University Hospitals of Leicester NHS
NHS Trust

Public Trust Board Paper E

Meeting title:	Trust Board					
Date of the meeting:	14 August 2025					
Title:	Integrated Performance Report and Executive Summary					
Report presented by:	Sarah Taylor, Deputy Chief Operating Officer					
Report written by:	Sarah Taylor, Deputy COO Emergency Care and Kully Kaur, Assistant Director of BI and Information					
Action – this paper is for:	Decision/Approval		Assurance	X	Update	
Where this report has been discussed previously						

To your knowledge, does the report provide assurance or mitigate any significant risks? If yes, please detail which
Yes, please refer to BAF

Impact assessment

Acronyms used

Purpose of the Report

This report complements the full Integrated Performance Report (IPR) and the exception reports within that which are triggered automatically when identified thresholds are met. The exception reports contain the full detail of recovery actions and trajectories where applicable.

The executive summary is split into 3 parts

1. Pathways updates for Urgent and Emergency Care, Elective, Cancer, and Maternity
2. Updates on Quality, Finance and Workforce
3. Update on transformation and productivity

Recommendation

The full IPR, encompassing all exception reports will be created for public access. A streamlined version of this report will be provided to the Board for the purpose of oversight after confirmation from Exec leads.

Any forthcoming changes to the IPR can be integrated using the change control process.

There have been discussions on presenting pathway analysis to Board to highlight the dependencies across metrics to deliver the pathway, this approach will be piloted with the emergency care pathway.

Summary

This report provides a high level summary of the Trust's performance against the key quality and performance metrics, together with a brief commentary where appropriate.

Main report detail

Key headlines in performance are summarised below:

Summary of UHL Performance: JUNE 2025

Arrow Indication indicates the direction of performance. Colour is a subjective assessment of performance against standards and expectations

Urgent & Emergency Care **Updates on Flow in Flow through Flow out** 	June 2025 saw a decrease of 20 Emergency department attendances to plan with a year to date overperformance of 359 attendances. Paediatric ED saw a decrease of 486 attendances compared to June 2024, thereby giving an overall significant increase was therefore felt in the adult department. Eye Casualty in June 2025 saw a decrease of 209 attendances to plan, an underperformance of 82 year to date against plan. 4-hour performance in June achieved the trajectory of 58.94% with a performance of 60.8% June 2025, LRI monthly ambulance handovers averaged 38.02minutes which is a deterioration on last year and on our current targets. The 12-hour performance (total time in dept) for June 2025 was 2.4% achieving trajectory. We have had 1 x 72 hr bed waits in ED and 0 x 8 hour ambulance waits in June. Emergency admissions in June 2025 were on plan and slightly under the number of admissions seen in June 2024. Actions for improvement – Achievements in June • Increased the number Same Day Emergency Care services with the new Frailty SDEC – April, May and June have achieved trajectory • Work with partners to ensure care plans are in place for those who use our services on a high frequency basis - we have seen a 21.2% reduction in repeat ED attendance within the cohort and an average reduction of 7.9 ED attendances per month. • Open additional capacity in the community – Preston Lodge will open in July 2025, ED redirect capacity in place • Further develop our medical day case services enabling more patients to be treated as a day case. • Work with partners to further improve our discharge pathways. • Implement and embed digital solutions such as e-beds – a more efficient bed management system. This will be developed post the PAS roll out • Transform the existing pathways for admission from ED into Medicine, Cardiology and Respiratory and reduce length of stay in June we have seen a 0.05 day LoS reduction Progress is overseen by the UEC Transformation Group and Operations and Performance Committee.
Elective Care **Referrals and**	Performance deteriorated in June from the May position. Some of this was expected with the roll out of the new PAS (Patient Administrative System) and the consequent planned reduction in activity from the 21st June. Teething

Outpatient performance **Elective activity** **Pathway Improvements** 	issues with the new system is having an impact with the second 'quick fix' due to take place on the 15th August, where it is hoped the majority of critical issues will be fixed. The majority of activity should be back to normal levels; however, it remains difficult to get a true understanding on this due to the large number of unoutcomed (clinical and clerical) attendances. This is currently being worked on by CMG teams. The validated end of June 25 position for 52-week waits is 2,605 patients which is 2.4% of the total waiting list size and 1059 patients above plan. The 52-week position is concerning given the month-on-month deterioration being seen. In addition, to the roll out of PAS leading to a reduction in activity, there has also been the impact of the pause in WLI weekend working, administration vacancies due to workforce control restrictions leading to less staff able to book patients and tighter controls on the use of administrative bank. The total waiting list has increased larger than forecast since the PAS roll-out. A separate update will be provided as part of the digital assurance at Trust Board describing the actions being taken to investigate and respond. As part of stepping up assurance given the deteriorating position a series of internal 'tiering' meetings for planned care are being arranged, starting from August. The meetings will follow a similar format to when in external tiering and will be chaired by the System Director for Planned Care or the Chief Operating Officer. With the following CMGs and specific specialities required to attend (CHUGGS – General Surgery and Gastro, MSS – ENT (paeds and adults), Maxilliofacial, Orthopaedics and Spines, W&C –paediatric cardiology, paediatric T&O, paediatric respiratory and gynaecology , RRCV – Cardiology).
Cancer **Referrals** **2 week wait** **Faster Diagnosis Standard** **62-day referral to treatment** 	Referrals year to date has seen a decrease of 0.7% compared to previous months. Conversion rates remain at 7%. The Trust continues to deliver FDS in May. June's FDS performance is at risk following unplanned loss of capacity in Skin and H&N resulting in longer waits to first appointment. 62-day performance in May achieved 58%. UHL will remain in Tier 1 until sustainable improvement can be delivered. 31-day performance remains a risk in surgical and radiotherapy, however radiotherapy backlogs continue to reduce with the 5th linac. 31-day performance will recover in Q4 of this year. Risks for cancer performance are the ability to deliver the required capacity for demand. Services are working to improve 62-day waits by reviewing opportunities for additional capacity and improved efficiency to progress delivery of the cancer waiting time standards.

Quality 	Incidence of Clostridioides difficile (C. diff) has risen this period, prompting an urgent review of cleaning standards alongside established infection prevention practices. This proactive approach is aimed at minimising further risk and ensuring a safe environment for patients and staff. Mortality rates remain within expected parameters, and clinical governance continues to provide appropriate oversight and assurance. Overall quality performance remains stable across key indicators, with continued focus on maintaining high standards of care. Complaints responsiveness continues to show positive trends, with divisional teams demonstrating improved agility in addressing concerns. This is contributing to greater patient confidence and satisfaction. The Friends and Family Test (FFT) results remain strong, reflecting sustained positive experiences across services. Ongoing efforts to strengthen feedback mechanisms and service recovery approaches are helping drive momentum in patient experience improvements.
Finance 	The month 3 position for the Trust is a deficit of £8.8m which is £2.8m adverse to plan. The main drivers are reduced patient care income £3.4mA (mainly elective care), under-recovered other operating income excluding donated assets of £1.9mA, offset by pay/non-pay underspend of £3mF and other £0.5mA. The Trust committed net capital expenditure of £5m in Month 3 after deducting charitable donations/capital grants, resulting in an underspend of £9m against CDEL target of £14m for M3. The cash position at the end of Month 3 was £75.5m, which is an increase of £35m from M2, which is mainly driven by the timing of the payroll, which took place after the closure of ledger for M3 reporting. The payroll value was £49.1m therefore the closing balance would have been £26.4m leading to a reduction of £14m from M2
Workforce 	The UHL Workforce and Financial plan identifies a 1611wte reduction in 2025/26, with 1000wte from our temporary workforce, and 611wte from substantive reductions through turnover and vacancy controls, whilst ensuring patient safety. In M3 the overall workforce size was 18,216 WTE (Whole Time Equivalent), which is 426 WTE under the planned position of 18,462 WTE (a favourable variance of 2.29%). • Agency WTE usage recorded a slight increase compared to previous month. However, usage remained positively below the plan by 45% (i.e 43 WTE). • Bank WTE usage continued to decrease since M1 and recorded a 30% favourable variance below the plan (i.e 277 WTE). • With a 0.61% variance (i.e 107 WTE) against the plan, Substantive workforce was recorded at 17,547 WTE. This position is mostly driven by an increase in the rate of Leavers compared to New Starters. • The net difference between Leavers and Starters was 18.27 WTE, there were more Leavers than New Starters There is continued work on workforce control programs to ensure alignment with the submitted Workforce and Finance plans while ensuring the delivery of

	safe patient care, e.g. the MARS scheme which opened on 21 July 2025. Workforce weekly reporting is in place to track and monitor workforce performance against the plan and highlight possible risks. The Medical Agency Price Cap Compliance group has commenced, with the recommendation of moving to a rate card reduction plan across the region by September. UHL have some specialist fragile areas which will require a longer period of rate reduction which has been agreed in principle. There are 3 Project Officers in Capital Projects which meet the special projects exemption. Exit plans will be put in place by the end of July, in line with the Trust's objective to reduce agency usage by 75%. In May, our turnover rate increased from 6.9% to 7.1% against the 10% target. We have achieved compliance on the Statutory and Mandatory training target of 95%. There has been a 0.4% decline appraisal performance. The focus remains on both improving performance and the quality of appraisals. The appraisal process and documentation are currently under review through engagement with key stakeholders. Sickness absence is reported a month in arrears, and we have seen a small reduction in May. Over the last 12 months, the highest levels of absence are in E&F (6.26%), W&C (5.80%), RRCV (5.50%) with local plans in place to support staff wellbeing and reduce sickness absence. A key area of focus has been accurate reporting of the reasons for sickness absence, and in 24/25 M8 we had over 10% of absences being recorded as 'unknown', compared to 4.65% in 25/26 M2. The workforce performance is reviewed through CMG Performance Review meetings, CMG Boards, Senior Leadership Teams, and Specialty Reviews. An amber rating remains in place.
Tranformation & Productivity **Key Overview** **e.g Urgent and Emergency Care, Elective, digital, Estates etc**	<u>Theatres</u> • Theatre Utilisation: utilisation in June 25 is 82.7%, reflecting stable performance across sites. • On-the-Day Cancellations (OTDC): remain static, with no consistent downward trend observed. A focused productivity session was held on 2nd July to reinforce best practices, data validation, and root cause analysis. Targeted interventions by speciality are being implemented, with performance monitored fortnightly and shared learning promoted across sites to drive improvement. • Day Case Performance (BADS): According to Model Health data (March 2025), the BADS day case rate is 83.4%, this marks a slight decline from February's rate of 83.5%. Internal UHL data indicates a further downward trend noted in June 2025, currently under review to assess potential impacts related to data accuracy and coding following the implementation of the new PAS. • Late Starts: Theatre late start performance has shown improvement with a continued downward trend through to June 2025 to 22.0%. To support

	further improvement, the LRI is developing an auto-send SOP for the golden patient - to streamline communication and reduce avoidable delays. <u>Outpatients</u> • The current Patient-Initiated Follow-Up (PIFU) rate is 5.4%, marginally below the target of 5.5%. Specialty-level targets have been agreed upon by the CMG and specialty leadership teams. Where services are already exceeding the national benchmark, stretch targets have been introduced to drive further improvement. • The Did Not Attend (DNA) rate currently stands at 6.5%, which is above the target of 5%. This increase is partly attributed to a data feed issue following the launch of the new PAS, which temporarily disrupted the delivery of automated appointment reminders via Accurx. • Work is underway to enhance the Accurx reminder system, with plans to implement a tiered reminder schedule at 14 days, 7 days, and 3 or 1 day prior to appointments to improve attendance rates. <u>UEC</u> • 4942 Monthly SDEC attendance delivered in June (5% above target) • Due to the post-PAS report testing the reporting team did not have capacity to provide Clinical Bed Bureau data for this month. • The ED Transport Tender has closed to bidders and is now in the evaluation/moderation phase. • UEC PAS development work completed, and post go live review underway. • Automated collection of SDEC Specific Friends and Family feedback began in 2 SDECS. Collation feedback based on the 10 SDEC quality markers in line with National SDEC Service Specification. Work planned to progress in other areas post PAS. • New pathway pilot in place for CDC patients to be streamed to Cardiorespiratory SDEC for treatment avoiding being sent via ED

Supporting documentation

The Integrated performance report contains further detail including exception reports of indicators which are not currently achieving targets.

