Issues

Actions

Context

N/A

- 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 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.
- 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

Jan 2026

Target: 6.9

Performance: 6.71 (Staff Survey)

Variance: Common cause variation.

Executive Owner: Suzanne Dunkley, Chief People Officer

Management/Clinical Owner: Chris Jones

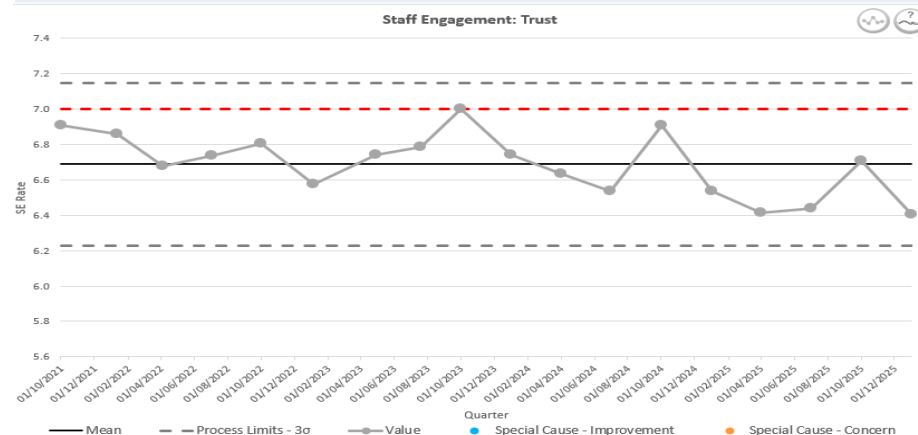
Sub-Groups: Staff Engagement Group, People and Culture Committee

Background

- 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.

What the chart tells us

- 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).



Issues

Annual Staff Survey:

- 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.

Actions

- Stakeholder engagement and presentations complete (EMT / SL / SEG) (WEB and LTHT Live 1/4/26)
- Developed and delivering a Trust wide High Impact Action plan: partnership actions across People Function and CSUs. These include creating a visible and trusted speaking up culture across CSU's, ensuring every colleague has high quality appraisal and 1:1 conversations, strengthening management capability, embed the refreshed LTHT values and use triangulated people data to shape targeted workforce actions addressing inequalities and workforce risks.
- Supporting CSUs to utilise results to inform existing Operational Workforce Action Plans, embed team utilisation, and bespoke local CSU High Impact Actions.
- Translation of High Impact Actions into communication visuals, supporting close the loop communication at Trust and CSU levels.
- Embedded assurance, via the new People Improvement Framework and CSU Joint Accountability Framework meetings.
- Trust-wide communications plan developed, including Feb and March LTHT Live, Trust communication routes, bespoke local comms, and storytelling.
- Soft launch of new results dashboard for all colleagues (12th March, 12pm); supporting results transparency, distribution, and utilisation.

Context

- 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



February 2026

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 February the Trust reported a year to date deficit of £17.2m, which is £2.6m adverse to the NHSE plan. The biggest drivers of the year to date deficit are pay expenditure being higher than planned and the Maternity Incentive Scheme rebate clawback.

Income to date is £1,957.7m which is £49.4m favourable to plan and expenditure to date is £1,974.9m, £52m adverse to plan. Year to date income variances are due to additional contract income, Education & Training funding mainly associated with the tariff uplift and additional Genomics income which are offset with costs.

Pay expenditure to date is £1,148.8m, £35.2m adverse to the NHSE plan which is partially due to investments approved in Women's and Children's CSU and is also driven by J32 winter ward remaining open longer than planned, cover for the resident doctor's industrial action in July, November and December, Building the Leeds way costs transferred from capital to revenue and bank reduction plans not yet delivering as expected. The Trust has also incurred agency costs associated with specialist staff supporting CAMHS patients in the Children's CSU which the West Yorkshire ICB have agreed to partially fund, with ongoing discussions regarding further funding. Non-pay expenditure to date is £826.1m (including depreciation and finance costs), £16.8m adverse to the plan. The non pay adverse variance relates mainly to the Maternity Incentive Scheme Year 5 & 6 rebate clawback and clinical supplies and services costs associated with activity.

