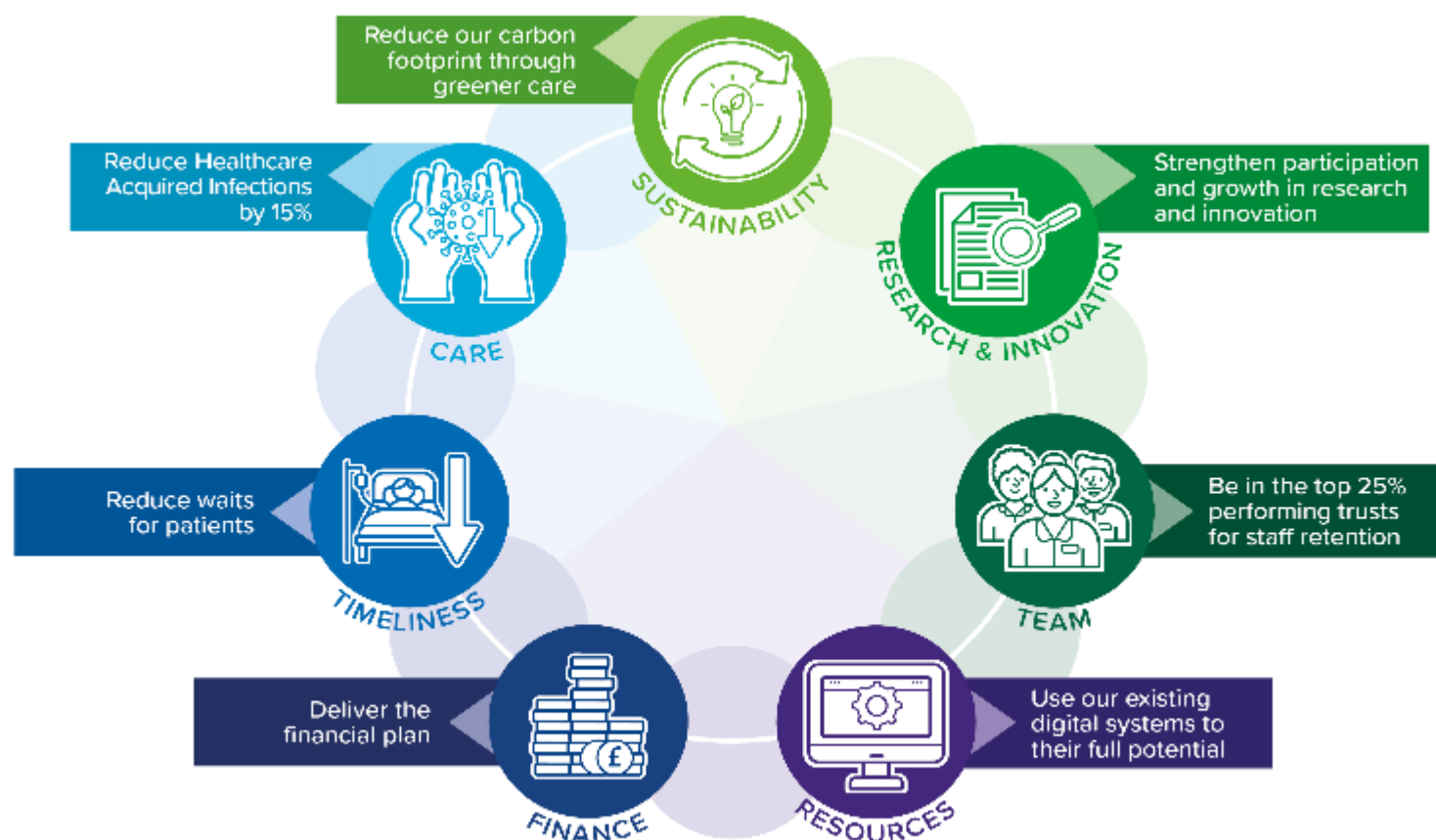


Integrated Quality & Performance Report

May 2024

C7 Commitments




































Summary - Performance

KPI	Latest month	Performance	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
AE Attendances per day	Apr 24	985.4	-			927.3	796.6	1058.1
Ambulance Handovers <15mins LGI	Apr 24	00:16:39	00:15:00			00:12:56	00:10:35	00:15:17
Ambulance Handovers <15mins SJUH	Apr 24	00:21:40	00:15:00			00:17:10	00:13:43	00:20:37
Last Minute Cancelled Ops	Apr 24	38	-			47	26	67
Cancelled Ops 28days	Apr 24	13	-			14	0	28
Cancer 28day FSD	Mar 24	75.4%	75.0%			72.8%	65.2%	80.3%
Cancer 31day	Mar 24	87.0%	96.0%			88.9%	83.6%	94.2%
Cancer 62 day	Mar 24	64.6%	85.0%			52.5%	37.4%	67.7%
Diagnostics	Apr 24	95.9%	95.0%			94.0%	91.9%	96.1%
DNA Rate	Apr 24	7.30%	-			7.60%	6.57%	8.63%
Outpatient DNA Volumes	Apr 24	8046	-			8752	6437	11068
ECS Monthly	Apr 24	77.4%	78.0%			74.1%	68.6%	79.7%
Elective LoS	Apr 24	4.4	-			4.1	3.1	5.1
Elective Readmissions	Apr 24	3.44%	-			3.59%	2.92%	4.27%
Non-Elective LoS	Apr 24	7.3	-			7.5	6.7	8.3
Non- Elective Readmissions	Apr 24	10.30%	-			10.73%	9.02%	12.45%
OPFU3months	Apr 24	36142	-			36435	34330	38541
RTT Performance	Apr 24	63.4%	92.0%			62.8%	60.8%	64.8%
RTT Total Waiting list	Apr 24	91034	-			92607	90868	94347
RTT 65 Week Breach Backlog	Apr 24	412	0			942	634	1250
RTT 78Week Breach Backlog	Apr 24	10	0			101	-15	217



Summary

KPI	Latest month	Performance	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
VTE	Mar 24	95.8%	95.0%			96.7%	96.0%	97.4%
CDI	Apr 24	13	-			16	3	28
MRSA	Apr 24	2	-			1	-2	3
E. Coli	Apr 24	19	-			25	7	42
Pseudomonas	Apr 24	1	-			3	-3	10
Klebsiellalla	Apr 24	9	-			11	1	21
Patient Level Metrics Score	Apr 24	94.3%	90.0%			94.0%	93.2%	94.7%
Environment Level Metrics Score	Apr 24	91.5%	90.0%			94.1%	92.0%	96.1%
Falls	Apr 24	203	-			197	163	230
Falls Rate per 1000 Bed Days	Apr 24	3.64	-			3.35	3.02	3.67
Developed Pressure Ulcers	Apr 24	84	-			75	30	120
Developed Pressure Ulcer Rate	Apr 24	1.51	-			1.32	0.55	2.08
Admitted with Pressure Ulcers	Apr 24	311	-			344	264	423
Admitted with Pressure Ulcers Rate	Apr 24	5.60	-			6.22	4.78	7.67
2222 Calls	Apr 24	56	-			57	35	80
Cardiac Arrest Calls	Apr 24	17	-			17	3	30
SHMI	Apr 24	111.3	100.0			112.2	110.9	113.6
Still Births	Mar 24	4.73	5.20			3.74	3.05	4.43
Rolling Extended Perinatal mortality rate (all NND)	Mar 24	10.86	-			10.60	9.43	11.76
Number of MNSI Referrals	Mar 24	2	-			1	-1	4
% Complaint Responses Sent Within Target Times (LR1 let	Mar 24	45.2%	80.0%			31.9%	9.8%	54.0%
% CSU Draft Comments Received Within Target Times (LR	Mar 24	53.8%	80.0%			40.2%	19.5%	60.9%
Response Lead Time (Hours)	Mar 24	00:00:00	-			00:00:00	19:14:30	04:45:30
Defect Rate	Jan 24	9.38%	15.00%			9.39%	#N/A	#N/A
PALS Concerns - % Patients contacted in 2 w/days	Mar 24	87.6%	80.0%			81.6%	77.3%	85.8%



Core Metrics

Measure	Commitment	Reporting Period	Performance	Target	Variance	Assurance
Rolling Overall Sickness Rate	Deliver the Financial Plan	Mar-24	5.17%	5.70%		
Rolling Voluntary Turnover Rate	Retention	Mar-24	6.46%	10.00%		
In-Month Agency Spend (as % of total pay bill)	Deliver the Financial Plan	Mar-24	1.10%	3.70%		
In-Month Vacancy Percentage	Retention	Mar-24	5.01%	N/A		
In-Month Mandatory Training Compliance Rate	Retention	Mar-24	86.09%	80.00%		
Quarterly Pulse Survey Engagement Score	Retention	Jan-24	6.7428	7		
<i>Annual Staff Survey</i>						
Annual Staff Survey Engagement Score	Retention	23/24	7	7		
Annual Staff Survey Response Rate	Retention	23/24	55.00%	65%		
Annual Response - Unlikely to look for a new job in the next 12 months	Retention	23/24	55.22%	Statistically Significant Improvement		Achieved
Annual Response - Satisfied with opportunities for flexible working patterns	Retention	23/24	58.21%	Statistically Significant Improvement		Achieved