The key changes to the IPR are:

- Removed executive highlight report this will be covered in the front sheet
- Removed highlight reports from metric pages
- Updated metrics to reflect changes requested
- Added in activity position (page 15)
- Highlight reports removed 3 month forecasting
- Highlight reports will only be required for those off track
- Removed explanation of SPC charts at the end

In the IPR there is a combination of national and locally agreed targets. For the locally agreed targets we will document the rationale for future reference.

The following metrics are part of the National KPIs that we do not report in the IPR. We are in the process of seeking clarification from Exec leads regarding where these metrics are reported or if there is a need to incorporate them within the IPR.

No.	NHS Oversight Framework national mandated KPIs
1	Proportion of patients discharged from hospital to their usual place of residence
2	Available virtual ward capacity per 100k head of population
3	National Patient Safety Alerts not completed by deadline
4	Potential under-reporting of patient safety incidents
5	Overall CQC rating
6	Performance against relevant metrics for the target population cohort and five key clinical areas of health inequalities
7	Proportion of acute or maternity inpatient settings offering smoking cessation services
8	Proportion of patients who have a first consultation in a post-covid service within six weeks of referral
9	Proportion of people over 65 receiving a seasonal flu vaccination
10	Acting to improve safety - safety culture theme in the NHS staff survey
11	CQC well-led rating
12	Aggregate score for NHS staff survey questions that measure perception of leadership culture
13	Staff survey engagement theme score
14	Staff survey bullying and harassment score
15	Proportion of staff in senior leadership roles who are from a) a BME background or b) are women

Integrated Performance Report

June 2025

Contents

- Performance Overview
- Exception Reports
- Finance
- Appendix - Data Quality Assessment

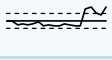
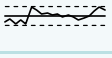
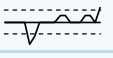
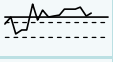
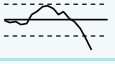
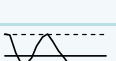
Performance Overview (Safe)

Domain	Key Performance Indicator	Target	Apr-25	May-25	Jun-25	YTD	Assurance	Variation	Trend	Data Quality Assessment	Local or National Target?	Exec Lead
Safe	Never events	0	0	0	0	0	?			Nov-22	National	Chief Nurse and Medical Director
	Clostridium Difficile per 100,000 Bed Days	167 Cases	6.7	13.0	22.3	14.7	?			Mar-24	Local	Chief Nurse and Medical Director
	Methicillin Resistant Staphylococcus Aureus	0	3	1	0	4	?			Mar-24	Local	Chief Nurse and Medical Director
	Methicillin-susceptible Staphylococcus Aureus	40	4	5	4	13	?			Mar-24	Local	Chief Nurse and Medical Director
	All falls reported per 1000 bed days	4.0	2.9	3.1		3.0	P			Aug-22	Local	Chief Nurse and Medical Director
	Rate of Moderate harm and above Falls per 1,000 bed days	0.19	0.12	0.09		0.09	P			Aug-22	Local	Chief Nurse and Medical Director
	Hospital Acquired Pressure Ulcers - All categories per 1000 bed days	1.7	1.8	1.6	1.7	1.7	?			Jun-21	Local	Chief Nurse and Medical Director
	% of all adults Venous Thromboembolism Risk Assessment on Admission	95%	98.4%	97.4%		96.7%	P	H		Oct-21	National	Chief Nurse and Medical Director
	Number of Patient Safety Incident Investigations (PSIIs) commissioned		2	0	1	3	Awating more data for assurance and variance			Nov-24	No Target	Chief Nurse and Medical Director
	Number of reported Patient Safety Incidents		2450	2497	2374	7321				Nov-24	No Target	Chief Nurse and Medical Director
	Rate of reported Patient Safety Incidents (per 1000 inpatient, outpatient and ED attendances)		18.1	18.5	18.1	18.3				Nov-24	No Target	Chief Nurse and Medical Director

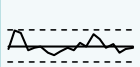
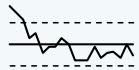
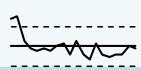
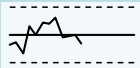
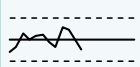
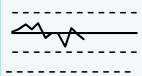
Performance Overview (Caring)

Domain	Key Performance Indicator	Target	Apr-25	May-25	Jun-25	YTD	Assurance	Variation	Trend	Data Quality Assessment	Local or National Target?	Exec Lead
Caring	Single Sex Breaches		28	7	24	59				Jul-22	No Target	Chief Nurse and Medical Director
	Inpatient and Day Case Friends & Family Test % Positive	95%	96%	96%	96%	96%	P	L		Jul-22	Local	Chief Nurse and Medical Director
	A&E Friends & Family Test % Positive	81%	84%	85%	84%	84%	?			Jul-22	Local	Chief Nurse and Medical Director
	% Complaints Responded to in Agreed Timeframe - 25 Working days	90%	57%	87%		72%	?			Jul-23	Local	Chief Nurse and Medical Director
	% Complaints Responded to in Agreed Timeframe - 60 Working days	90%	95%			95%	?			Jul-23	Local	Chief Nurse and Medical Director

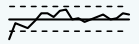
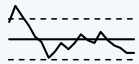
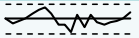
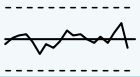
Performance Overview (Well Led)

Domain	Key Performance Indicator	Target	Apr-25	May-25	Jun-25	YTD	Assurance	Variation	Trend	Data Quality Assessment	Local or National Target?	Exec Lead
Well Led	Turnover Rate	10%	6.9%	6.9%	7.1%		P	H		Aug-22	Local	Chief People Officer
	Sickness Absence	3%	4.7%	4.6%		4.6%	F	L		Mar-25	Local	Chief People Officer
	% of Staff with Annual Appraisal	95%	84.8%	85.5%	85.1%		F			Mar-25	Local	Chief People Officer
	Statutory and Mandatory Training	95%	94%	93%	95%		F	H		Dec-22	Local	Chief People Officer
	Adult Nursing Vacancies	7%					?			Dec-23	Local	Chief People Officer
	Paed Nursing Vacancies	10%					F	L		Dec-23	Local	Chief People Officer
	Midwives Vacancies	7%					?			Dec-23	Local	Chief People Officer
	Health Care Assistants and Support Workers Vacancies - excluding Maternity	5%					F			Dec-23	Local	Chief People Officer
	Health Care Assistants and Support Workers Vacancies - Maternity	5%					P	L		Dec-23	Local	Chief People Officer
	% Bank spend of Pay Bill	8%	6.5%	5.8%	5.4%		P			TBC	National	Chief People Officer
	% Agency spend of Pay Bill	3.2%	0.5%	0.4%	0.4%		P	L		TBC	National	Chief People Officer
	Agency Off Framework activity- No. of shifts	0	10	3	0		Awating more data for assurance and variance			May-25	National	Chief People Officer
	Non Clinical Agency- No. of Staff	0	9	3	3		Awating more data for assurance and variance			May-25	National	Chief People Officer
	Agency Staff above Price cap	0	24	25	30		Awating more data for assurance and variance			May-25	National	Chief People Officer
	Agency shifts above £100/hr but not signed off by Chief Exec	0	0	0	0		Awating more data for assurance and variance			May-25	National	Chief People Officer
	Agency Shifts below £100/hr and is 50% above published price cap But not signed off by Chief Exec	0	0	0	0		Awating more data for assurance and variance			May-25	National	Chief People Officer
	Bank shifts above £100/hr but not signed off by Chief Exec	0	0	0	0		Awating more data for assurance and variance			TBC	National	Chief People Officer

Performance Overview (Effective)

Domain	Key Performance Indicator	Target	Apr-25	May-25	Jun-25	YTD	Assurance	Variation	Trend	Data Quality Assessment	Local or National Target?	Exec Lead
Effective	Published Summary Hospital-level Mortality Indicator (SHMI)	100	100			100 (Jan 24 to Dec 24)	Assurance and variance not applicable			May-21	National	Chief Nurse and Medical Director
	12 months Hospital Standardised Mortality Ratio (HSMR)	100	100			100 (Mar 24 to Feb 25)	Assurance and variance not applicable			May-21	National	Chief Nurse and Medical Director
	Crude Mortality Rate		0.9%	0.9%	0.9%	0.9%				May-21	No Target	Chief Nurse and Medical Director
	DNA Rate - IMD Deciles 1 and 2	5%	8.7%	9.3%	8.8%	9.0%				Feb-24	Local	Director of Health Equality and Inclusion
	DNA Rate - IMD Deciles 3 - 10	5%	5.5%	5.8%	5.7%	5.7%				Feb-24	Local	Director of Health Equality and Inclusion
	Gestation at Booking 71+ days, IMD Deciles 1 and 2					38.9%				Dec-24	No Target	Director of Health Equality and Inclusion
	Gestation at Booking 71+ days, IMD Deciles 9 and 10					26.3%				Dec-24	No Target	Director of Health Equality and Inclusion
	Gestation at Booking 71+ days, White British					24.4%				Dec-24	No Target	Director of Health Equality and Inclusion
	Gestation at Booking 71+ days, Black African or Black Caribbean					47.2%				Dec-24	No Target	Director of Health Equality and Inclusion
	Gestation at Booking 71+ days, Asian Indian, Bangladeshi or Pakistani					35.6%				Dec-24	No Target	Director of Health Equality and Inclusion

Performance Overview (Responsive Emergency Care)

Domain	Key Performance Indicator	Target	Apr-25	May-25	Jun-25	YTD	Assurance	Variation	Trend	Data Quality Assessment	Local or National Target?	Exec Lead
Responsive (Emergency Care)	Emergency Department 4 hour waits LLR	78%	75.4%	76.4%	75.9%	75.9%				Mar-23	National	Chief Operating Officer
	Emergency Department 4 hour waits UHL	61%	59.7%	61.5%	60.8%	60.7%				Mar-23	National	Chief Operating Officer
	Mean Time to Initial Assessment	15	7.6	7.9	16.9	10.6				Nov-24	National	Chief Operating Officer
	% 12 hour trolley waits in Emergency Department (DTA)	10.3%	3.1%	2.5%	2.4%	2.7%				Mar-23	National	Chief Operating Officer
	% of 12 hour waits in the Emergency Department	10.3%	10.1%	9.0%	9.0%	9.5%				Mar-23	National	Chief Operating Officer
	Average Clinical Handover time for ambulance handovers (Minutes)	30	46	35	40	40	Awating more data for assurance and variance			Data sourced externally	Local	Chief Operating Officer
	Non Elective Average Length of Stay	7.2	7.5	7.3	7.0	7.2				TBC	Local	Chief Operating Officer
	% of Patients Discharged on Discharge Ready Date	88.3%	88.1%	88.5%	89.2%	88.6%				TBC	Local	Chief Operating Officer
	Average Delay (Post Discharge Ready Date)	3.8	4.5	3.9	3.7	4.0				TBC	Local	Chief Operating Officer
	Trust Bed Occupancy	92.0%	86.9%	85.4%	86.5%					Dec-23	National	Chief Operating Officer
	Long Stay Patients (21+ days) as a % of G&A Bed Occupancy	10%	16.5%	13.0%						Apr-23	Local	Chief Operating Officer

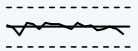
Please note the in month RAG ratings are based on trajectories for some of the indicators (see slide 14).

Performance Overview (Responsive Elective Care)

Domain	Key Performance Indicator	Target	Apr-25	May-25	Jun-25	YTD	Assurance	Variation	Trend	Data Quality Assessment	Local or National Target?	Exec Lead
Responsive (Elective Care)	Referral to Treatment Incompletes	105,500	107,836	106,383	109,601		F			Jun-23	Local	Chief Operating Officer
	Referral to Treatment (RTT) 18 wk performance	62.3%	56.0%	57.0%	56.6%		F			TBC	Local	Chief Operating Officer
	Referral to Treatment (RTT) – First Attendance - % waiting less than 18 weeks	68.1%	61.9%	62.2%	64.9%		Awating more data for assurance and variance			TBC	Local	Chief Operating Officer
	Referral to Treatment (RTT) 52+ weeks as a % OF Total Incompletes	0.9%	2.0%	2.0%	2.4%		F			TBC	Local	Chief Operating Officer
	6 Week Diagnostic Test Waiting Times	5%	18.7%	20.7%	22.7%		F			Jul-23	National	Chief Operating Officer
	Theatre Utilisation	85.0%	83.3%	83.0%	82.7%	83.0%	F	H		Dec-23	National	Chief Operating Officer
	Patient Initiated Follow Up	5.5%	6.0%	6.1%	5.4%	5.8%	?	H		Oct-23	Local	Chief Operating Officer
	% Outpatient Did Not Attend rate	4.9%	6.1%	6.5%	6.5%	6.3%	F	L		Apr-23	Local	Chief Operating Officer
	% Outpatient Non Face to Face	25%	29.0%	29.6%	26.4%	28.4%	P			Apr-23	National	Chief Operating Officer

Please note the in month RAG ratings are based on trajectories for some of the indicators (see slide 14).