There remain a number of risks to achieving the financial plan which the Trust continues to work through mitigations to reduce. Recent confirmation of elective overperformance being recognised and affordable from ICBs and Specialised Commissioning, along with funding to cover the costs of Industrial Action, indicate that the breakeven plan can be achieved, albeit with risks remaining.

Under the NHS oversight Framework the latest published segmentation and league table gives the Trust a combined finance score of 3, based on Q2 financial performance. The M11 YTD adverse variance to plan of £2.6m (0.14% of turnover) would result in a NOF score of 2.

Capital & Cash Position



February 2026

Executive Owner: Jenny Ehrhardt (Director of Finance)

Capital

The Trust's capital expenditure forecast for 2025/26 has been decreased to £100.2m due to MSE donated plan being reduced by £0.6m to be in line with the latest forecast and MSE PFI CAPEX reduced by £0.1m. However, this was slightly offset by additional PDC of £0.1m for the Maternity & Neonatal Programme and £0.1m for The Community Diagnostics Centre Pathway Programme.

The programme is broken down as follows:

Programme	Forecast 2025/26 £000
Medical Equipment	15,255
Informatics	19,784
Building & Engineering	59,695
Building the Leeds Way	1,000
Operational Capital	1,500
Leases	3,000
Total	100,235

The expenditure to 28 February 2026 was £54.8m, this was £1.6m behind forecast mainly due to B&E schemes. Leases YTD expenditure increased to £1.7m as we recognised a remeasurement for Unit G37a Trinity Walk lease based on the 25/26 rent increase and also the extension to the HEP C VAN lease.

There is a clear plan to deliver the full year plan by the end of Quarter 4.

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 to the Finance & Performance Committee.

Cash

The February 2026 closing cash balance is £99.1m, an increase of £47.9m from last month. This is £22m more than the fundamental review M7 best case of £77.1m, which is mainly due to the delay in capital expenditure (c£16m), and a quick turnaround of the January VAT return which enabled extra cash to be received in month (£1.8m).

Total receipts for the month amounted to £229m which included £6.4m of PDC funding and £3.8m in total for the December and January VAT returns.

Total payments in month were £181m, comprising £105m for payroll and £76m for accounts payable.

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 3.64%. A total of £31k 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