Core Metrics

Ambulance Handover

Reduce waits
for patients



April 2024

Target: <15mins

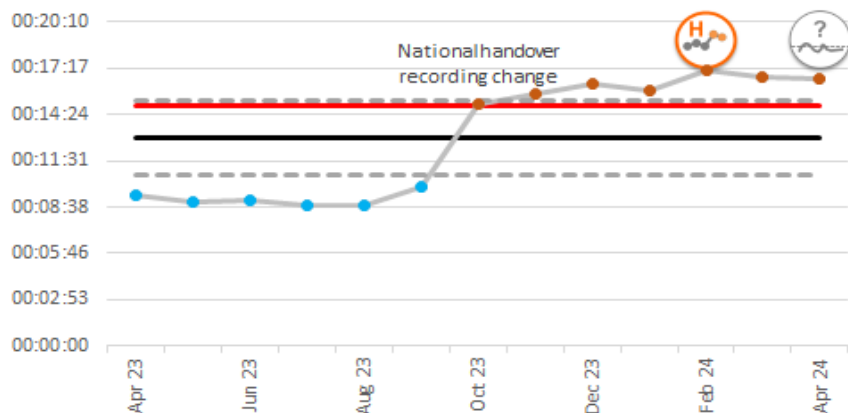
Performance – LGI : 00:16:39

Performance – SJUH : 00:21:40

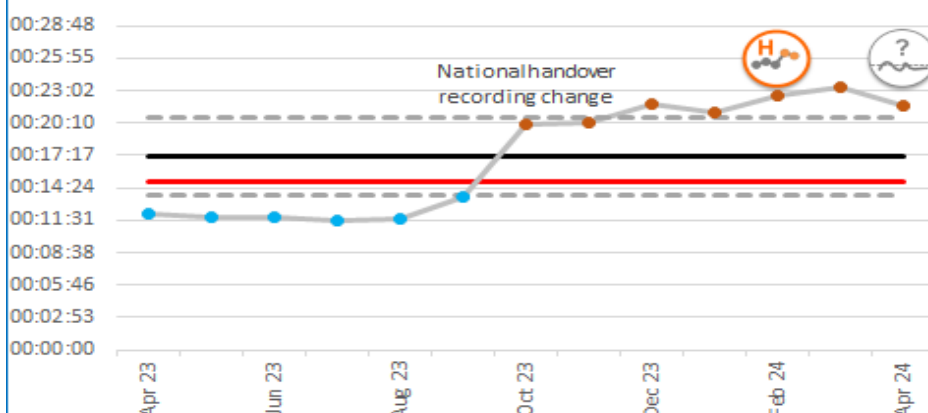
Executive Owner: Clare Smith (Chief Operating Officer)

Variance: Special cause variation.

Ambulance Handovers <15mins LGI



Ambulance Handovers <15mins SJUH



Background	Context	Action
<p>Background / target description:</p> <ul style="list-style-type: none"> 100% of all handovers should take place within 15 minutes 	<ul style="list-style-type: none"> Increase in recorded ambulance handover times due to reporting changes made in October 2023. This has added 5-8 minutes onto LTHT handover times LGI – In April 2024 there were 1116 handovers over 15 minutes (42.9%). Average handover time at LGI was 16:39 minutes SJUH- In April 2024 there were 1915 handovers greater than 15 minutes (68.7%). Average handover time at SJUH was 21:40 minutes Out of 183 hospitals LGI placed 21st in the country and SJUH placed 77th for ambulance handover for March 24 (latest data available). In April, 55 unvalidated 1-hour breaches were reported by YAS. When validated in partnership with YAS, all breaches were not correct. LTHT validate data submitted by YAS to NHS England and often contains data quality inaccuracies. Handover data is managed by YAS and submitted directly to NHSE 	<ul style="list-style-type: none"> Continued sharing of delivery and best practice at the WYAAT UEC group where YAS are present. Data quality challenges continue to be escalated at this forum. Band 7 nurse lead assigned per site to focus on barriers to achieving handover within 15 minutes Separate action plans being developed by site, led by matron, due to different challenges Escalation plan for YAS assessment nurse developed to avoid long delays and circulated Relaunch of the LTHT/YAS meetings with new attendees and focus on improving the patient journey Shared learning and feedback from the ambulance handover perfect week with further feedback to be shared All handovers over 1 hour are now validated with YAS

Emergency Care Standard

Reduce waits
for patients

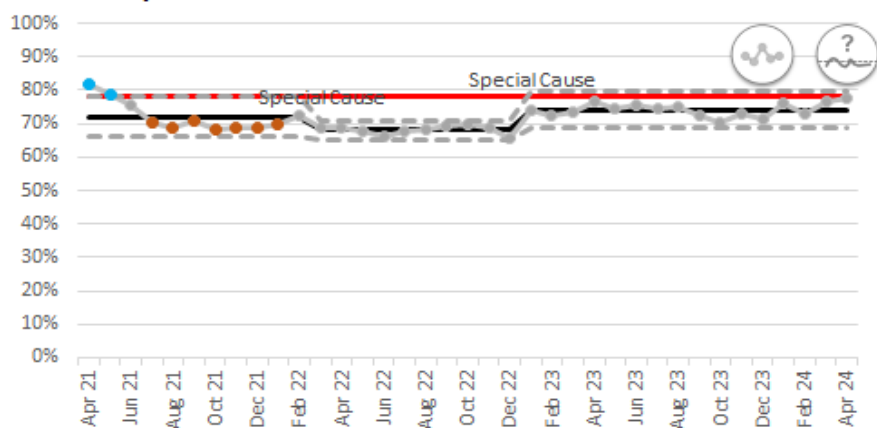


April 2024

National Planning Priority Target 2024/25: 78%

Performance: 77.4%

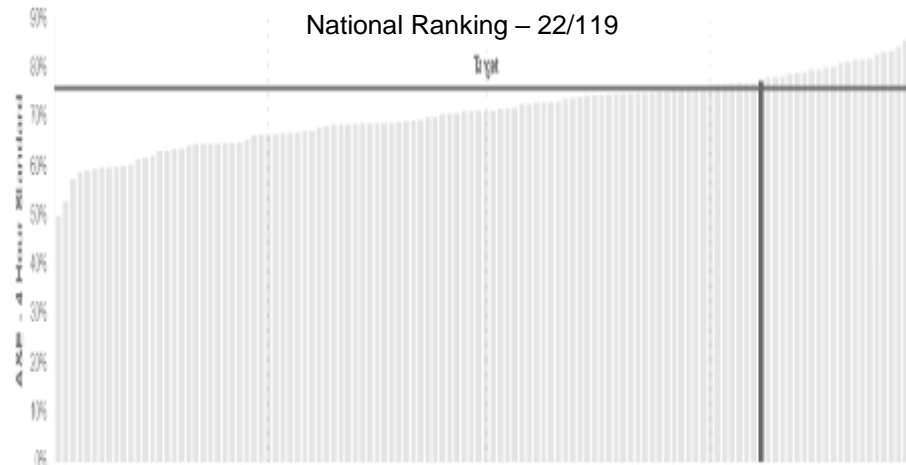
ECS Monthly



Executive Owner: Clare Smith (Chief Operating Officer)

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

National Ranking – 22/119



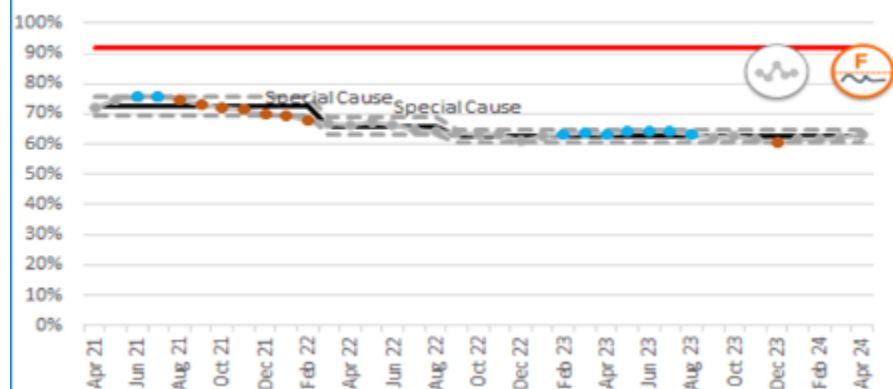
Background	Context	Action
<ul style="list-style-type: none"> The constitutional standard is 95% of attendees to A&E are admitted, transferred or discharged in 4 hours 2024/25 national planning recovery requirement is to deliver 78% by March 2025 	<ul style="list-style-type: none"> ECS delivery for April 2024 was 77.4% LTHT ranked 22 out of 119 Trusts for ECS performance in April 2024 Attendances across all sites in April 2024 increased by 11.3% compared to April 2023 	<ul style="list-style-type: none"> An extended observation unit has opened at SJUH enabling ongoing observations or patients awaiting results (where appropriate) to wait in an area outside the main A&E footprint. A review of this assessment footprint and where it is best located to support more patients alongside a review of the daily numbers of patients able to use this area and breaches saved is underway The minor injury service has returned to SJUH A&E supporting ECS for SJUH site and currently supports 14.4 patients per day. With 99.8% ECS for this patient group. Focus on daily management to reduce 4-hour breaches in real time and ensure data quality through validation continues A trajectory has been created to support delivery of 78% ECS by March 25 with a supporting action plan in line with the 2024/25 Priorities and Operational Planning Guidance A 6-month review of the med /elderly SDEC is planned to take place alongside an