Performance Overview (Responsive Cancer)

Domain	Key Performance Indicator	Target	Apr-25	May-25	Jun-25	YTD	Assurance	Variation	Trend	Data Quality Assessment	Local or National Target?	Exec Lead
Responsive (Cancer)	28 Day Faster Diagnosis Standard	80%	79.4%	77.7%		78.6%				May-24	National	Chief Operating Officer
	Cancer 31 Day Combined	96%	76.7%	72.4%		74.6%				May-24	National	Chief Operating Officer
	62 Day Backlog Combined	152	330	359	374					Dec-24	Local	Chief Operating Officer
	Cancer 62 Day Combined	70%	66.8%	58.0%		62.5%				May-24	Local	Chief Operating Officer

Please note the in month RAG ratings are based on trajectories for some of the indicators (see slide 14).

Performance Overview (Finance)

Domain	Key Performance Indicator	Target YTD	Apr-25	May-25	Jun-25	YTD	Assurance	Variation	Trend	Data Quality Assessment	Exec Lead
Finance	Trust level control level performance	£-6m	-£1.4m	-£5.8m	-£1.6m	-£8.8m				Jun-22	Chief Financial Officer
	Capital expenditure against plan	£14m	£1.4m	£0.7m	£2.9m	£5m				Jun-22	Chief Financial Officer
	Cost Improvement (Includes Productivity)	£9.5m	£2.3m	£3.8m	£3.4m	£9.4m				Dec-23	Chief Financial Officer
	Cashflow	No Target	-£21.7m	£21.3m	£35.1m	£75.5m				Jun-22	Chief Financial Officer
	Aged Debt	No Target	£17.2m	£17.4m	£15.4m					Feb-24	Chief Financial Officer
	Invoices paid within 30 days (value)	95%	100%	95%	98%					Feb-24	Chief Financial Officer
	Invoices paid within 30 days (volume)	95%	99%	97%	97%					Feb-24	Chief Financial Officer

Performance Overview (Activity)

Domain	Activity Type	Plan 25/26	Plan in Month (M3)	Activity In Month (M3)	Variance In Month (M3)	Plan YTD	Actual YTD	Variance YTD	YTD Variance to 19/20
Activity	New Outpatients (inc. NFTF)	270,077	22,820	21,845	-975	66,362	62,509	-3,852	-4,491
	Follow Up Outpatients (inc. NFTF)	601,725	49,963	50,364	401	148,948	143,883	-5,065	-4,424
	Outpatient Procedures	220,367	18,122	19,872	1,750	54,780	54,026	-754	16,246
	Daycase	137,582	11,681	10,183	-1,498	35,614	29,520	-6,094	2,468
	Inpatient	22,053	1,748	2,004	255	5,444	5,591	146	561
	Emergency	114,624	9,335	9,998	662	27,984	28,656	672	3,825
	Non Elective	22,843	1,882	3,186	1,304	5,698	6,906	1,208	1,559
	Emergency Department (inc. Eye Casualty)	282,655	23,808	23,318	-491	71,086	70,931	-155	5,379
	Diagnostic Imaging (inc. Direct Access)	398,464	31,934	36,058	4,124	88,694	101,036	12,341	59,938
	Other	11,473,688	939,863	1,119,077	179,213	2,730,969	2,959,782	228,813	735,464
	TOTAL	13,544,078	1,111,157	1,295,903	184,746	3,235,579	3,462,840	227,261	816,525

**Source Early Cut and Forecasting File*

The DM01 plan for imaging activity for M3 was 3,443 below plan in month (28,255 vs 24,812) and was 5,049 below plan YTD (82,805 vs 77,756).

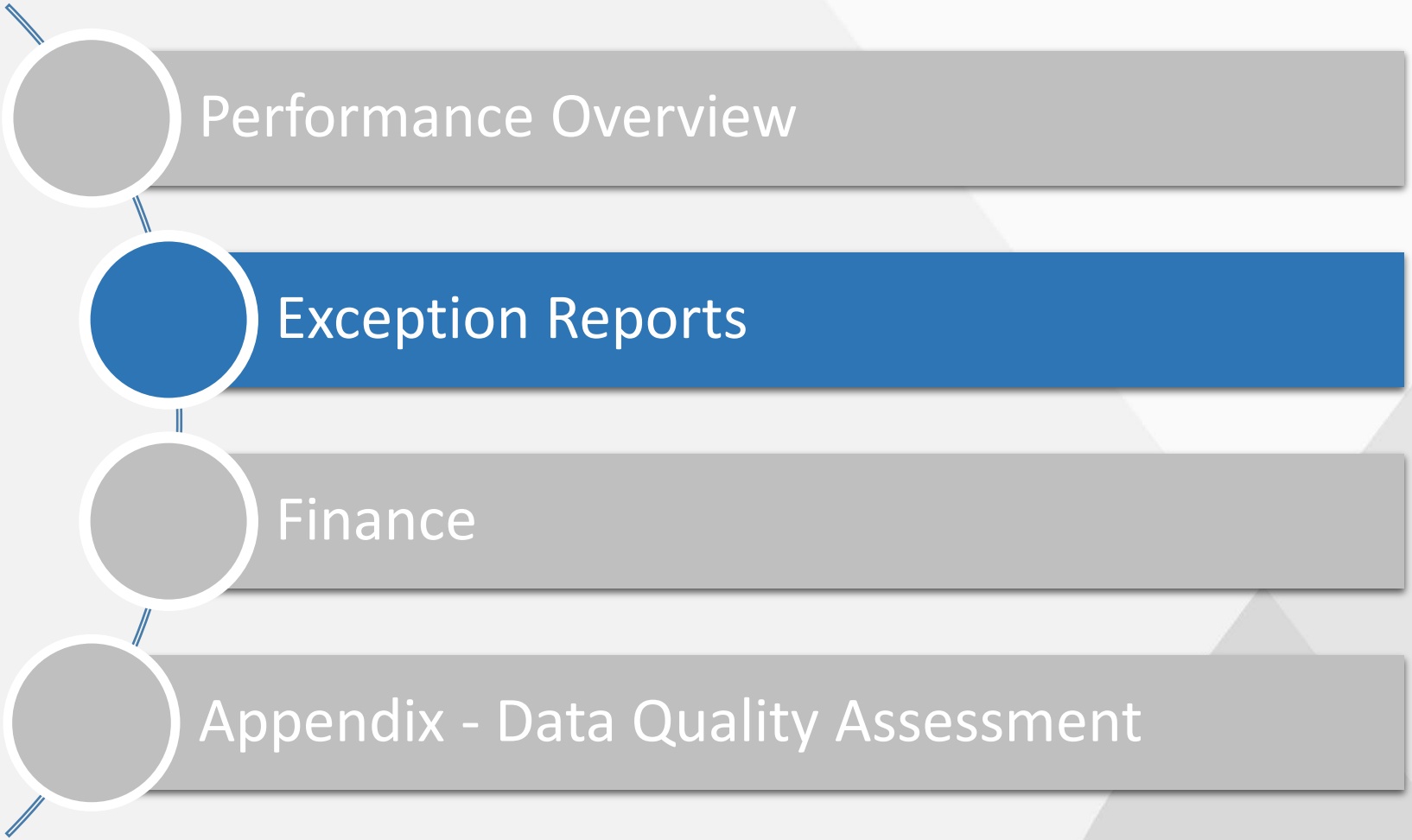
Performance Overview (Workforce Performance Overview)

Activity Type	WTE	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25
Performance against the workforce plan (Contracted Substantive)	Planned in Month	16,928	16,948	16,993	17,016	17,069	17,114	17,114	17,114	17,114	17,392	17,479	17,530	17,650	17,646
	Actuals in Month	17,052	17,171	17,163	17,231	17,373	17,333	17,290	17,421	17,504	17,515	17,562	17,601	17,623	17,590
	Variance (Actual vs Plan)	124	223	170	215	305	219	176	307	390	123	84	71	-27	-56
	% Variance (Actual vs Plan)	0.73%	1.32%	1.00%	1.26%	1.78%	1.28%	1.03%	1.79%	2.28%	0.71%	0.48%	0.41%	-0.15%	-0.32%

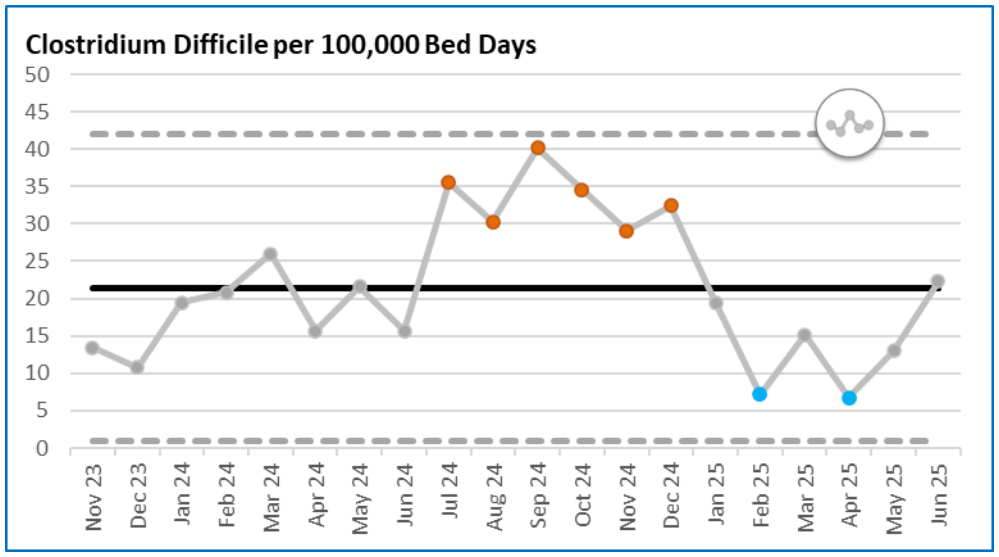
Planned data is from the NHSE submitted 24/25 workforce plan and the actuals are from a combination of the ESR and finance ledger figures.