February 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)	1,289.6	107.5	120.9	13.4	1,176.9	1,213.2	36.3
Non-PbR Drugs, Blood and Devices	395.9	33.0	30.6	(2.4)	362.9	351.4	(11.5)
Sub-Total Commissioner Income	1,685.5	140.5	151.5	11.0	1,539.8	1,564.6	24.8
Other Clinical Income	11.8	1.0	1.6	0.6	10.8	14.0	3.2
Total Clinical Income	1,697.2	141.5	153.1	11.6	1,550.5	1,578.6	28.0
Other Income (non Covid)	305.3	26.0	27.7	1.7	276.7	290.6	13.9
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	167.5	180.8	13.3	1,827.3	1,869.2	41.9
Pay Costs	(1,207.0)	(100.4)	(106.2)	(5.8)	(1,113.8)	(1,149.0)	(35.2)
Sub-Total Pay	(1,207.0)	(100.4)	(106.2)	(5.8)	(1,113.8)	(1,149.0)	(35.2)
Non Pay Costs (excl Non-PbR Drugs, Blood and Devices)	(389.0)	(31.1)	(36.7)	(5.6)	(358.2)	(393.2)	(35.1)
Non-PbR Drugs, Blood and Devices	(396.4)	(33.0)	(30.3)	2.7	(363.3)	(347.7)	15.6
Sub-Total Non Pay	(785.4)	(64.1)	(67.0)	(2.9)	(721.5)	(741.0)	(19.5)
Total Expenditure	(1,992.4)	(164.5)	(173.2)	(8.7)	(1,835.3)	(1,890.0)	(54.7)
EBITDA	10.2	3.0	7.6	4.6	(8.0)	(20.8)	(12.8)
EBITDA%			4.2%			-1.1%	
Depreciation	(54.3)	(5.1)	(4.5)	0.6	(49.0)	(47.7)	1.3
Amortisation	(4.5)	(0.4)	(0.4)	(0.0)	(4.2)	(4.3)	(0.1)
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	3.8	5.0	1.3
Other Gains and (Losses)	0.0	0.0	0.1	0.1	0.0	0.2	0.2
Finance Costs	(24.0)	(1.2)	(1.7)	(0.5)	(13.1)	(24.9)	(11.8)
Dividends payable on Public Dividend Capital (PDC)	(10.8)	(0.9)	(0.8)	0.1	(9.9)	(9.2)	0.7
Retained Surplus/(Deficit) BEFORE ERF/TIF	(89.9)	(4.2)	0.7	4.8	(91.0)	(101.7)	(10.7)
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)	(1.0)	0.2	1.2	(3.6)	(2.0)	1.7
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)	(5.2)	0.8	6.0	(84.1)	(103.6)	(19.5)
Elective Recovery Fund (ERF)	97.7	8.1	9.4	1.3	88.6	94.0	5.4
Adjusted Surplus/(Deficit) INCLUDING ERF	11.0	2.9	10.2	7.3	4.5	(9.7)	(14.2)
Adjust PFI revenue costs to UK GAAP basis	(11.0)	(1.6)	(1.2)	0.4	(19.1)	(7.6)	11.6
Adjusted financial performance surplus/(deficit)	0.0	1.3	9.0	7.7	(14.6)	(17.2)	(2.6)

Statement of Financial Position



February 2026

Executive Owner: Jenny Ehrhardt (Director of Finance)

	Year to date movement			In Month	
	Closing 31st March 2025 £m	As at 28th Feb 2026 £m	Year to date movement £m	Prior Month £m	In-month movement £m
Non-Current Assets:					
Property, Plant And Equipment	804.1	793.3	(10.8)	804.0	(10.7)
Intangible Assets	10.8	24.3	13.5	7.0	17.4
Trade And Other Receivables	12.5	17.0	4.5	16.9	0.1
Total Non-Current Assets	827.5	834.7	7.2	827.8	6.9
Current Assets:					
Inventories	29.4	29.5	0.1	29.1	0.4
Trade And Other Receivables	72.3	95.5	23.3	98.4	(2.9)
Cash and Cash Equivalents	82.2	99.1	17.0	51.2	47.9
Non-Current Assets Held for Sale	0.0	0.0	0.0	0.0	0.0
Total Current Assets	183.8	224.2	40.3	178.7	45.4
Total Assets	1,011.3	1,058.8	47.5	1,006.5	52.3
Current Liabilities:					
NHS Trade Payables	(4.4)	(3.8)	0.6	(2.3)	(1.5)
Trade and Other Payables	(211.0)	(261.5)	(50.5)	(226.0)	(35.5)
Borrowing / DH Loans	(2.1)	(2.2)	(0.1)	(2.2)	(0.0)
Other Financial Liabilities - PFI	(21.8)	(23.2)	(1.4)	(23.1)	(0.1)
Provisions For Liabilities And Charges	(7.9)	(2.5)	5.4	(2.5)	0.0
Total Current Liabilities:	(247.2)	(293.2)	(46.0)	(256.1)	(37.1)
Net Current Assets/ (Liabilities)	(63.4)	(69.0)	(5.6)	(77.3)	8.3
Total Assets Less Current Liabilities	764.1	765.6	1.6	750.5	15.1
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)	(270.2)	8.5	(271.5)	1.3
Provisions For Liabilities And Charges	(10.0)	(9.0)	1.0	(9.0)	0.0
Total Non-Current Liabilities	(297.9)	(287.3)	10.5	(288.7)	1.3
Total Assets Employed	466.2	478.3	12.1	461.8	16.5
Financed By Taxpayers Equity					
Public Dividend Capital	641.8	661.6	19.8	655.2	6.4
Retained Earnings	(175.6)	(183.3)	(7.7)	(193.3)	10.0
Revaluation Reserve	0.0	0.0	0.0	0.0	0.0
Total Taxpayers Equity	466.2	478.3	12.1	461.8	16.5