April 2024

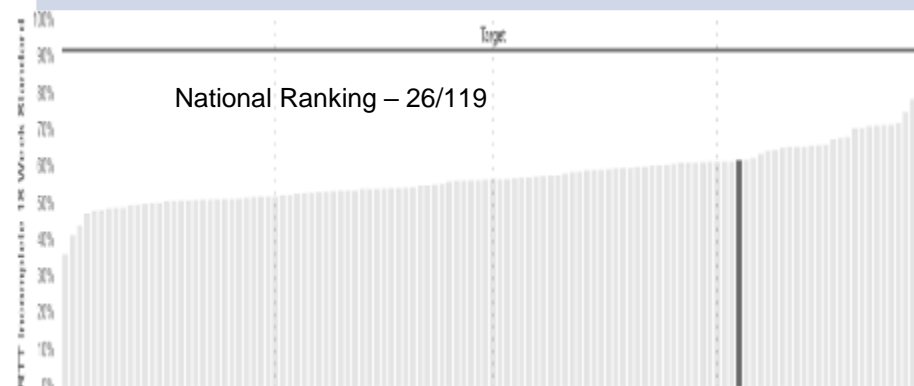
Target: 92%
Performance: 63.4%

RTT Performance



Executive Owner: Clare Smith (Chief Operating Officer)

Variance: Common cause variation. The process will not achieve the target



Background	Context	Action
<ul style="list-style-type: none"> Ensure 92% of patients are treated within 18 weeks of referral Reduce maximum waiting times to below 65 weeks by end of September 2024 	<ul style="list-style-type: none"> RTT delivered at 63.4% for April 2024, an improvement of 1.4% on March 2024. The number of over 18 week waiting patients has decreased for the fourth consecutive month, with an April 2024 total of 33,285. The total waiting list size has seen a decrease of 906 patients, going from 91,937 in March 2024, to 91,031 in April 2024. April 2024 saw a further reduction of 3 patients over 78 weeks, with 10 patients still waiting over 78 weeks at month end. We have improved with regards to national ranking, going from 30th to 26th best performing. 	<ul style="list-style-type: none"> Regular meetings with CSUs and COO and actions identified to support reduction in 65 week waits Weekly Planned Care Production Board reviewed at Service Delivery to monitor performance with follow up actions by DOPs with CSUs E-outcomes progresses and will support with the management of patient's RTT pathways, reducing delays in outpatient clinic cash up and errors. Review of our advice & guidance processes to avoid unnecessary outpatient activity and provide capacity for patients requiring review. In-depth manual validation of RTT pathways for our long waiting patients to ensure accuracy and progression to treatment Continuing use of mutual aid from WYAAT providers The performance team continue to support CSUs with queries on patient choice (C Coding), unfit patients and have delivered training and guidance via 'Report Support' sessions and implementation of robust Standard Operating Procedures.

RTT 65 Weeks

Reduce waits
for patients



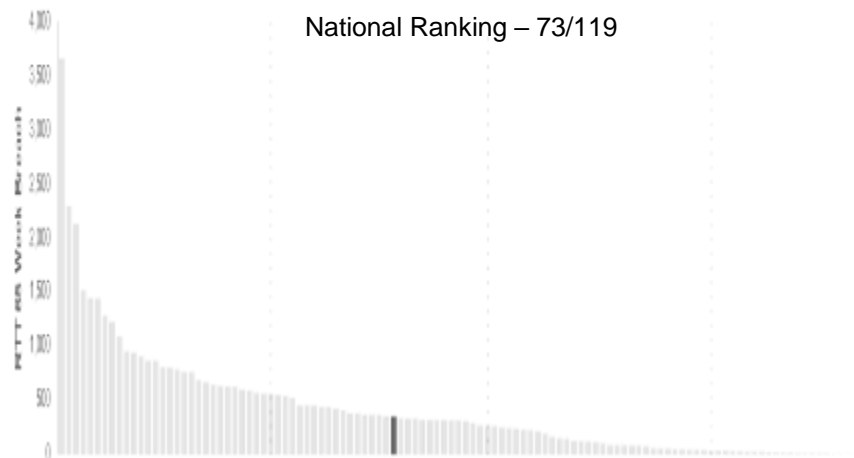
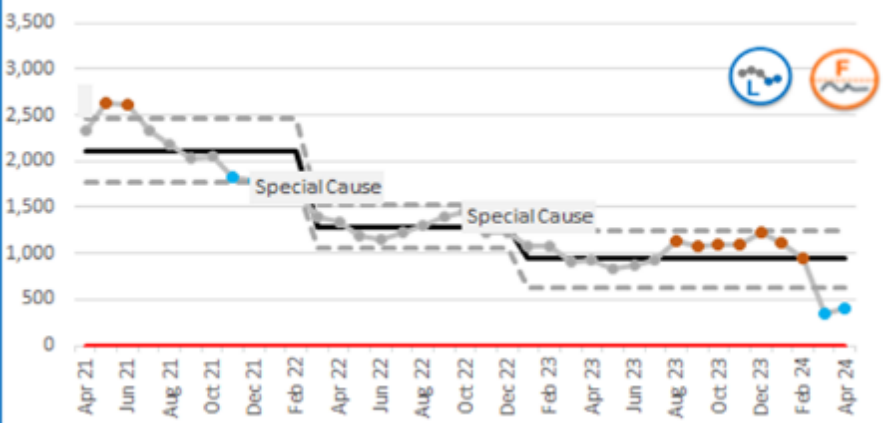
April 2024

National Planning Priority Target 2024/25: 0
Performance: 392

Executive Owner: Clare Smith (Chief Operating Officer)

Variance: Common cause variation. The process will not achieve the target

RTT 65 Week Breach Backlog



Background	Context	Action
<ul style="list-style-type: none"> Reduce maximum waiting times to below 65 weeks by September 2024 	<ul style="list-style-type: none"> April 24 reported 392 patients waiting 65 weeks, which is 44 more than March 2023. 65 weeks highest point was in May 2021 when at 2,618. Planning guidance for 2024/25 has set a target for Trusts to eliminate any remaining waits above 65 weeks by September 2024. The trust has 6,521 patients to treat before September 2024. 	<ul style="list-style-type: none"> Weekly Production Board being used to monitor delivery Clearance trajectories for 65 week waiting patients agreed with CSUs. Frequent 65-week meetings with CSUs, DOP and a clear escalation process with the Deputy COO and COO as required. Continued use of mutual aid from WYAAT providers In-depth manual validation of long waiting patients on RTT pathways to ensure accurate reporting and progress treatment. The Trust has been stepped down from of Tier 2 for elective care but continues to do patient level reviews weekly to progress care. Reallocation of theatre capacity to support dating of long-waiting patients.

Cancer 28 Day Faster Diagnostic

Reduce waits
for patients

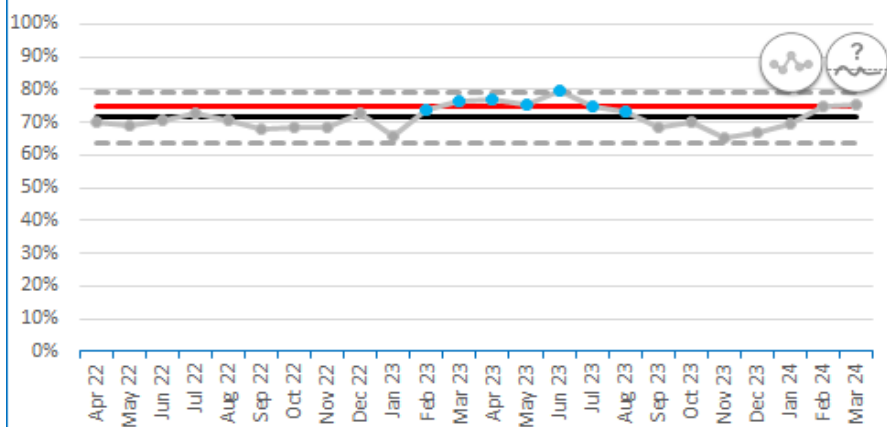


March 2024

Target: 75%

Performance: 75.4%

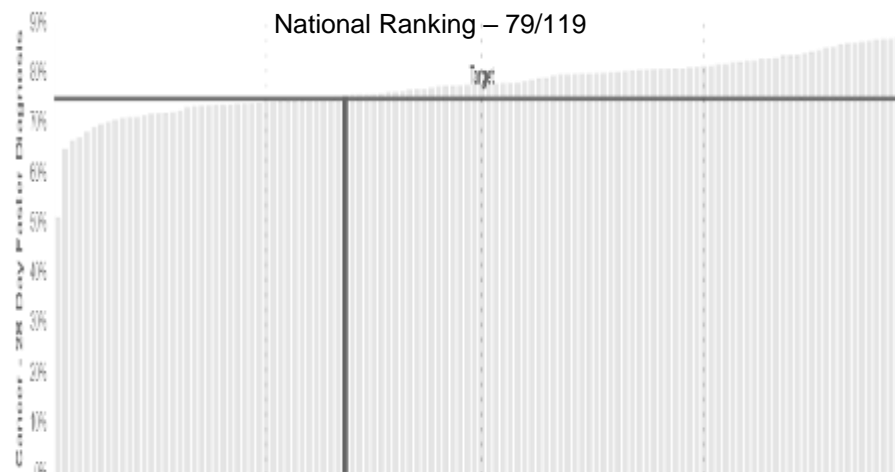
Cancer 28day FSD



Executive Owner: Clare Smith (Chief Operating Officer)

Variance: Common cause variation.