Performance Overview (Monthly Trajectory Values)

	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26
Emergency Department 4 hour waits UHL	58.8%	58.9%	57.7%	58.9%	59.7%	59.2%	59.1%	58.3%	58.2%	58.1%	59.4%	59.6%
% 12 hour trolley waits in Emergency Department (DTA)	12.2%	11.6%	11.2%	11.0%	10.9%	10.6%	10.0%	9.5%	9.4%	9.5%	9.4%	8.8%
Average Clinical Handover time for ambulance handovers (Minutes)	41	31	37	35	33	41	41	45	40	49	32	28
Non Elective Average Length of Stay	7.3	7.2	6.8	7.3	7	7.2	7.1	7	7	7.4	7.4	7.4
% of Patients Discharged on Discharge Ready Date	89.5%	89.7%	89.0%	87.8%	87.8%	86.9%	88.4%	87.4%	88.9%	88.1%	87.8%	88.3%
Trust Bed Occupancy	91.0%	89.0%	89.0%	89.0%	88.0%	89.0%	91.0%	92.0%	90.0%	93.0%	93.0%	93.0%
Referral to Treatment Incompletes	108508	108040	112078	110980	109387	107643	106145	106099	106849	106537	106189	105500
Referral to Treatment (RTT) 18 wk performance	56.0%	56.5%	57.6%	57.0%	57.2%	58.1%	59.3%	59.7%	59.4%	60.2%	61.7%	62.3%
Referral to Treatment (RTT) – First Attendance - % waiting less than 18 weeks	59.00%	60.00%	61.50%	61.70%	62.50%	63.40%	64.40%	65.40%	64.90%	65.50%	67.40%	68.10%
Referral to Treatment (RTT) 52+ weeks as a % OF Total Incompletes	1.8%	1.6%	1.4%	1.3%	1.3%	1.3%	1.2%	1.2%	1.1%	1.1%	1.0%	0.9%
6 Week Diagnostic Test Waiting Times	17.0%	16.0%	14.0%	13.0%	12.0%	11.0%	9.5%	8.0%	8.0%	7.0%	6.0%	5.0%
Patient Initiated Follow Up	5.50%	5.50%	5.50%	5.50%	5.50%	5.50%	5.50%	5.50%	5.50%	5.50%	5.50%	5.50%
28 Day Faster Diagnosis Standard	77.0%	77.0%	78.0%	78.0%	77.0%	77.0%	78.0%	78.0%	77.0%	77.0%	79.0%	80.0%
Cancer 31 Day Combined	74.6%	79.1%	77.6%	78.1%	79.5%	78.5%	83.0%	79.3%	80.9%	88.1%	90.0%	90.0%
Cancer 62 Day Combined	59.1%	60.1%	61.2%	62.1%	63.1%	64.1%	65.1%	66.2%	67.1%	60.0%	69.0%	70.1%


Performance Overview
Exception Reports
Finance
Appendix - Data Quality Assessment

Safe – Clostridium Difficile



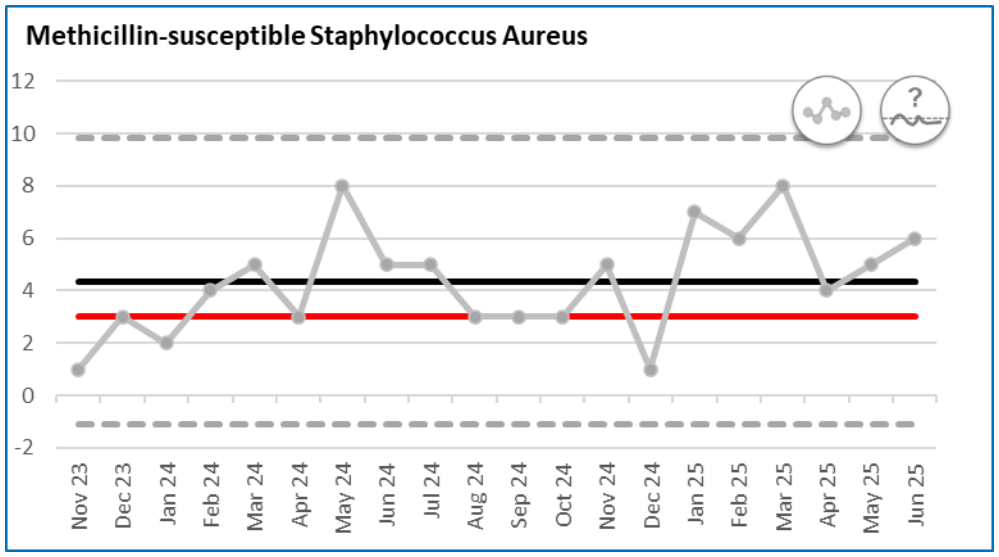
Cases			Cases per 100,000 Bed Days		
Jun 25	YTD	Target	Jun 25	YTD	Target
16	33	167	22.33	14.73	

National Position & Overview

	June	Total	
CDIFF NHSE Threshold 25/26	14	167	
* Actual Infections (HOHA) 25/26	10	20	
* Actual Infections (COHA) 25/26	6	13	
* **Actual Infections Total (HOHA & COHA)** 25/26	16	33	
UHL 100,000 Bed Days (HOHA) 25/26	22.33	**14.73**	*YTD UKHSA Report
National Average	22.44		
National Highest	71.41		
National Lowest	0		

Root Cause	Actions	Impact/Timescale
• 955 CDI strain has not been identified • No changes to current themes identified across UHL which include: • Laxatives not reviewed for altered bowel output prior to specimen sample sent. • Delay in isolation into a single room on suspicion of infection. • Poor compliance with stool chart documentation	• Formal and informal teaching sessions at ward level, to be conducted by IPNs and CDI Nurse and Tillets (Supplier of Abx) • Re iterate in all training sessions the importance of early isolation • Ward staff to review patients presentation and isolation requirements on a daily basis • In absence of revised National CDI guidance, a HCAI reduction plan will be presented at TIPOG and TIPAC for 2025/2026	• Any immediate actions to be taken will be raised in TIPOG and the wards accordingly

Safe – Methicillin-susceptible Staphylococcus Aureus

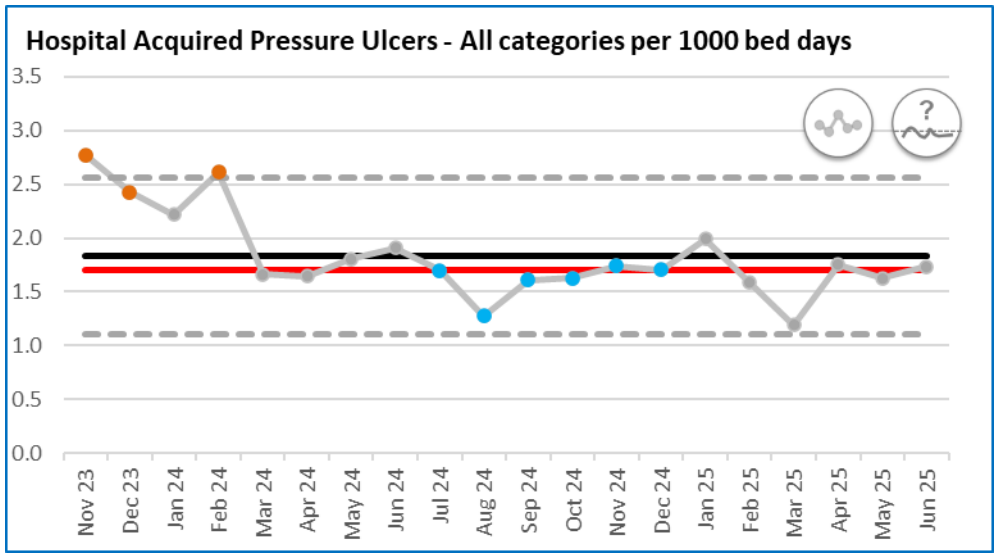


Current Performance		
Jun 25	YTD	Target
6	15	40

National Position & Overview	June	Total	
MSSA NHSE Threshold 25/26	3	40	
* Actual Infections (HOHA) 25/26	4	10	
* Actual Infections (COHA) 25/26	2	5	
*** Actual Infections Total (HOHA & COHA)** 25/26	6	15	
UHL 100,000 Bed Days (HOHA) 23/24	8.4	**6.92**	*YTD UKHSA Report
National Average	10.15		
National Highest	71.81		
National Lowest	0		

Root Cause	Actions	Impact/Timescale
• No new emerging themes locally or Nationally. • UHL themes include: Issues with compliance of the PVAD and CVC management	• A HCAI improvement plan as part of the IP programme of work for 2025/2026 will be submitted to TIPAC in July 25 • HCAI is scheduled as a routine agenda item at TIPOG • Monitoring of actions required following the PVAD/CVC audits will continue to be monitored through TIPOG • ANTT programme continues across UHL • PVAD Cannula Pathway embedded into Nervecentre	• Trust wide PVAD audit scheduled for April 2025 • Trust wide CVC scheduled for May 2025 • Trial Phase of Cannula Pathway on Nervecentre underway • A full review (MDT MRSA summit) of the MRSA policy and current UHL practise is underway and a report will be produced by the end of Q2

Safe – Hospital Acquired Pressure Ulcers - All categories per 1000 bed days



Current Performance		
Jun 25	YTD	Target
1.7	1.7	1.7

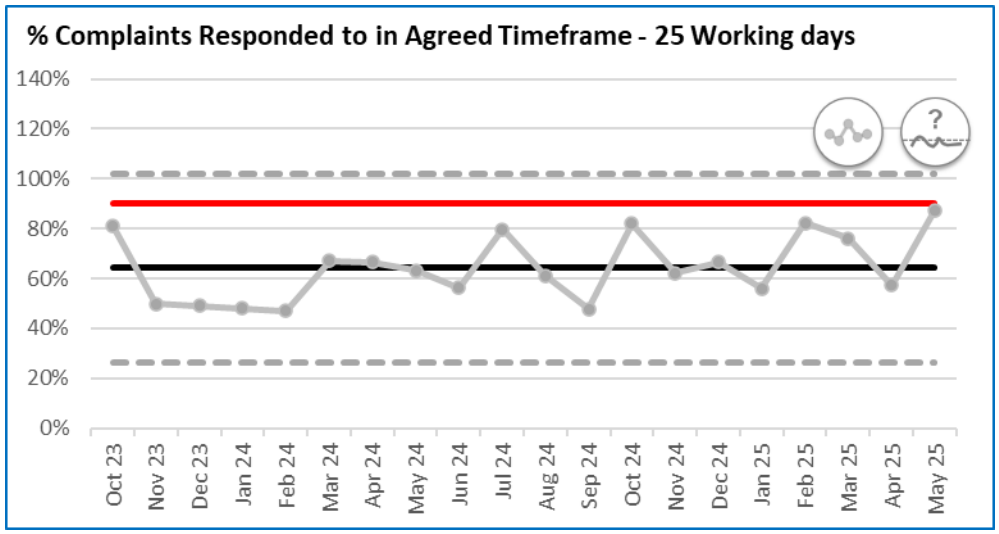
National Position & Overview

Currently there remains no national bench marking or reporting to provide comparative data, however the UHL position in June 2025 has risen to 95 HAPUS affecting 79 patients. The number of confirmed HAPUS has remained above 90 throughout Quarter 1.

95 HAPUs in total numbers and 1.7 per 1000 OBD. This is an increase from last years average position of 1.63 per 1000 OBD.

Root Cause	Actions	Impact/Timescale
• Appropriate escalation on to correct supportive surface (Mattresses and Cushions)	• Mattress Escalation Tool has now been approved and shared across clinical areas.	• Weekly review of Dolphin usage, with support of TV team – Increasing number of resolved DTIs, patient reviewed weekly for up to 4 weeks.
• Reduced prioritisation response times in alignment with categorisation and prioritisation tool.	• Review of TV Team rostering is underway, noting that service is not currently funded for weekend or BH Cover.	• TV Roster adjusted accordingly to mitigate potential excessive annual leave, currently reviewing BH service demand.
• Variance in staff knowledge, dependent on categorisation. • PAD usage remains high, reducing Continence promotion & potentially increasing MASD and reduced mobility to the bathroom facilities.	• Ongoing monitoring of HAPUs during weekly HAPU Validation Meeting, chaired by the Deputy Chief Nurse and TV Lead including the continence team. • Education support continues with Pioneer • Weekly complex case reviews continue with Pioneer MDT.	• Ongoing weekly monitoring. • Monthly education sessions • Weekly complex case reviews
• Variance in MUST completion and early dietician referral, impacting upon nutritional status, weight, and wound healing	• Hospital Acquired Malnutrition and MUST completion, entering onto the UHL Risk Register. • Assistance with Meal times being promoted across clinical areas, x2 weekly weights and accurate MUST Completion	• Risk to be completed by end August • Fundamentals of care roll out to commence immediately with a focus on all fundamentals of care including nutritional support