Cash Flow Statement



February 2026

Executive Owner: Jenny Ehrhardt (Director of Finance)

Cash Flow	Closing 31st March 2025 £m	As at 28th Feb 2026 £m	Previous Month £m
<u>Operating Activities</u>			
EBITDA	112.1	73.2	56.2
Donated assets received credited to revenue but non cash	(7.3)	(5.5)	(5.3)
Interest paid	(14.6)	(12.9)	(11.8)
Dividend paid	(7.0)	(5.1)	(5.1)
Decrease/(increase) in inventories	(0.8)	(0.1)	0.3
Decrease/(increase) in trade and other receivables	13.9	(23.9)	(26.9)
(Decrease)/Increase in trade and other payables	(9.8)	50.4	19.1
(Decrease)/Increase in provisions	1.6	(6.4)	(6.4)
Net cash inflow/(outflow) from Operating Activities	88.2	69.6	20.0
<u>Cash Flows from Investing Activities</u>			
Interest received	4.6	5.0	4.6
(Payments) for property, plant and equipment	(79.4)	(57.0)	(50.5)
Proceeds from disposal of property, plant and equipment	0.2	0.2	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	5.5	5.3
PFI lifecycle prepayments (cash outflow)	(6.2)	(6.2)	(5.6)
Net cash outflow from Investing Activities	(75.9)	(52.5)	(46.0)
Net cash inflow before Financing	12.3	17.1	(26.0)
<u>Cash Flows from Financing Activities</u>			
Public dividend capital received	44.3	19.8	13.4
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)	(19.0)	(17.3)
Net cash inflow/(outflow) from Financing Activities	21.7	(0.2)	(4.9)
Increase/(decrease) in cash	34.0	17.0	(30.9)
Cash at the beginning of the year	48.2	82.2	82.2
Cash at the end of the financial period	82.2	99.1	51.2

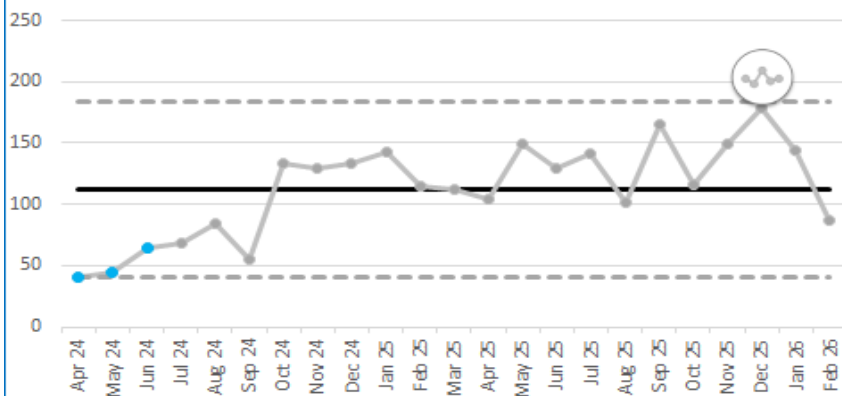
Supplementary Metrics Produced by Exception

Cancelled Ops

February 2026

Target-28-day breaches: 0
Performance – LMCO: 87
Performance – 28-day Standard: 33