National Ranking – 79/119



Background

- Patients should not wait more than 28 days from referral to finding out whether they have cancer or not
- The current target is for 75% of patients to find out within 28 days by March 2024 and by March 2025 this increases to 77%

Context

- Delivery of the 28-day Faster Diagnosis Standard has maintained the improvement since the start of 2024
- In March 2024 the delivery was 75.4%, an improvement on the February position of 74.7%, and achieving the national target of 75%

Action

- There was improvement across all tumour groups for this CWT standard, although work is still ongoing to maintain this level of achievement
- The Skin performance is still not quite at 75%, and with 939 of the 3710 patients informed about their diagnosis after 28 days, the Dermatology team have put plans in place to reduce triage to less than a week consistently. Gynae and H&N also have plans to improve and maintain how they inform patients by reviewing their OPA and diagnostic procedures at this appointment
- Focus is still required on correct recording of the outcomes of discussions with patients, as well as ensuring they are informed as soon as possible by alternative methods than face-to-face OPA's if necessary

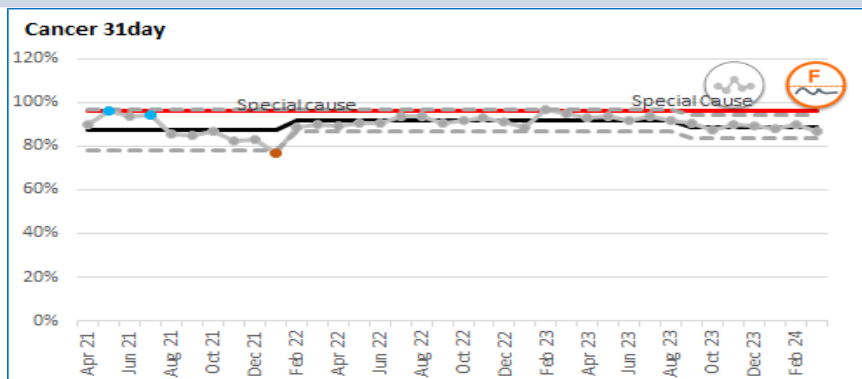
Cancer 31 day

Reduce waits
for patients



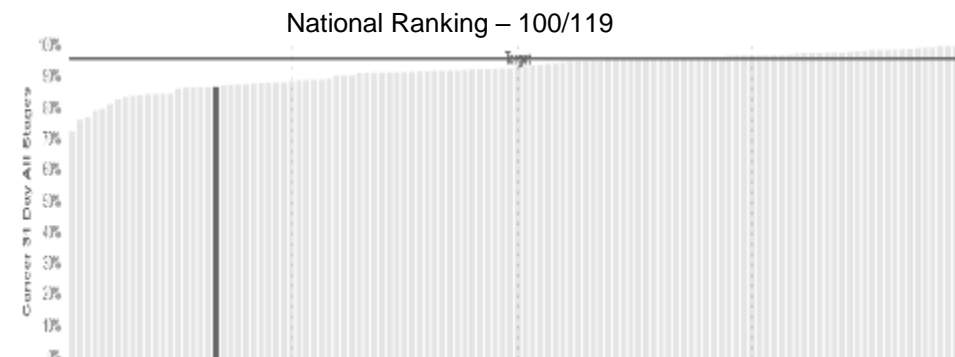
March 2024

Target: 96%
Performance: 86.8%



Executive Owner: Clare Smith (Chief Operating Officer)

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



Background	Context	Action
<ul style="list-style-type: none"> 96% of patients should receive their first definitive treatment (FDT) within 31 days This includes patients receiving first and subsequent Cancer treatments 	<ul style="list-style-type: none"> All patients receiving chemotherapy are treated within 31 Day from decision to treat 86.8% of patients receiving first treatments in March were treated within 31 days. This includes a higher percentage of patients receiving Radiotherapy as a Cat A priority than subsequent treatments, but those who are Cat B or lower priority are unlikely to be seen within 62 Days from referral Patients waiting for subsequent treatments in both Radiotherapy and Surgery will have a longer wait <ul style="list-style-type: none"> 83.8% of subsequent treatments in RT are seen in 31 days, usually Cat B or lower 83.5% of subsequent surgical treatments are seen within 31 days, predominantly longest for Melanoma treatments 	<ul style="list-style-type: none"> Melanoma treatments, both new and subs, are more likely to have a longer wait for surgical treatments with only 55.1% of patients treated in March being seen within 31 days. An SBAR and request for additional short term capacity at Westcliffe has been submitted whilst the internal capacity gap can be resolved Radiotherapy continue to cover gaps in staffing and to ensure that the most urgent treatments (Cat A) are seen within 31 days – waits for lower priority treatments are longer than 31 days. Options paper is being developed on recovery plans. This will also outline a trajectory for improvement. AMS are reviewing the Prostate pathway with Oncology to ensure that Cat B patients get appropriate alternative treatments where possible.

Cancer 62 Days

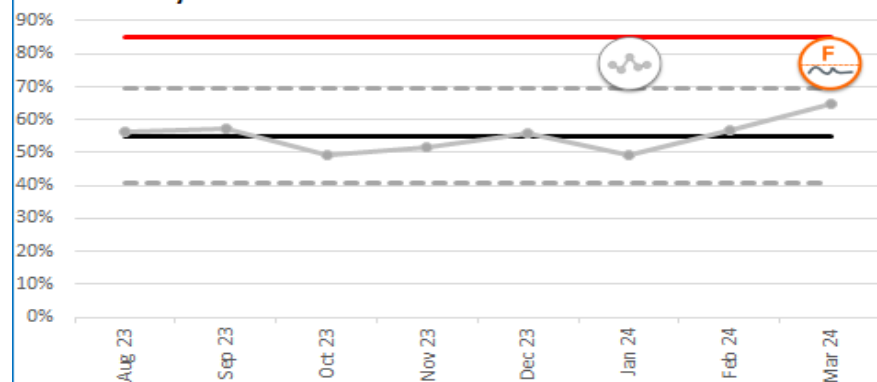
Reduce waits
for patients



March 2024

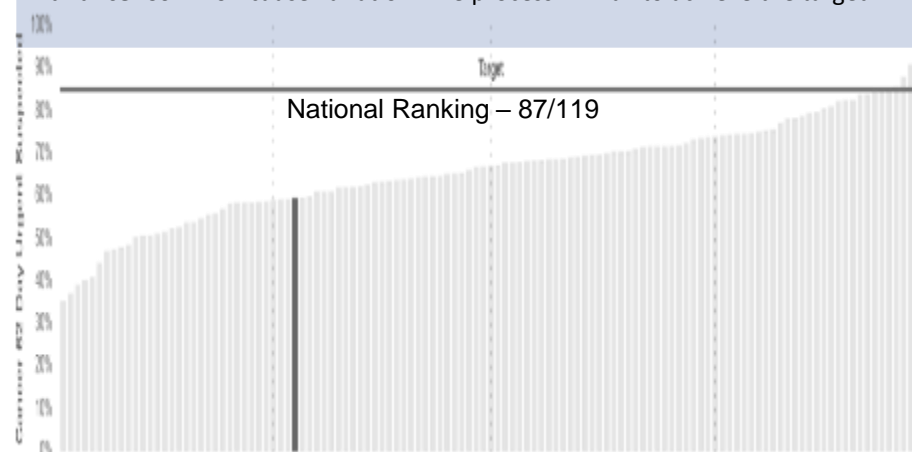
Target: 85%
Performance: 64.6%

Cancer 62 day



Executive Owner: Clare Smith (Chief Operating Officer)

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



Background	Context	Action
<ul style="list-style-type: none"> 85% of patients receive their first definitive treatment for cancer within 62 days of a referral for suspected cancer By March 2024 the plan is to deliver 69% 62-day backlog for 2023/24 planning guidance is to reduce to 274 by March 2024 	<ul style="list-style-type: none"> 292 of 450.5 patients with cancer were treated within 62 days in March, an improvement from 56.8% in February. This includes all GP referrals, screening and upgrades The backlog at the end of March was 276, an improvement from 458 at the end of February, with significant work across all CSU's contributing to this year end position. 	<ul style="list-style-type: none"> Recruitment is underway to improve internal capacity that supports the skin pathway which continues to be supported by the use of Westcliffe until this is completed. Workforce reviews are also being used to ensure that staff currently available deliver the best value support to the pathway 62 Day Escalation meetings have identified bottlenecks in a number of cancer pathways and has prompted work to improve flow in these areas. This work is supported by project managers working in all the large tumour groups. A key objective is consistent improvement which will improve timeliness of care across the organisation Radiology and Pathology are liaising with individual CSU's to determine how patients can be prioritised and timely reports provided The complex diagnostics within the Lung Pathway are being reviewed to determine which tests could be performed at earlier stages in the pathway, supported by the clinical leads Improving waits for MDT's are being explored with support from Pathology

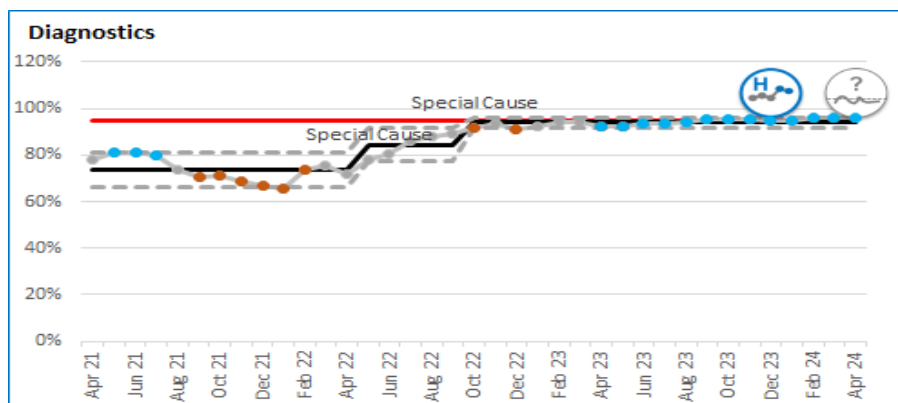
Diagnostic Waits

Reduce waits
for patients



April 2024

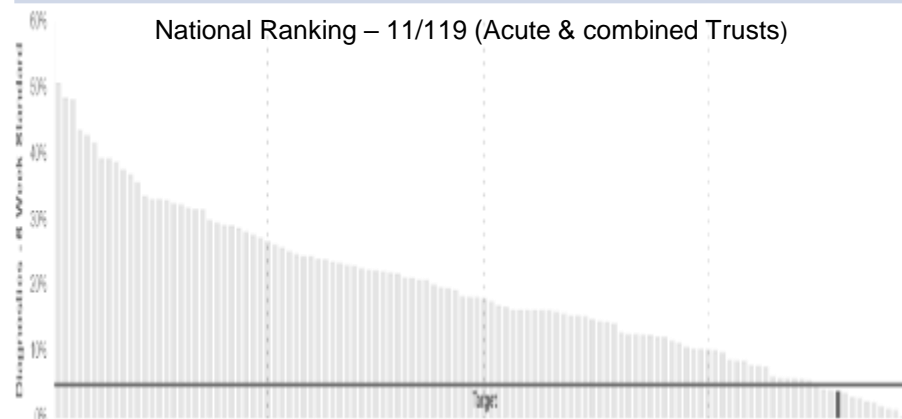
Target: 95%
Performance: 95.9%



Executive Owner: Clare Smith (Chief Operating Officer)