Caring – % Complaints Responded to in Agreed Timeframes



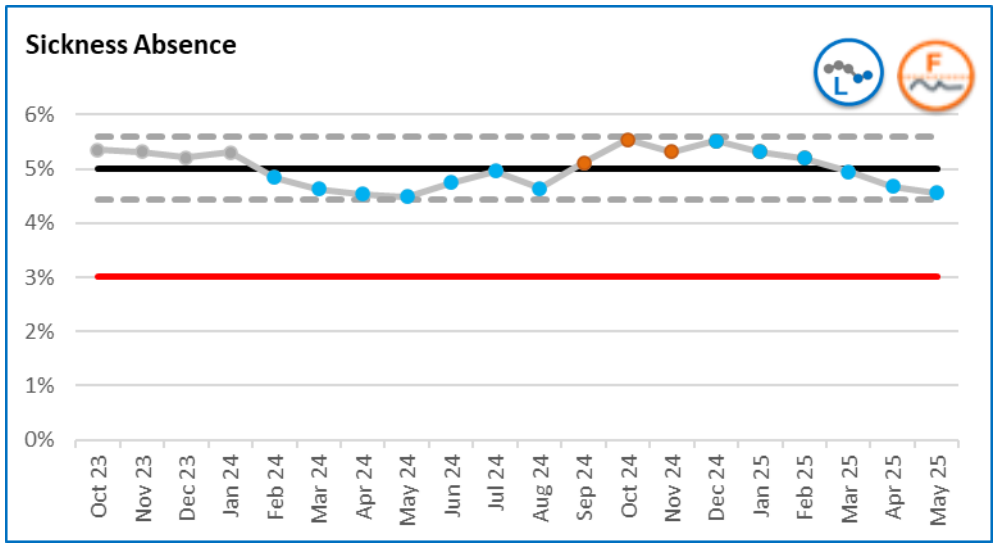
25 Working Days		
May 25	YTD	Target
87.1%	72.3%	90%

60 Working Days		
Apr 25	YTD	Target
94.7%	94.7%	90%

National Position & Overview

Root Cause	Actions	Impact/Timescale
• Significant improvement in 25 working day response time from May to June 25, due to changes in internal processes within the Complaints team	• Continue to monitor and take interventional actions as required	• Ongoing

Well Led – Sickness Absence



Current Performance		
May 25	YTD	Target
4.6%	4.6%	3%

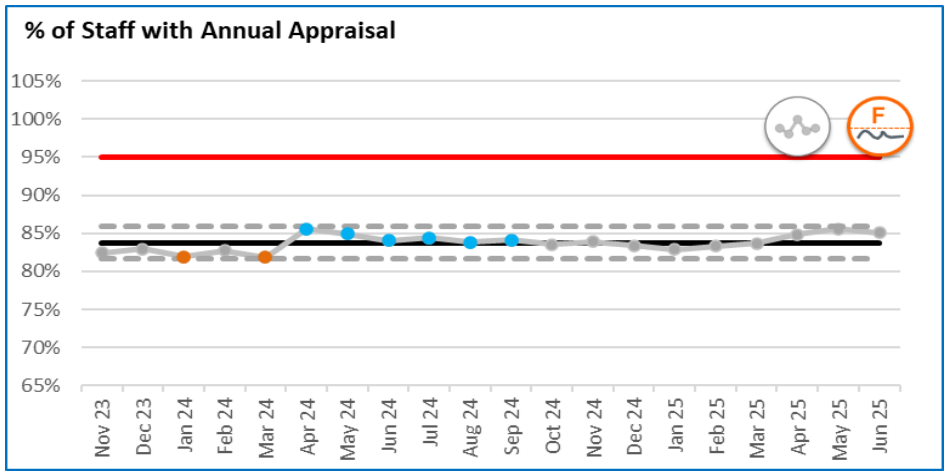
National Position & Overview

Peer data not available.

We have seen a small reduction in sickness absence between April (4.68%) and May (4.56%).

Root Cause	Actions	Impact/Timescale
• Clinical CMG's have seen a 0.23% reduction in sickness absence, and Corporate Directorates an increase of 0.35%. • Over the last 12 months, the highest levels of absence are in E&F (6.26%), W&C (5.80%), RRCV (5.50%). • The areas achieving the 3% target are within the Corporate Directorates • The top 3 reasons for sickness absence are anxiety/stress/depression (19.79%), Other known reasons (17.05%) and cough/cold/flu (12.99%)	• Improving accurate reporting reasons for sickness absence is essential for CMGs to ensure appropriate local and Trust wide interventions – reducing the 'unknown' absence reasons. • Wellbeing information is shared through corporate and local induction, HWB Ambassadors, monthly restaurant stands and weekly and monthly newsletters • Sickness absence data is reviewed with CMG's through PRM, Board and Specialty Meetings and local 'Making if all happen / Health and Wellbeing' reviews. • RRCV have undertaken a deep dive to inform their local actions and health and wellbeing support. Drop-in sessions for managers are also being arranged. • E&F have prioritized training for managers, implemented 'making it all happen' meetings for hot spot areas and recently moved to Optima for improved reporting and recording of sickness absence. • W&C are focusing on long term sickness absence and medical absences, and have rolled out line manager training and scheduled drop- in sessions. • For longstanding and complex cases, case conferences with OH occur. • The ER and Health and Wellbeing UHL Connect site covers all aspects of support, training, information, TALK toolkit for wellbeing conversations, template documents etc.	• The NHS Long Term Workforce Plan highlights improved retention of our workforce as one of its key pillars, which includes supporting them to stay well. • Through the 2024 Staff Survey results, we have continued to improve in the in the People Promise Theme "We are safe and healthy". • We are seeing an improvement in recording reasons for sickness absence over the last 3 months, where in 24/25 M8 we had 10.06% of absences recorded as 'unknown' reason, and in 25/26 M2 we have seen a further reduction to 4.65%.

Well Led – % of Staff with Annual Appraisal



Current Performance		
Jun 25	YTD	Target
85.1%	-	95%

National Position & Overview

Peer data not available.

June figures have seen a drop of 0.4 following a period of improvements. We are 9.9% away from the Trust target of 95%.

Root Cause	Actions	Impact/Timescale
• A number of colleagues have had appraisals within the last 12 months, outside the reporting/ incremental date and therefore show as non-compliant. • Appraisal reporting/ inputting is still a contributing factor in some areas and plans are underway to support a more efficient way of capturing this across services • In month, the appraisal average for UHL has decreased by 0.4 on the previous month • The decrease in the Trust's compliance in month has been due to minimal decreases in some clinical and corporate areas with the Research CRN team meeting compliance at 95%	• It has been acknowledged in previous exception reports that we would be unlikely to reach full compliance of 95% in the short term. • CMG reports are provided, highlighting performance and areas of focus, to enable targeted support and action. • The roll out of Managers Self-Serve over the coming year should see improvements in appraisal performance, particularly through reporting (see 'root cause') • Line managers at CMG level are asked to review appraisal performance and identify any additional targeted support required. Management guidance will be developed in the coming months.	• In June 2024 Appraisal performance was at 84.0% which was an decrease in compliance on the previous month of May 2024; this year we see an improved position compared to the 2024 figure. • Appraisals are reviewed through regular line management and Board oversight meetings. • CMG/ Directorate leadership to focus on quality appraisal discussion as essential to the employee experience and achieving our key objectives within areas in the coming year. Engagement work has taken place to review how we carry out appraisals. • The 2024 Staff survey has seen an improvement in the People Promise Theme 'We are always learning' aligned to appraisals.

Well Led – Non Clinical Agency- No. of Staff

Current Performance		
Jun 25	YTD	Target
3	15	0

Awaiting more data for SPC chart

National Position & Overview

NHSE Agency Rules stipulate trusts are required to use only substantive or bank workers to fill admin and estates shifts. Trusts should only use agency workers to fill these shifts where they meet exemptions (special projects & exceptional patient safety risks)

Root Cause	Actions	Impact/Timescale
• There are 3 Project officers in capital projects which meet the special projects exemption.	The service has been requested to advise on exit plans.	Exit plans will need to be in place by end of July in line with the Trust's objective to reduce agency usage and spend by 75% and also to become compliant with this KPI. Further letter received from NHSE in June highlighted the requirement to eliminate agency use in 25/26.

Well Led – Agency Staff above Price cap

Awaiting more data for SPC chart

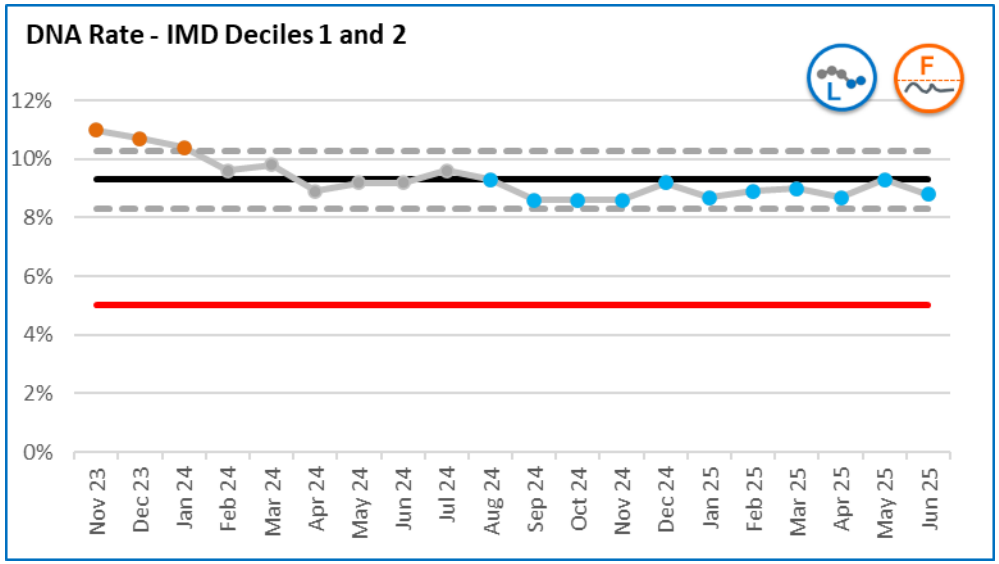
Current Performance		
Jun 25	YTD	Target
30	79	0

National Position & Overview

The price caps set by NHS England apply to the total amount a trust can pay per hour for an agency worker. Trusts should not pay more than the price caps to secure an agency worker, except in exceptional patient safety circumstances

Root Cause	Actions	Impact/Timescale
• Historically, all medical posts are over the agency price caps – this is a national issue • Nurses in roles such as Paediatrics, Childrens, Midwifery, ED, Theatres, chemo were over price cap due to specialist nature of the roles. • AHP specialist roles such as Sonography and Cardiac Physiotherapists are over price cap due to the specialist skill sets and specialist nature of the roles.	All Nursing complies with the general nursing agency price cap so we are compliant in this staff group.	• The Medical Agency Price Cap Compliance group has commenced – with the recommendation of moving to a rate card reduction plan across the region by September. UHL have some specialist fragile areas which will require a longer period of rate reduction which has been agreed in principle. • System review for AHP/HCS staff groups and transition by 30th June 25 so will have greater influence and control over price cap compliance. Conversations commenced with agency suppliers in respect of expectations of price cap compliance. We are over price cap only in specialist roles. Attendance at regional group by Chief AHP.

Effective – DNA Rate (IMD Deciles 1-2 & IMD Deciles 3-10)



DNA Rate – IMD Deciles 1-2			DNA Rate – IMD Deciles 3-10		
Jun 25	YTD	Target	Jun 25	YTD	Target
8.8%	9.0%	5%	5.7%	5.7%	5%

National Position & Overview

There is no national target for DNA rates, but understanding the role inequity plays in differential rates of non-attendance is vital to UHL's attempts to improve Theatre and Outpatients utilization, whilst enabling high quality care for all. This understanding also plays a broader role in supporting the achievement of targets on productivity and the Trust's aim of embedding health equality & inclusion in all we do.

Root Cause

- A total number of **6,217 patients DNA'd** their appointment in June 2025.
- **1,445** responded to the DNA florey – **26.6**% of delivered texts
- Patients in the most deprived IMD quartile account for **18.4%** of DNAs vs. **17.5**% from the least deprived quartile.
- **"I didn't know I had an appointment"** remains the most common reason for DNA in June (33% of responses) followed by **forgetting the date/time and trying to cancel/requesting to cancel or rebook** (25% combined) across all IMD quartiles.
- Note there are higher number than usual of DNAs with unknown IMD data (27% of total) which may be due to data flows/migration issues after the implementation of new Nervecentre PAS on 22nd June 2025.

Actions

- All IMD1 and IMD2 patients called two weeks prior to their appointment.
- Text appointment reminders (all) 7, 5 and 1 day before.
- DNA rate data is available for each CMG to identify specific areas of inequality.
- Multi-agency MDT established to support the most vulnerable groups eg Inclusion.
- DNA rates included in PRM packs and WAM discussions moving forwards.
- Engagement with communities to explore barriers to access.
- Trialing of AI to support cancellations/re-booking.
- Work starting in Community services.