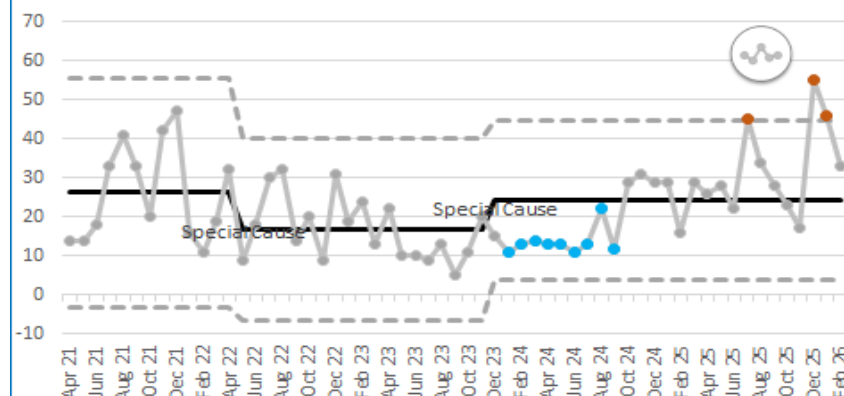
Last Minute Cancelled Ops



Executive Owner: Tim Hiles (Chief Operating Officer)

Variance: LMCO – Common cause variation.
28 day – Special cause of concerning nature

Cancelled Ops 28days



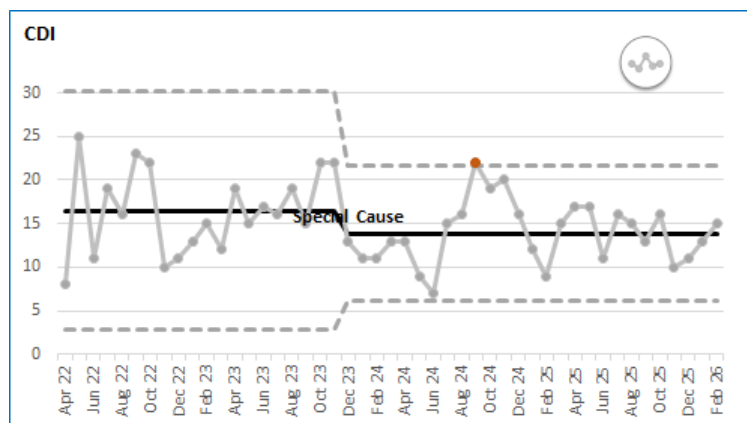
Background	Performance	Key Issues	Current Actions
Ensure all patients who have operations cancelled on the day of surgery, for non-clinical reasons are offered another binding date to be treated within a maximum of 28 days (zero tolerance standard)	Cancelled Operations 87 LMCO in February 2026 which is a decrease from 144 in January. Cancellation reasons: 'Ran out of theatre time' 45% of the total non-clinical LMCO on-the-day in February. Reduction in cancellations due to 'Ward bed capacity' in February 28 Day Breaches - There were 33 breaches of the 28-day standard in February 2026 which is a decrease from the 46 in January	Risk of increased numbers of LMCO and 28-day breaches during winter due to: - bed pressures - Increased NC2R patients in the bed base - higher number of cancellations on day - Increasing attendances and TCIs in ED - Industrial action (theatres)	- Improving bed occupancy positions are resulting in fewer recent cancellations for no bed - Earlier planning for February half term and Easter holidays this year than previous years 28-day breach numbers continue to be 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

February 2026

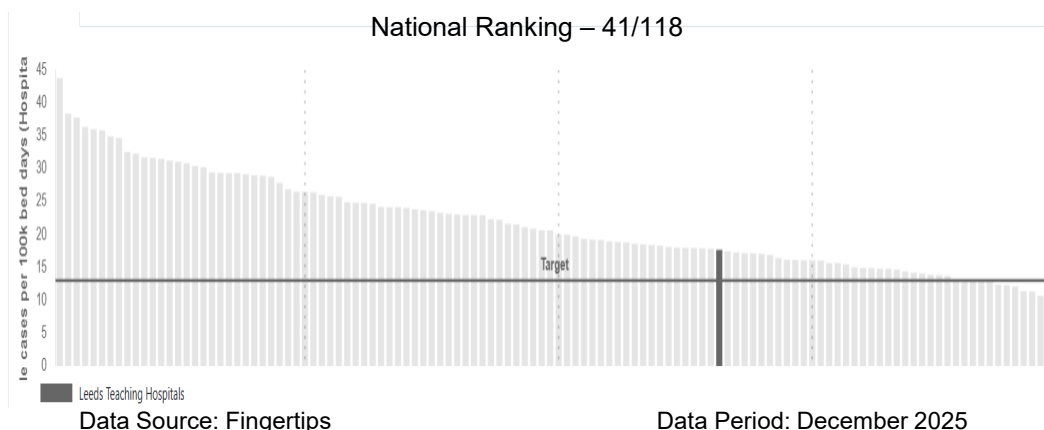
Target: 13
Performance: 15
YTD vs Threshold: 110%