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

National Ranking – 11/119 (Acute & combined Trusts)



Background	Context	Action
<ul style="list-style-type: none"> 99% of patients wait no more than 6 weeks for a routine diagnostic test 2023/24 National Planning priority is to deliver 95% by March 2025 	<ul style="list-style-type: none"> CT & MRI have continued to see increased demand with delays for Paediatric GA MRI and shortfalls in capacity for Cardiac CT Ultrasound experiencing waits above 6 weeks due to staffing pressures and capacity shortfalls for some specific body site scans Children's diagnostic services (colonoscopy, cystoscopy and gastroscopy) are heavily reliant on theatre capacity due to patients requiring GA for their diagnostic test Capacity shortfalls in Paediatric Audiology have resulted in increased 6-week breaches April 2024 diagnostic performance position is in line with March, the highest recorded for LTHT since February 2020 LTHT national ranking 11 out of 119 Trusts for Diagnostics performance in March 2024 	<ul style="list-style-type: none"> CT – options being reviewed to increase capacity for Cardiac CT which is the main cause of > 6ww breaches. Mid-Yorkshire NHS Trust to start Cardiac CT service which will reduce referral volumes – it is expected that this service will commence in June 2024 Ultrasound – some capacity challenges for specialist areas. Ongoing work to mitigate staffing shortfalls and deliver required service Pioneer weekend sessions and internal consultant weekend lists to support paediatric diagnostics during March/April 2024 have seen a reduction in waits over 13 weeks, however further capacity will be required to continue to reduce long waits Paediatric Audiology focus on reducing overdue follow-up waits has some short-term impact on 6-week diagnostic capacity. There will be some recovery seen in coming months as new staff are trained

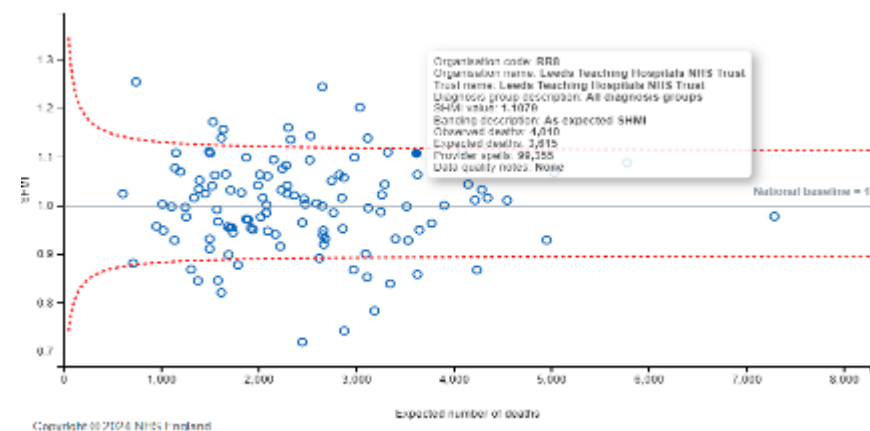
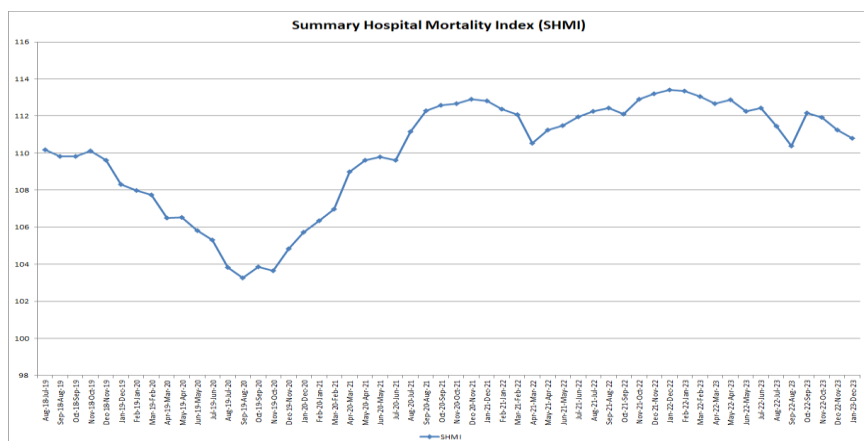
Mortality

Jan 23 – Dec 23

Target: 100
Performance – SHMI: 110.79

Executive Owner: Dr Magnus Harrison (Chief Medical Officer)

Variance: Common cause variation.



Background

- 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.

Context

- The Trust SHMI for January 2023 – December 2023 was 110.79 and “As Expected”.
- It is the second lowest SHMI value since October 2022’s publication.

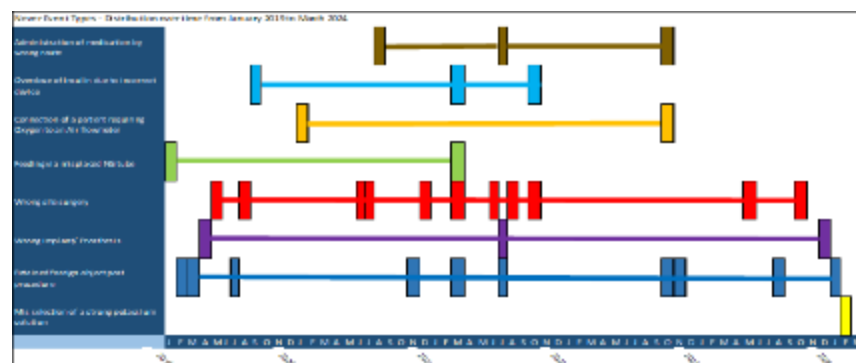
Action

- 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 (SJ) methodology is used to identify learning and provide assurance on quality of care.

Never Events

Q4 (2023/24)

Target: 0
Performance : 6 (YTD)



Executive Owner: Dr Magnus Harrison (Chief Medical Officer)

Variance: Common cause variation.

Never events by Type April 2022 to present by financial quarter

	Q1 22-23	Q2 22-23	Q3 22-23	Q4 22-23	Q1 23-24	Q2 23-24	Q3 23-24	Q4 23-24	Total
Administration of medication by the wrong route	0	0	1	0	0	0	0	0	1
Connection of a patient requiring Oxygen to an Air flowmeter	0	0	1	0	0	0	0	0	1
Wrong site surgery	0	0	0	0	1	0	1	0	2
Wrong implant/ Prosthesis	0	0	0	0	0	0	1	0	1
Retained foreign object post-procedure	0	0	2	0	0	1	0	1	4
Mis-selection of a strong potassium solution	0	0	0	0	0	0	0	1	1
Total	0	0	4	0	1	1	2	2	10

Background

- 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

Context

The number of Never Event incidents are reported to our commissioners each quarter via the national Strategic Information System (StEIS) and notified to the ICB .
The chart shows that there have were four Never Events in 2022/23.
There have been Six Never Events reported this financial year (April 23-March 24):

- Wrong Site Surgery in Quarter 1.
- Retained Foreign Object Post Procedure in Quarters 2 and 4.
- Wrong Site Surgery in Quarter 3.
- Wrong implant/ prosthesis in Quarter 3.
- Mis-Selection of Strong Potassium solution in Quarter 4.

Action

All Never Event incidents are subject to a Patient Safety Incident Investigation (PSII). Investigations for two of the incidents this financial year are currently under investigation. One investigation (from Q2) has been completed. Learning from Never Events are subject to review at the WYAAT shared learning group chaired by LTHT.