Impact/Timescale

IMDs 1 & 2 have an average DNA rate of **8.8%** for June 25. Disaggregate by contact these rates are:

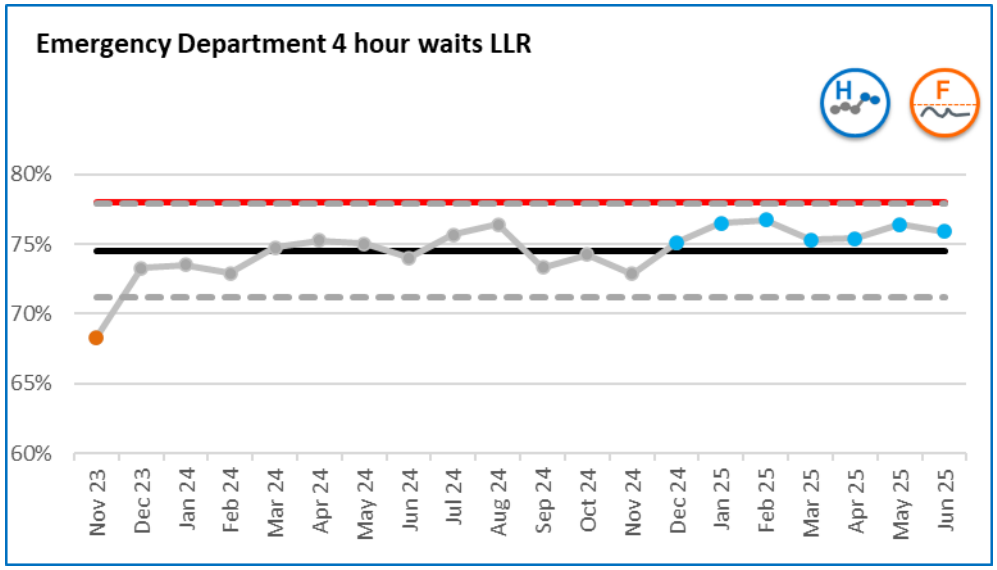
IMD1
- Patients contacted DNA rate **4.60%**
- Patients not contacted DNA rate **9.95%**

IMD2:
- Patients contacted DNA rate **4.94%**
- Patients not contacted DNA rate **11.09%**

Inclusion Healthcare:
- DNA rate for those contacted **0.00%**
- DNA rate for those not contacted **66.67%**

Paediatric Outpatients
- WNB rate contacted **4.55%**
- WNB rate not contacted **11.90%**

Responsive (Emergency Care) – ED 4 Hour Waits



LLR Performance			UHL Performance		
Jun 25	YTD	Target	Jun 25	YTD	Target
75.9%	75.9%	78%	60.8%	60.7%	61%

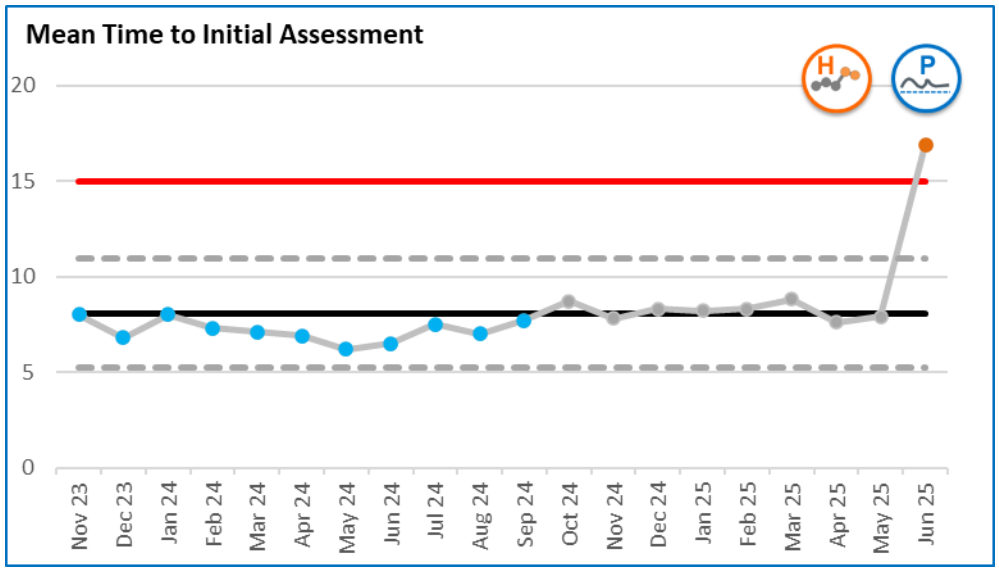
National Position & Overview

The UHL plan for June (57.1%) was achieved.

In June, UHL ranked 61 out of 123 Acute Trusts based on it's acute footprint. The National average was 75.5%. 39 out of the 123 Acute Trusts achieved the target. UHL ranked 10 out of the 18 UHL Peer Trusts. The best value within our peer group was 84.4% and the worst value was 67.4%.

Root Cause	Actions	Impact/Timescale
• High attendances to ED resulting in overcrowding in ED and the inability to assess and treat patients in a timely manner • High periods of inflow particularly in walk-in impacting on ambulance arrivals • UHL bed occupancy >92% resulting in an inability for patients to move out of ED	• Interprofessional standards audits, and improvement plans in place with individual specialities • Increase in SDEC (GPAU) activity with straight to SDEC for ED and EMAS • Deflection of minor illness patients to reduce numbers waiting in ED to DHU sites • Daily breach validation • Additional UTC capacity in community • Increase redirection and streaming	• Monitored through Performance Review Meetings and UEC Transformation Group • Improvement plan in place and activity is increasing • In place • Oadby and Merlin Vaz redirection remains in place System are working to increase productivity to increase capacity. • Additional capacity from July 2025 (completed) and impact being monitored

Responsive (Emergency Care) – Mean Time to Initial Assessment



Current Performance		
Jun 25	YTD	Target
16.9	10.6	15

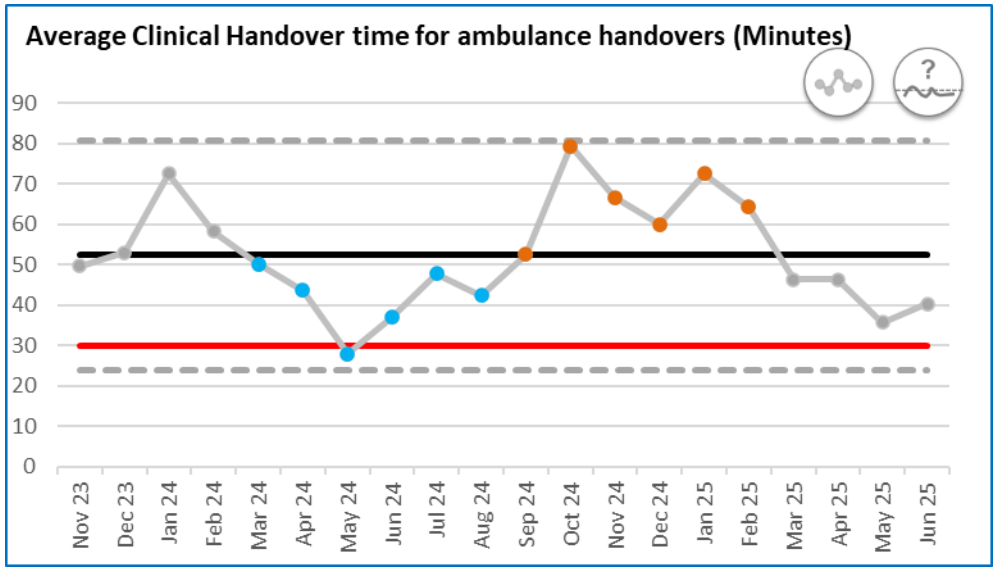
National Position & Overview

National data not currently available for reporting.

Please note that there are potential data quality issues affecting the performance on the days NerveCentre was offline during the PAS migration (20th/21st June). If we exclude these two dates then the mean time to initial assessment in June reduces from 16.9 minutes to 7.6 minutes, which is in line with previous performance levels.

Root Cause	Actions	Impact/Timescale
• PAS implemented which has caused data quality issues on embedding new practices. Validation of the position is within normal performance levels and better than target	• PAS governance groups in place to address all issues to business as usual	• Target for resolve by next reporting period

Responsive (Emergency Care) – Average Clinical Handover time for ambulance handovers (Minutes)



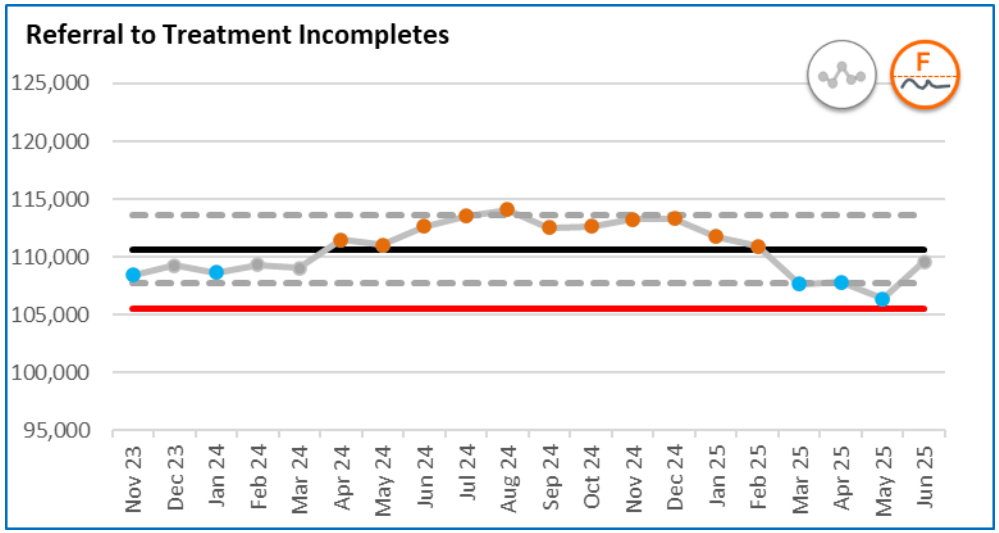
Current Performance			
Jun 25	YTD	Jun 25 Plan	Target
40	40	37	30

National Position & Overview

LRI ranked 21st out of 23 sites in the East Midlands in June (source EMAS monthly handover report).

Root Cause	Actions	Impact/Timescale
• Poor outflow across the emergency care pathway. • High inflow of walk-in patients competing with ambulance patients for trolley space • Sick patients walking in due to inability to get an ambulance	• Utilisation of pre-transfer unit at LRI • Utilisation of GPAU for bed waits • Utilisation of EDU for bed waits • Rapid flow and Boarding • Embed PTCDA and Urgent Care Co-ordination hub • Development of system winter plan • Development of UHL winter plan • Development of extra-ordinary actions – Implement release to respond	• In place • In place • In place • In place • Ongoing – daily / weekly monitoring • Completed • In place • Implemented March 2025 – monitoring in place

Responsive (Elective Care) – RTT Incompletes



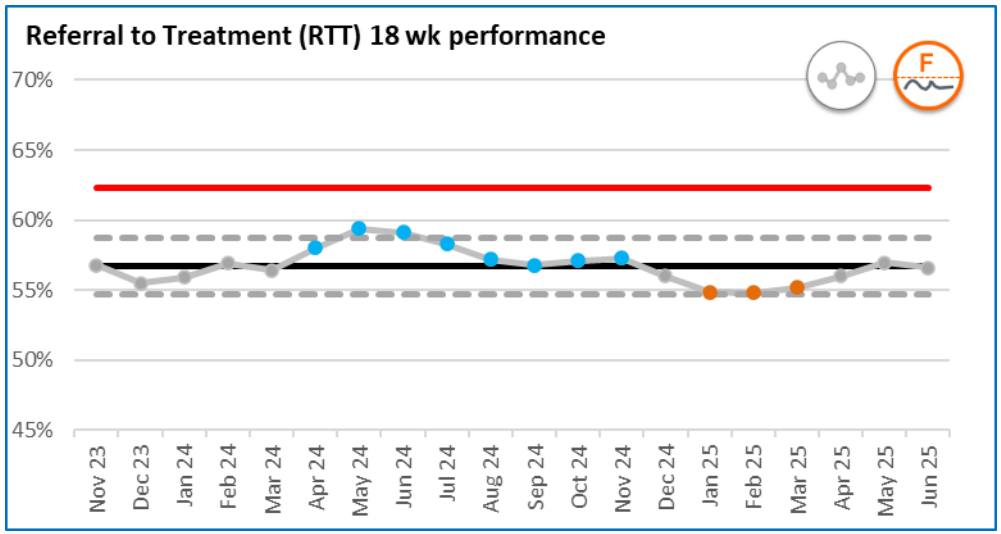
Current Performance		
Jun 25	Jun 25 Plan	25/26 Target
109,601	112,078	105,500