Data as at 04/03/26

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

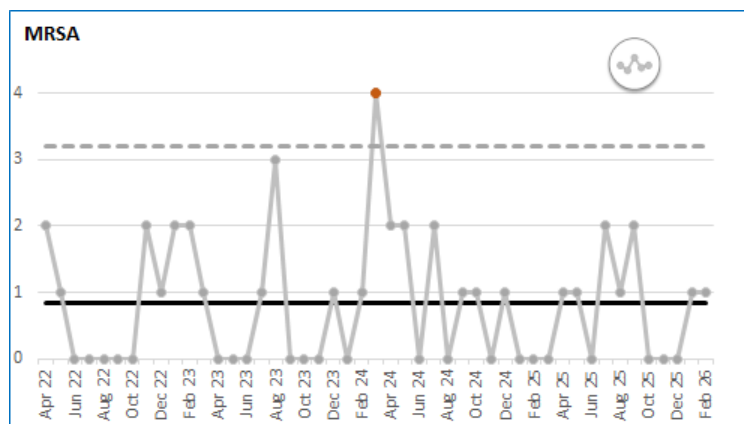
Data Period: December 2025

Background	Context	Action
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.	- The SPC chart demonstrates fluctuation around the mean; the number of cases for February 2026 is 15, which is above the threshold for the month. - National comparator Hospital Onset data from December shows LTHT's position remaining in the third quartile ranked 41st out of 118 NHS Trusts, which is an improvement from our previous position of 50.	- Renewed attention on decluttering the bed space and clinical area to promote effective cleaning. - Focus on Hands Ready. - Antimicrobial stewardship – monitoring of #CARES improvement through monthly HCAI production board slides