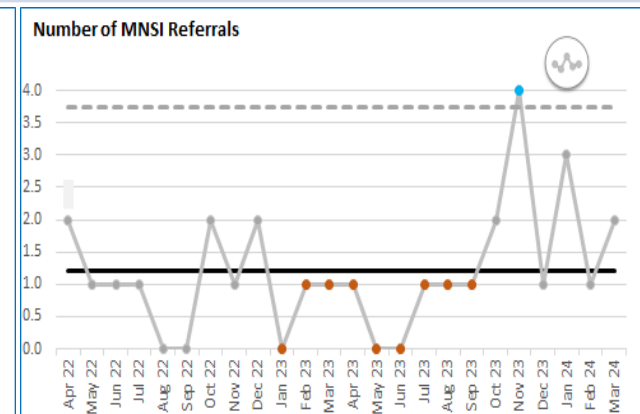
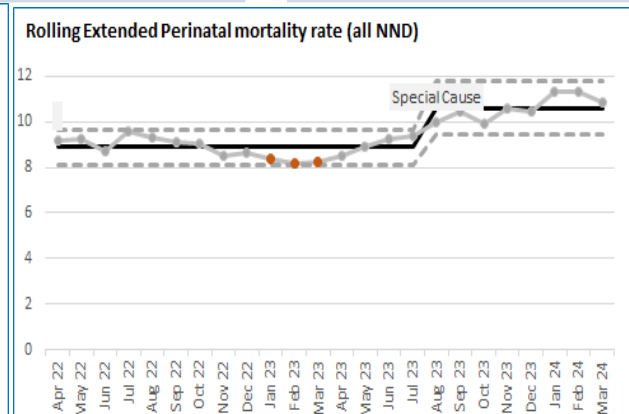
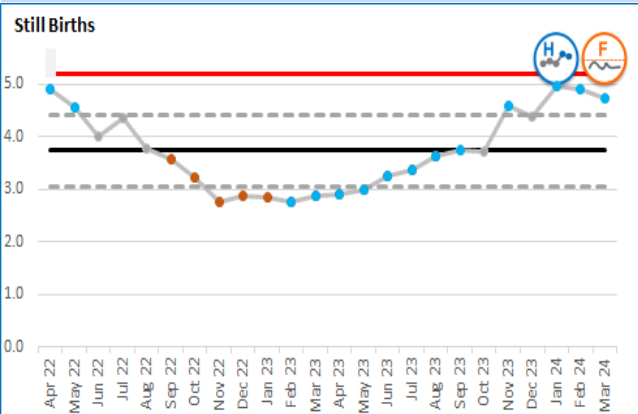
Maternity

March 2024

Still Birth Rate: 4.73
Extended Perinatal Mortality Rate: 10.9
Number of MNSI Referrals: 2

Executive Owner: Rabina Tindal (Chief Nurse)

Variance: Common cause variation.



Background

Context

Action

- These charts show the rolling stillbirth and the rolling extended perinatal death rate per 1000 births.
- The MBRRACE definitions below are used for mortality:
- 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.
- The monthly referrals to MNSI are graphically represented.

- 3 x stillbirths during March 2024:**
- 1 had all antenatal care outside of LTHT until 34 weeks. Attended LTHT with reduced fetal movements and intrauterine death confirmed on admission.
- 1 attended at Term with meconium and contracting and intrauterine death confirmed on admission.
- 1 intrauterine death mid trimester who was born with live twin at Term.
- 2 inborn neonatal deaths:**
- 1 associated with extreme prematurity and 1 with severe congenital cardiac anomalies.
- 1 outborn neonatal death:**
- Associated with extreme prematurity
- MNSI referrals**
- Active cooling and stillbirth as above admitted with uterine activity
- LTHT is a tertiary unit and receives referrals for complex congenital abnormalities some of which have an impact on expected survival rates.

- 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.
- Use appreciative enquiry to review the findings of the reviews and use outputs to inform service improvements.
- Continue to work with MNSI to review themes and learning.
- Review MNSI referrals within WY&H LMNS to identify opportunities for shared learning.
- Continue to review perinatal mortality through a health equity lens.

Sickness Absence Rate

March 2024

Target: 5.7%
Performance: 5.17%

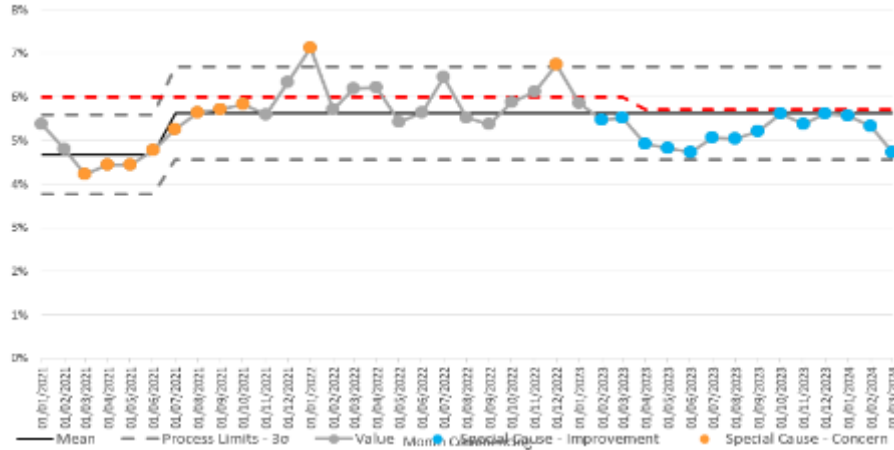
Variance: Common cause variation. The process will regularly achieve the target

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

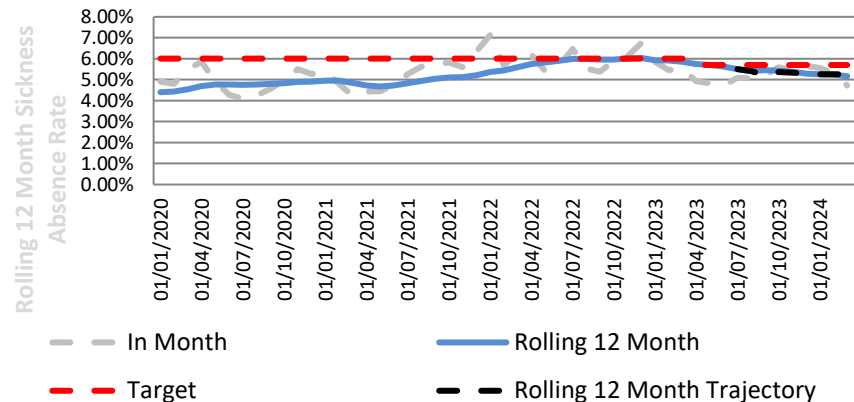
Management/Clinical Owner: Chris Carvey

Sub-Groups: Workforce Committee

In-Month All Sickness Absence: Trust



Sickness Absence Projection



Background	What the chart tells us	Issues	Actions	Context
<p>In April 2023 we assumed that we will see lower COVID related sickness absence throughout the 2023/24 financial year compared to the previous 2 financial years.</p> <p>As a result of the actions of the Operational HR team, in collaboration with the Senior HR Business Partners, Clinical Service Units Triumvirate teams and Line Managers, we will see a reduction of 0.3% in Non-COVID related sickness absence throughout 2023/24. The target line for 2023/24 on the graph on slide 4 has been updated to reflect this.</p>	<ul style="list-style-type: none"> The in-month rate has been below mean for all of 2023. In addition the expected peak over winter was lower than the worst case forecast. March in-month sickness rates have dropped to 4.71% compared to 5.56% in March 2023 	<ul style="list-style-type: none"> N/A 	<ul style="list-style-type: none"> The Supporting Attendance process has been audited by PWC (Q3 2023/24). The draft report has been received and has been given a moderate risk rating. The proposed actions have been finalised, based on the recommendations in the report. The Occupational Health and Wellbeing team continues to prioritise supporting our staff back into work. A deep dive took place at January Workforce Committee. Clinical Service Unit line managers supported by the Operational HR Team and the Health and Wellbeing team will focus actions on effective sickness absence management with a particular focus on frequent short-term absence. Further work to develop common pathways for staff to receive health and wellbeing support either to prevent absences, maintain wellness or support recovery. In 2024/25 Operational HR and Occupational Health and Wellbeing will look to link up with peer Trusts (Oxbridge and London) to identify any further improvement opportunities. The target line for 2024/25 has therefore been reset to 4.9%. 	<ul style="list-style-type: none"> N/A

Voluntary Turnover Rate

March 2024

Target: 10%
Performance: 6.46%

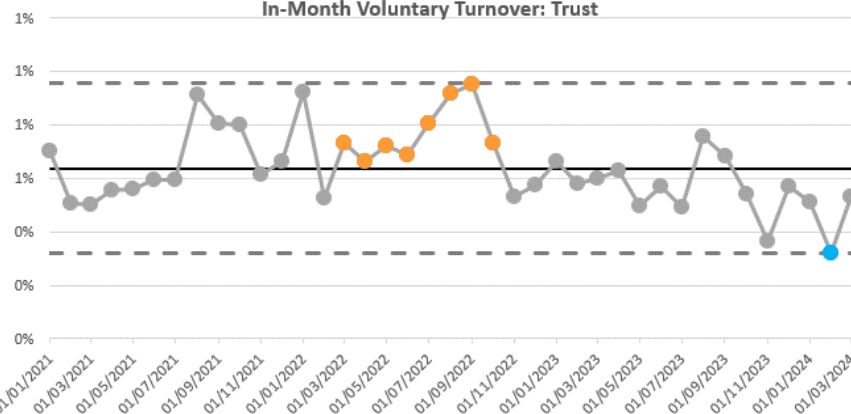
Variance: Common cause variation. The process will regularly achieve the target

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

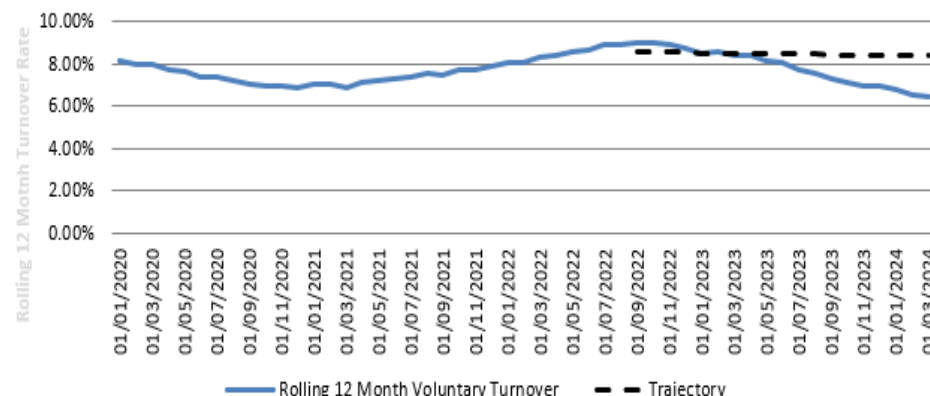
Management/Clinical Owner: Michelle Litten