National Position & Overview

At the end of May, UHL ranked 15 out of 18 trusts in its peer group with a total waiting list size of 106354 patients. The best value within our peer group was 64230, the worst value was 190129 and the median value was 86674.5. (Source: NHSE published monthly report)

Root Cause	Actions	Impact/Timescale
• Continued growth in demand against a significant number of specialities • Continued workforce challenges within ITAPS reducing theatre capacity • Estate- lack of theatre capacity and outpatient capacity to increase sessions and also age of estate leading to problems with losing capacity for maintenance work • Emergency pressures resulting in elective cancellations, with paediatric specialties particularly challenged during winter months. • **Trustwide roll out of e-triage through eRS in Q3 and 4 of 24/25 led to a 'false' reduction in total waiting list and those waiting under 18 weeks. The reported waiting list size has increased from July 25 as these patients are included within the new PAS.** • **Activity and administrative actions, including validation, have been reduced since PAS implementation on 22 June.**	• Validation actions to respond to national ambition of 90% of patients who have been waiting over 12 weeks to be validated within the last 12 weeks. • Planned additional data quality validation each month to support overall reduction of WL – as per funded National Validation 'Sprint' exercise 25/26. • Theatre productivity and outpatient transformation workstreams to improve productivity and increase capacity. • Focused actions with the CMGs regarding meeting activity plans in the EMPCC business case • Community Diagnostic Center opened end of May • Developing options appraisal for future surgical hub funding and a plan for the theatre redevelopment programme. • Continued learning and fix finding in new PAS • Project to implement FDP (Federated Data Platform) RTT Validation module across UHL/UHL in the Community	• Our focus remains on ensuring clean waiting lists in 25/26 as operational plans set a target of 105,500 for overall WL by the end of March 26. • Above baseline for validation sprint in Q1. Participating in Q2 sprint July-Sept 25. • EMPCC will provide an extra 100,000 appointments every year for outpatient consultations and low-complexity treatments, including day case surgery. • CDC will support an increase in diagnosis and therefore, supporting an increase in clock-stops (FYE additional 89,000 tests) • Expect business as usual validation to return to pre PAS implementation figures within 3 months (September 25). • Increased volumes of validation, better visibility across corporate and clinical services of clean PTL.

Responsive (Elective Care) – RTT 18 Week Performance



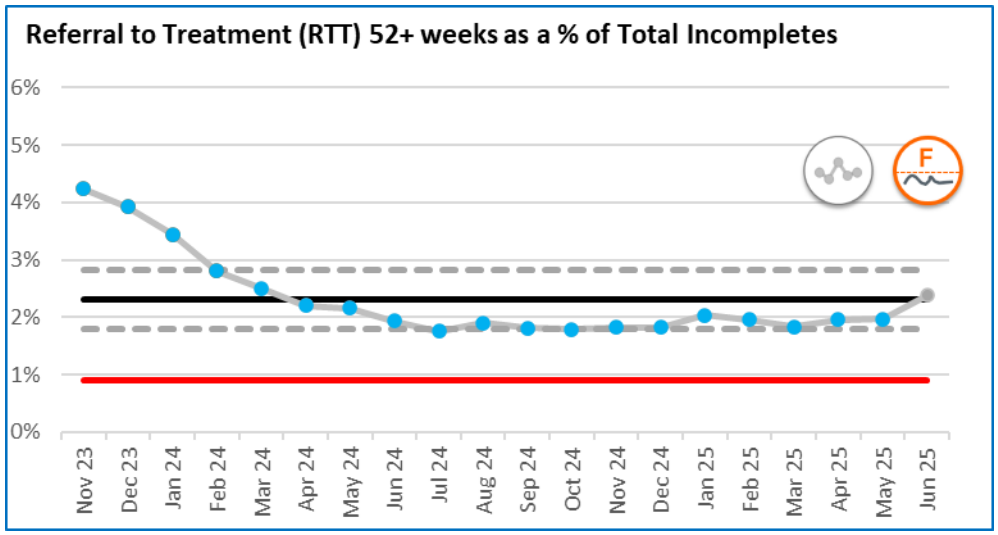
18 Week Performance			First Attendance - 18 Week Performance		
Jun 25	*Jun 25 Plan*	25/26 Target	Jun 25	*Jun 25 Plan*	25/26 Target
56.6%	*57.6%*	62.3%	64.9%	*61.5%*	68.1%

National Position & Overview

At the end of May, UHL ranked 11 out of 18 trusts in its peer group with RTT 18 Week Performance at 57.0%. The best value within our peer group was 73.1%, the worst value was 51.7% and the median value was 58.0%. (Source: NHSE published monthly report)

Root Cause	Actions	Impact/Timescale
• Impact of reduced outpatients and Inpatient activity during Covid, which built up a significant backlog. • Continued growth in demand against a significant number of specialities • Emergency pressures resulting in elective cancellations, with paediatric specialties particularly challenged. • Nervecentre PAS implementation at the end of June 25 has led to the inclusion of patients waiting e-triage on the WL. These will be in our reported month end position from July 2025 and will have a positive impact on 18ww performance due to the majority of additions being less than 18weeks.	• Planned additional data quality validation each month to support overall reduction of WL – as per funded National Validation 'Sprint' exercise 25/26. • Demand and Capacity modelling to support future planning. • Assessment of demand for elective treatment by specialty to understand where maximum impact for UHL can be delivered to support 18wk standard improvements. • Theatre productivity and outpatient transformation workstreams to improve productivity and increase capacity.	• Targeted validation in the sprint periods and month end processes to maximise removals of the longest waiters and those waiting over 18 weeks. • PAS nerve centre implementation in June 25 will mean all referrals awaiting clinical triage will be automatically added to NC/PTL before triage. This will result in a higher total PTL, but improve 18 wk overall and to first attendance performance. These will be in our reported month end position from July 2025. • Outpatient clinic standardisation plan agreed at TLT in July will support an increase in outpatient clinic appointments supporting improved 18ww performance.

Responsive (Elective Care) – RTT 52+ weeks as a % Of Total Incompletes



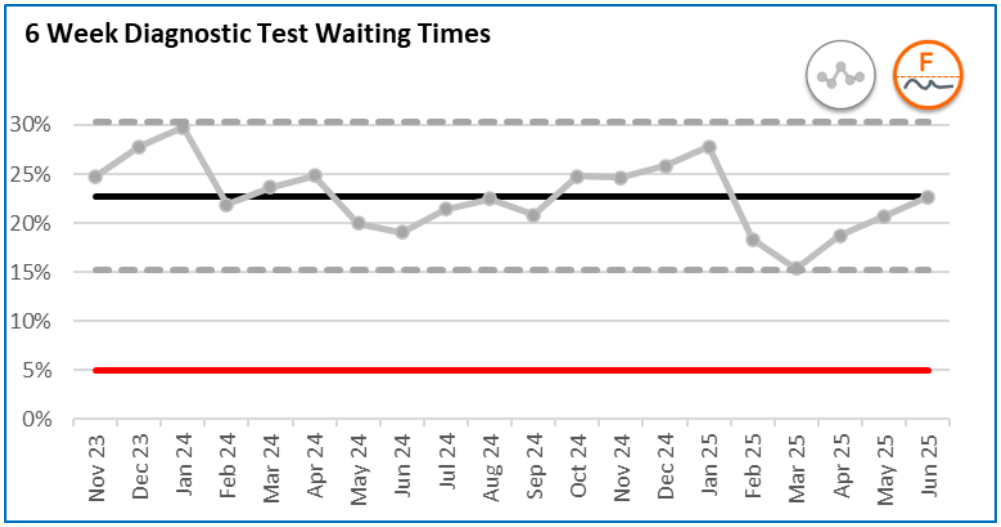
Current Performance		
Jun 25	Jun 25 Plan	Target
2.4%	1.8%	0.9%

National Position & Overview

At the end of May UHL ranked 5 out of the 18 Trusts in it's peer group with 2.0% of patients on the waiting list waiting over 52+ weeks. The best value within our peer group was 1.6%, the worst value was 5.4% and the median value was 2.9%. (Source: NHSE published monthly report)

Root Cause	Actions	Impact/Timescale
• Impact of COVID-19 on planned activity capacity led to a growing backlog • Challenged Cancer position and urgent priority patients requiring treatment • Workforce challenges in anaesthetics leading to cancellations of theatre lists • Admin workforce challenges across a range of posts, particularly band 2/3 impacting on ability to book patients • Emergency pressures are resulting in elective cancellations, with paediatric specialties particularly challenged. • Increased volumes of patients on waiting list (increased demand) and reduction of additional activity funded previously through ERF. • Reduction in activity due to PAS rollout. Activity not yet up to pre-roll out levels.	• Using ERF to fund insourcing in particularly challenged specialities to increase predominately outpatient capacity e.g. ENT, Gastro, Maxfac, Ophthalmology • Super-clinics planned to increase capacity to see new outpatients. • Continued roll-out and focus on PIFU and DNA processes to increase capacity for new patients • Focus on productivity to increase capacity and reduce waits. • Standard Operating Procedures developed linked to the access policy, improving data quality. • Weekly performance meetings with CMGs to be introduced to provide support and challenge to Clinical and Operational leads. • Paediatric ENT Superweek of elective operating planned w/c 21/7.	• **52ww as % of the total WL** - Our operational plan for 25/26 sets us the ambition of achieving <1% of our total waiting list to be waiting 52+ weeks by the end of March 26. June performance was 2.4% against the 1.8% plan. Our peer and national benchmarked position remains better than the peer median of 2.9% in May 2025. • **52 week waits –** June plan was 1,601 and we finished above plan at 2,605. 52+ww are increasing rather than reducing, with the bulk of waiters in Maxfax, Orthopaedics/Spines, ENT/Paeds ENT and General Surgery. • **65 week waits –** June position (145) was worse than forecast 130, largely due to continued emergency pressures leading to elective cancellations. We do not currently have a route to zero for 65wws. Plan being developed. • **78 week waits** – June performance was 6 78ww, with 2 forecast in July (expected treatment start dates in August).

Responsive (Elective Care) – 6 Week Diagnostic Test Waiting Times



Current Performance

June 25	YTD	Jun 25 Plan	Target
22.7%	-	14.0%	5.0%

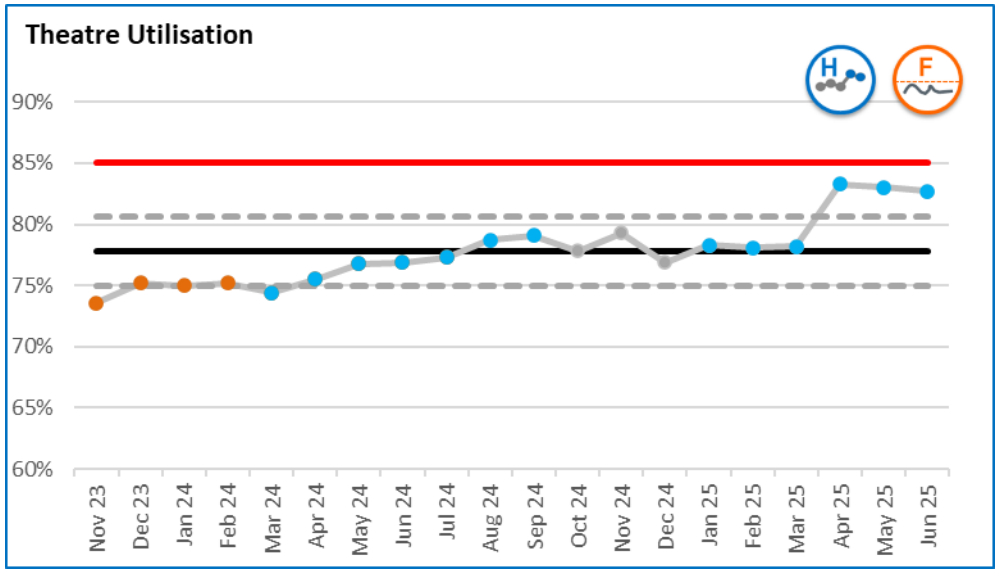
National Position & Overview

Published National data at the end of May 25 shows 1.7 m patients on the diagnostic waiting list with 22% waiting over 6 weeks. For June 25, UHL with 27,310 patients would comparatively rank as the 6th highest waiting list. The 6-week trajectory for June was set to deliver 14.4%, the actual was 22.7%, 8.3% behind plan, driven by NOUS, Echo and Audiology. There were 6,196 patients waiting >6 weeks an increase of 521 from May 25.