MRSA

February 2026

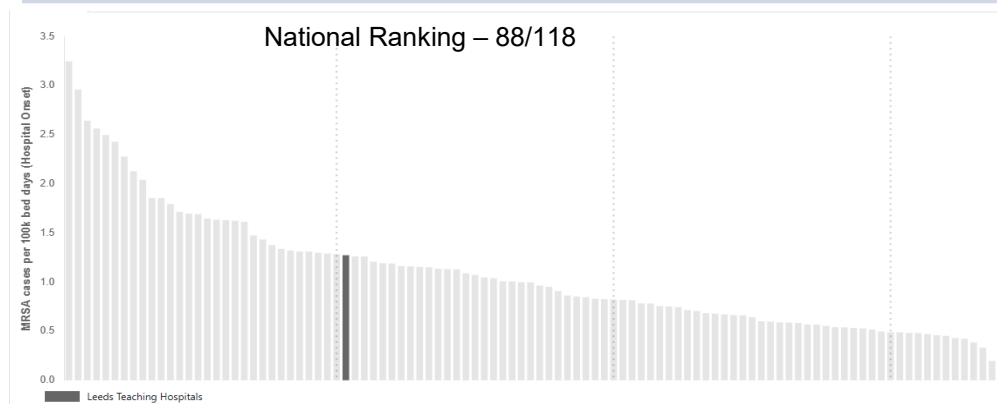
Target: 0
Performance: 1



Data as at 04/03/26

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

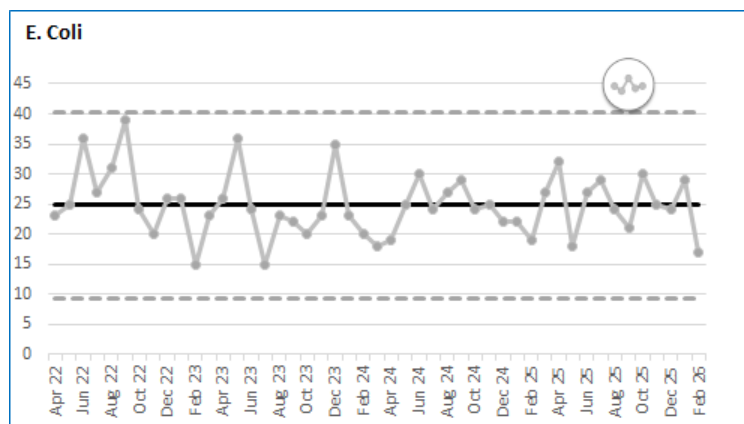
Data Period: December 2025

Background	Context	Action
There is a National 'zero tolerance' approach to MRSA bloodstream infections.	- The SPC chart shows LTHT has recorded 1 case in February 2026 against a zero-tolerance approach. - National comparator Hospital Onset data from December shows LTHT's position has moved to within the second quartile of the table and is ranked 88th out of 118 NHS Trusts. This is an improvement from the previous position of 92.	- Trust wide 'Scrub away MSSA' campaign delivered during February focusing on Hands, devices and decolonisation - MRSA Risk Factor data, Diabetes Mellitus, Skin Disease, Wounds, and Prior MRSA/MSSA colonisation, shared with CSU's to be utilised in patient specific actions. - Trust Vascular Access Device Safety (VADS) group prioritising support for introduction of:

E. Coli

February 2026

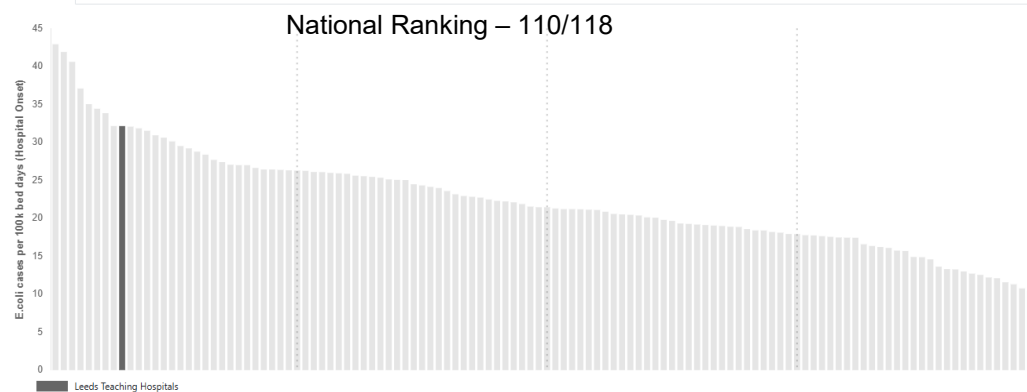
Target: 21
Performance: 17
YTD vs Threshold: 119%



Data as at 04/03/26

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: December 2025

Background	Context	Action
The Trust HCAI thresholds for <i>Clostridioides difficile</i> infection (CDI), Methicillin Resistant <i>Staphylococcus aureus</i> (MRSA) and Gram-negative bloodstream infections (GNBSI) are determined nationally from NHSE and form part of the NHS Standard Contract. Publication occurred on June 9, 2025, and shared across the organisation.	- The SPC chart shows a sharp decrease in cases below the mean. The number of E. coli cases for February 2026 is 17, which is below the threshold of 21. - National comparator Hospital onset data from December shows LHT's position remaining within the first quartile of the table and is ranked 110th out of 118 NHS Trusts, a slight deterioration on the previously recorded position of 105.	- 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. - The Trust wide task and finish group has completed the review of ANTT training and proposed the standardised ANTT training package. Funding needs to be established.

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 Mutual 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