Sub-Groups: Workforce Committee

In-Month Voluntary Turnover: Trust



Rolling 12 Month Voluntary Turnover



Background	What the chart tells us	Issues	Actions	Context
<ul style="list-style-type: none"> Rolling Voluntary Turnover has reduced ahead of forecast throughout 2023/24. 	<ul style="list-style-type: none"> Voluntary Turnover increased in March 24 however it is still below mean and the rolling rates are still trending downwards. 	<ul style="list-style-type: none"> N/A 	<ul style="list-style-type: none"> Retention In-Year Commitment refreshed for 2024/2025 People Promise Exemplar Programme providing the self-assessment and project management underpinning to the development of the Retention A3, and focused improvement work throughout 2024/2025 Corporate Retention A3 complete Headline Trust Retention KPIs established: <ul style="list-style-type: none"> Trust turnover to be in the top 25% of Acute Teaching and Acute large trusts : LTH starting position (Nov): 20th/73 trusts (LTH 9.6% (above average). Top Quartile target position currently, 8.3%). Trust <u>voluntary</u> turnover to improve to under 5.77%. NHS Staff Survey engagement score - improvement from 7.0 to 7.2. 	<ul style="list-style-type: none"> Our In-year Retention Commitment's closing position has surpassed the improvement target, as outlined above. The NHS People Promise Exemplar Programme self-assessment enabled the identification of stretch targets for 2024/2025 (outlined within the 'Actions' column), following an analysis of retention metrics and national comparisons, and required improvement areas for the year ahead. These are now reflected within the 2024/2025 Corporate Retention A3, and progress against the refreshed stretch targets will therefore be reflected in IQPR updates moving forwards.

Agency Spend

March 2024

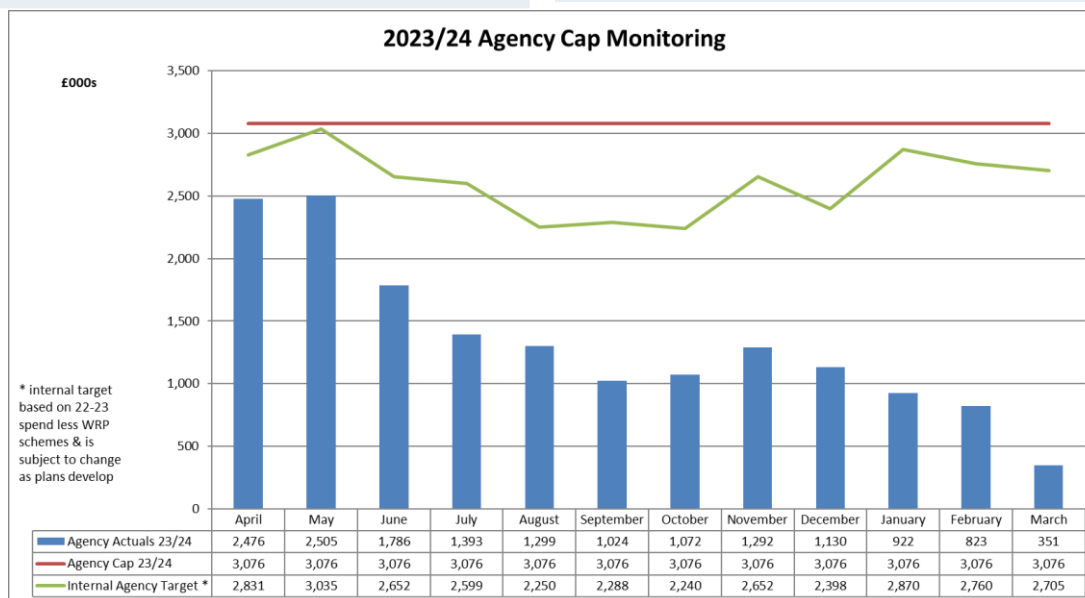
Target: 3.7%
Performance: %

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

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

Management/Clinical Owner: Johnny Gamble

Sub-Groups: Workforce Committee



Background	What the chart tells us	Issues	Actions	Context
<ul style="list-style-type: none"> The agency cap for 2023/24 was set by NSHE at 3.7% of the pay bill equating to approximately £3.1m per month. A more challenging internal target was developed based on 2022/23 expenditure levels less WRP schemes. This target has been monitored as we have progressed through 2023/24. 	<ul style="list-style-type: none"> We have achieved the NHSE and internal target for this financial year. 	<ul style="list-style-type: none"> N/A 	<ul style="list-style-type: none"> The Trust has worked hard to reduce the reliance on agency staff and this has been achieved by aligning our workforce plans to service delivery along with our success in retaining our workforce; successful international and local recruitment into registered and non-registered roles, as well as our success in reducing unplanned absence. For 2024/25 the Leeds Improvement Method (LIM) principles of daily management will support further reductions in the use of agency spend and other variable pay. The NHSE Agency cap for 2024/25 is 3.2% of the total pay bill, and internal Target is yet to be established. 	<ul style="list-style-type: none"> N/A

Vacancy Rate

March 2024

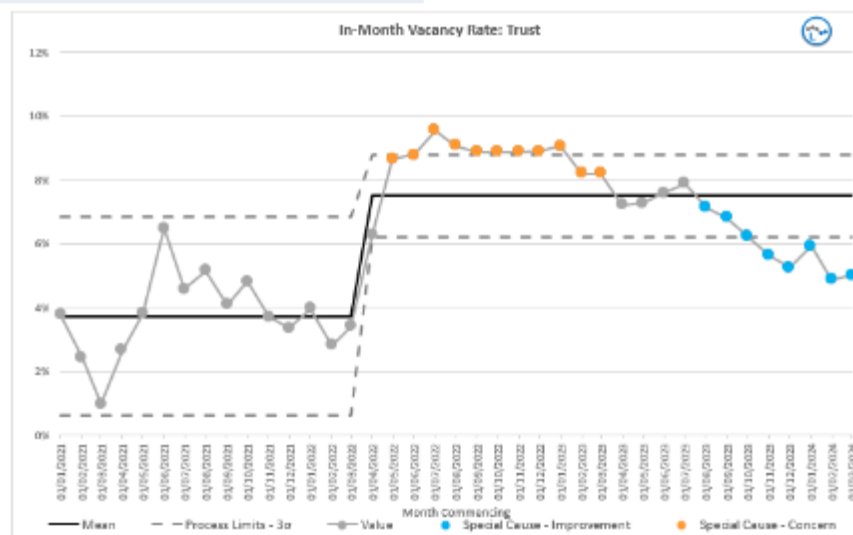
Target: N/A
Performance: 5.01%

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

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

Management/Clinical Owner: Jenny Lewis

Sub-Groups: Workforce Committee



Background	What the chart tells us	Issues	Actions	Context
<ul style="list-style-type: none"> Control Limits were re-cast at April 2022 due to an increase in the budget line. Changes in budget are not aligned to recruitment patterns, particularly with relation to the recruitment of newly qualified registered staff. Vacancy is calculated comparing substantive staffing numbers with funded FTE from the financial ledger which is adjusted for reductions arising from Waste Reduction Programmes and Vacancy Factor targets. 	<ul style="list-style-type: none"> Vacancies have reduced across most professional groups including registered and non-registered nursing and medical. 	<ul style="list-style-type: none"> N/A 	<ul style="list-style-type: none"> Our success in retaining our workforce along with successful international and local recruitment into registered and non-registered roles has supported our reduction in vacancies across the Trust. Senior HRBPs are working closely with CSUs and corporate teams to ensure operational workforce plans include actions to address high vacancies and exploring alternative recruitment options e.g. alternative roles (ACP, PA, Nursing Associates) along with apprenticeship options. However, some level of vacancy supports our flexible workforce (bank) colleagues. As part of our in-year commitment on retention, all CSUs have developed A3s to address retention and actions from this are in their workforce plans. CSU vacancy information is monitored monthly at the HR huddle as well as monthly in a joint Finance/HR meeting. 	<ul style="list-style-type: none"> N/A

I&E Position 2023/24

2023/2024

Executive Owner: Simon Worthington (Director of Finance)

For the financial year 2023/24 the Trust achieved a surplus of £12.3m, subject to audit - the seventh consecutive year of a surplus. The Trust's financial plan and forecast up to Month 11 was breakeven. In March the Trust was informed of several tranches of non recurrent income from the Integrated Care Board (ICB) totalling £11.8m. A further £0.5m of income redistribution between providers in the Leeds Place was agreed, resulting in the final surplus of £12.3m.

Waste Reduction Programme (WRP): To achieve its financial plan the Trust ended the year delivering waste reduction and mitigations of £131.8m against a target of £131.5m, which is significantly higher than in previous years. It should be noted that this included £29m of technical items which are non recurrent in nature. This, combined with other spending decisions results in the Trust entering the new year with an underlying deficit of £52m.

I&E Position 2024/25

April 2024

Executive Owner: Simon Worthington (Director of Finance)

Overall, the planning context for 2024/25 is a challenging one, with major deficits forecast across the country. Excluding technical issues, the Trust has submitted a balanced financial plan, which requires £110m of waste reduction to be found. The profile of the plan is small monthly deficits at the beginning of the year, moving to small monthly surpluses towards the end.

In April the Trust reported a deficit of £8.6m, which was £3.5m adverse to the NHSE plan. The main areas of variance are substantive staffing being higher than forecast £2.1m and variable pay costs £1.2m higher. The remaining balance relates to other issues including income, where elective activity is lower than planned.

As a result of the adverse M1 results further mitigation plans have been put in place and a Trustwide initiative using Leeds Improvement Methodology has been run to reduce variable pay. At this stage we continue to forecast a balanced position for year end, however, there remains a significant risk to delivery.

Capital & Cash Position

April 2024

Executive Owner: Simon Worthington (Director of Finance)

Capital Capital

2023/24

Capital expenditure was finalised at £99.0m for the financial year 2023-24.

2024/25

The Trust's capital expenditure forecast for 2024/25 is £77.5m. The programme is broken down as follows:

Programme	Forecast 2024-25 £000
Medical Equipment	15,208
Informatics	10,426
Building & Engineering	44,012
Building the Leeds Way	4,900
Leases	5,000
Contingency	(2,043)
Total	77,503

Expenditure to 30 April 2024 is £2.9m which was in line with forecast.

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

Cash

2023/24

The Trust ended the financial year with cash of £48m which was £13m more than in the forecast due to additional funding received from the ICB in March. Better Payments Practice Code ("BPPC") compliance for the year was 97%, the third consecutive year that the 95% target has been met.

2024/25

Cash at the end of April was £47m, a reduction of £1m from the year end balance (£48m). Total receipts for the month amounted to £179m including Q1 LDA funding from NHS England of £24m Total payments in month were £180m comprising £94m for payroll and £86m for accounts payable which included £20m of payment of capital invoices which were included in capital creditors at the year end.

Payments to our suppliers in April totalled £86m. Better Payments Practice Code compliance for the month was 93% slightly below the 95% target.

The latest cash forecast shows that the Trust will not require cash support during the first quarter of the financial year. However if the current I&E trajectory is maintained, it is probable that revenue support will be required later in the year.

Supplementary Metrics Produced by Exception

Reduce waits
for patients



Length of Stay

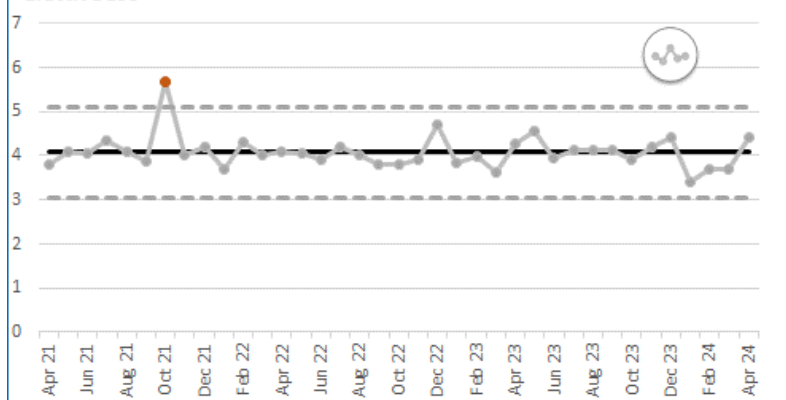
April 2024

Target: Reduce Length of Stay by 0.9 days

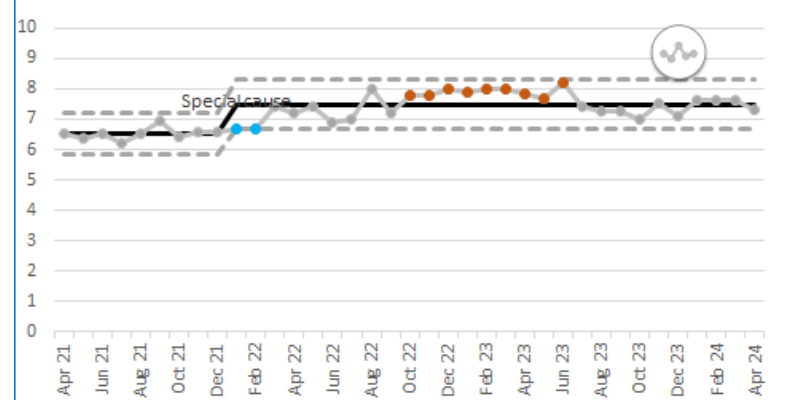
Executive Owner: Clare Smith (Chief Operating Officer)

Variance: Common cause variation.

Elective LoS



Non-Elective LoS



Background

- Aim to reduce length of stay by 0.9 days which will be closer to peer average
- Extended waits for social worker assessments, community bed availability and packages of care impact on the LOS of patients
- LTHT has a higher proportion of long length of stay (21+ days) patients compared with regional and national acute Trusts

Context

- Overall, when comparing April 24 to April 23 there was a reduction of 0.4 days for elective and non-elective LOS
- Non-elective admissions from A&E have increased by 7.2% for April 2024 in comparison to April 2023
- Non-elective LOS for April 2024 was 7.3 days. This is a reduction from 7.9 days for the same period last year
- Elective LOS for April 2024 was 4.4 days and in April 2023 was 4.3 days

Action

- Medical/elderly SDEC now established in new footprint at SJUH with focus on enhanced pathways to avoid admission where clinically appropriate- currently delivering a 33% increase in SDEC attendances Continued work to embed and maximise this SDEC opportunity. Next steps to review MSAA (LGI SDEC) opportunity
- Remote Monitoring Virtual Ward established with focus on maximising early discharge using this service across multiple specialities and increase the number of beds saved to 16 per day
- Dr Foster peer data on LOS reviewed and improvement trajectories for bed holding CSU's agreed. This will be supported through the service delivery contract and the LOS efficiency programme
- To support the system-wide Home First Programme to deliver against submitted trajectory of reducing the number of no reason to reside patients

Cancelled Ops

Reduce waits
for patients



April 2024

Target: 0

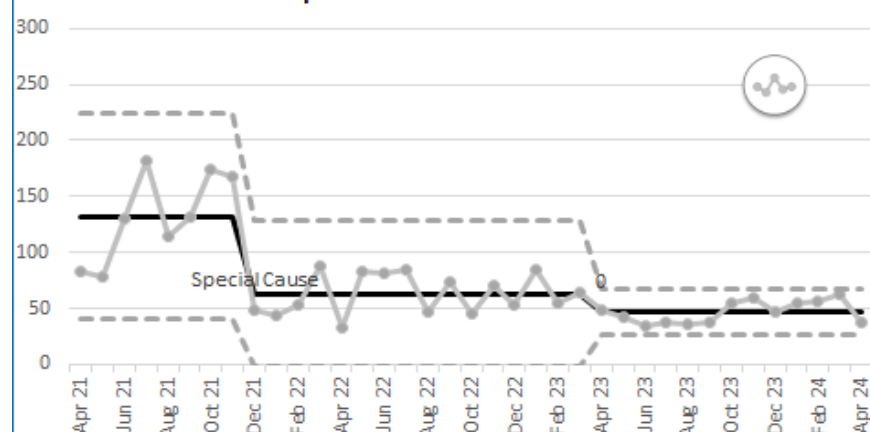
Performance – LMCO: 38

Performance – 28 day Standard: 13

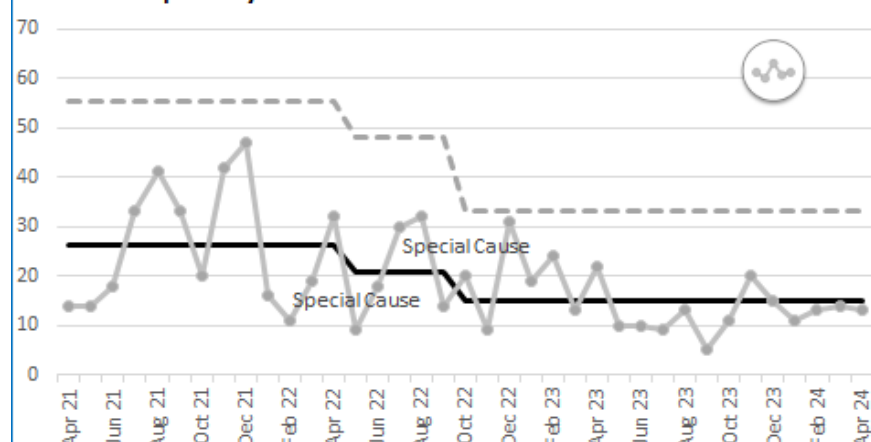
Executive Owner: Clare Smith (Chief Operating Officer)

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

Last Minute Cancelled Ops



Cancelled Ops 28days










Background	Context	Action
Ensure all patients who have operations cancelled on the day of surgery, for non-clinical reasons are offered another binding date to be treated within a maximum of 28 days (zero tolerance standard)	<p>Cancelled Operations</p> <ul style="list-style-type: none"> There were 38 LMCO in April 2024. This is a significant reduction to the 63 in March 2024. This is also a reduction to the 48 LMCO in April 2023. <p>28 Day Breaches</p> <ul style="list-style-type: none"> There were 13 breaches of the 28-day standard in April 2024. This is a reduction to the 14 breaches in March 2024. This also a significant reduction to the 22 breaches in April 2023 For 2023/2024 Q4 LTHT performed 57th out of 118 peers 	<ul style="list-style-type: none"> Improve theatre utilisation and cases per session through the Theatre Productivity PID workstreams Continue to monitor utilisation and cases per session through the Theatre Productivity PID Work with services to improve scheduling through the re-launch of the 6-4-2 process and revised SOP Improve theatre scheduling through the launch of the new scheduling tool Deep dive into breach data to understand current limitations by specialty to relisting patients within 28 days Continue to monitor LMCO and 28-day breaches

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