Root Cause	Actions	Impact/Timescale

Diagnostics pressure areas are in the main:
• NOUS
• MRI
• Sleep Studies
• Echo
Root cause
• Clinical workforce gaps
• Admin recruitment
• Reporting and coding errors (sleep)
• Overall NOUS and Echo waiting list growth
• Pressure from emergency and cancer pathways
	• QLIK & PAS WLMDS training
	• Review existing protocols to reduce repeated investigations
	• Increased productivity of resource
	• Increase capacity
	  ◦ New endoscopy unit – Oct 25
	  ◦ Hinckley Community Diagnostics Centre – from May 25
	• Clinical decision support tool (i-Refer) implemented for MRI, CT & NOUS October 24
	• Expand direct access diagnostics 25/26
	• Sleep
	  ◦ Additional capacity
	  ◦ Review of workforce opportunities
		• Training following PAS upgrade – Aug 25
		• Validation – ongoing
		• Productivity metrics for CT, MRI and Endoscopy. June saw improvements in DNA for CT and improved session utilisation in Endoscopy. Outpatients modalities added from Q2 and showing Cystoscopy and Sleep Adult utilisation above 80% and Urodynamics at 75%.
		• MRI vans x2 on site supporting recovery, funding for 1 confirmed for 25/26.
		• Sleep additional capacity through increases to in clinic utilisation and outsourcing with 100 patients left to finalise. Review of sleep pathways and workforce recommendations in progress – Q2
		• NOUS demand review ongoing
		• Review of MRI D&C – August 25

Responsive (Elective Care) – Theatre Utilisation



Current Performance		
Jun 25	YTD	Target
82.7%	83.0%	85%

National Position & Overview

GIRFT has set a target for Integrated Care Systems and providers to achieve 85% theatre touch time (capped) utilisation by 2024/25. This supports the aims of NHS England's 2022/ 23 priorities and operational planning guidance to secure sustainable elective recovery.

Root Cause

UHL's OTDC rates have fluctuated between 9% and 11% within the last months, there has been no sustained downward trend despite improvements with overall utilisation.

Site	% Utilisation	% late starts over 15-mins	ACPL	% OTDC
Community	81.5% ↑	36.8% ↓	4.92	5.62% ↑
EMPCC	73.0% ↓	16.3% ↑	2.99	11.43% ↑
GGH	89.0% ↑	8.7% ↓	1.26	7.34% ↑
LGH	85.8% ↓	14.2% ↑	2.09	6.50% ↓
LRI	76.6% ↑	35.2% ↓	2.11	9.33% ↑

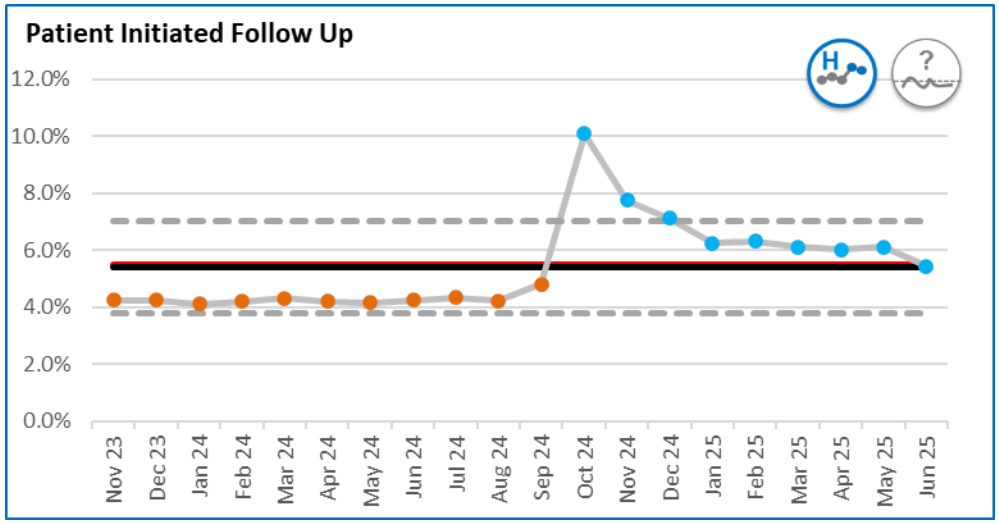
Actions

- A Cancellation Focus Group was delivered in July to improve data quality and facilitate collaborative root cause analysis.
- Data Quality Validation was conducted throughout June and July to establish a reliable baseline for performance.
- Engagement with GIRFT is underway to identify further improvement opportunities and obtain expert guidance.
- EMPCC utilisation to be maximised across all operating lists to exceed the 85% target.
- A service-level review of list utilisation and escalation processes is ongoing to address underperformance.
- Continued focus on maintaining and improving utilisation across all sites

Impact/Timescale

- Targeted interventions expected to reduce OTDC rates over the next quarter (Q2 25/26).
- Improved accuracy in reporting and understanding of true performance - Completed by end of July 2025, validated data to further guide performance reviews from August 25.
- GIRFT support will initially focus on ophthalmology - findings and recommendations to be shared across all specialties to drive wider improvement.
- Continued focus on sustaining high utilisation, particularly at EMPCC – Immediate and ongoing through fortnightly performance reviews
- Services instructed to implement immediately; impact expected within 4–6 weeks and monitored through monthly/weekly TPAB.

Responsive (Elective Care) – PIFU

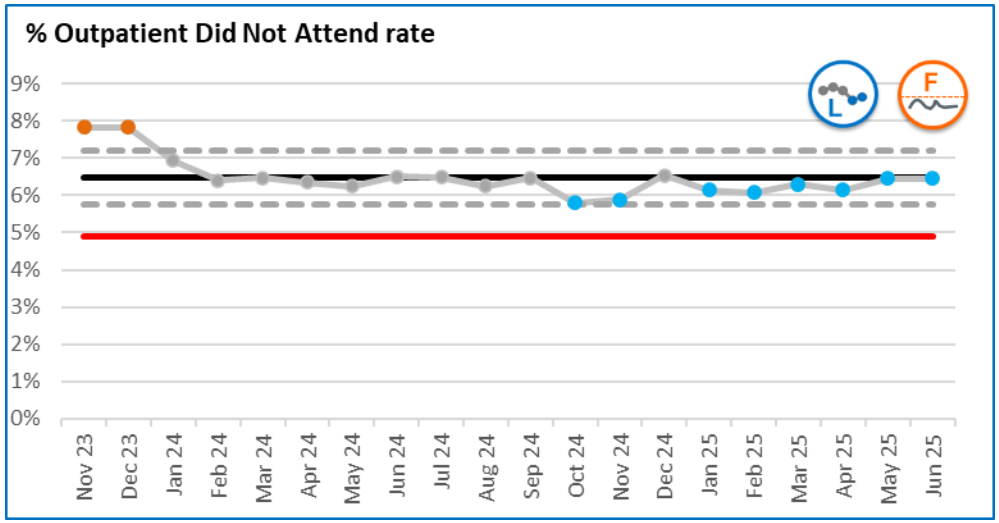


Current Performance		
Jun 25	YTD	Target
5.4%	5.8%	5.5%

National Position & Overview

Root Cause	Actions	Impact/Timescale
• Clinical support of rolling out PIFU within individual specialties and identifying appropriate cohorts of patients • Clear Communication about PIFU with clinical, nursing and administration teams • Review of all types of contact with patients such as helplines, shared care agreements to be recorded as PIFU. This is a nationally recognised approach. • Concern that there will be a higher demand for follow ups if patients are offered PIFU and admin burden	• Targets for each specialty have been agreed by the CMG and specialty leadership team. Where specialties are currently achieving above the national benchmark a stretched target has been set. • PIFU focused specialty meetings will continue for specialties below target • Continuous monitoring of PIFU performance for all specialties via the weekly report • Continue to share Further Faster and GIRFT benchmarking and resources • Appropriate recording of helplines as PIFU alongside a planned routine reviews. This agreement is needed by specialties offering helplines. • Reporting of PIFU Initiation rates at specialty level • Continue to promote and implement Digital PIFU via Accurx. This will assist with triage for patient requests to avoid admin time	• Continuous monitoring of PIFU performance via the Monthly Outpatient Transformation Board , fortnightly speciality meetings and at level 2/3 access performance meetings . • Regular updates , and links to admin resources to be provided to wider organisation through UHL operational briefings • New Clinic Outcome form to be launched in October 24 to support the capturing of PIFU outcomes accurately.

Responsive (Elective Care) – Outpatient DNA Rate

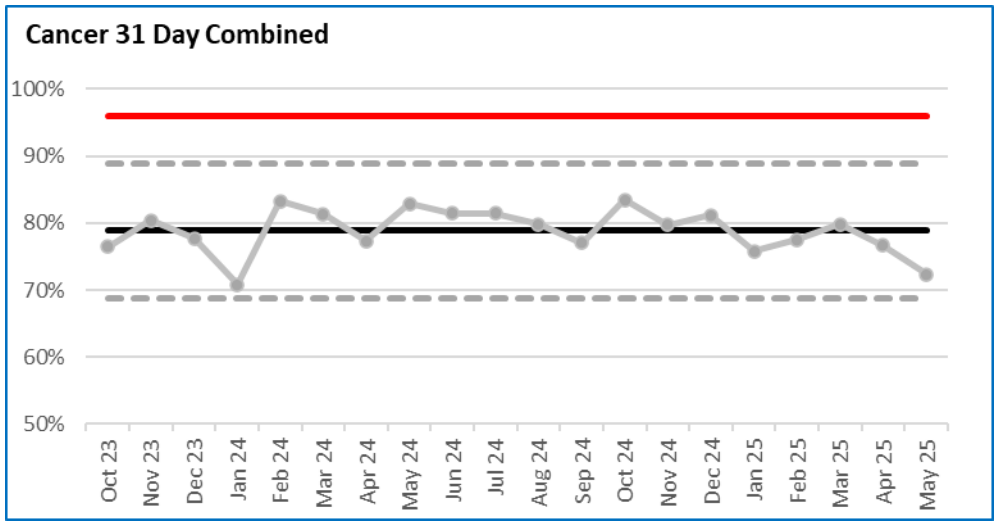


Current Performance		
Jun 25	YTD	Target
6.5%	6.3%	4.9%

National Position & Overview

Root Cause	Actions	Impact/Timescale
1. The launch of the new PAS has meant an issue with the data feed going to Accurx so patients did not receive automated reminders for a while 2. Late cancellations/rebooks often mean patients do not receive their appointment letters on time so unaware of appointment 3. Due to lack of admin staff, patients unable to get through to department to let them know they're unable to attend, or admin are not actioning cancel/rebook requests in Accurx. 4. Services are not always maintaining their appointment reminder house keeping in Accurx 5. For telephone appointments, clinicians not giving the patient enough time to answer or only calling the patient once	1. Complete Neurons ticket when made aware of any issues with clinic lists in Accurx or feed going from UHL to Accurx 2. Remind services of the need to check the patients details are correct and up to date at every contact 3. Services to text patients appointment details if changes are made to appointments 4. Booking Centre are making additional calls to 'Health Inequalities' cohort now including Paediatrics. 5. DNA florey is being sent to patients who DNA and further analysis is being done around the reasons for DNA. The 'Other' option has been removed from the florey and 2 more questions added. 6. Accurx automated clinic appointment reminders have gone live in the majority of services including Imaging and Therapies. Clinic lists are also available in Accurx for most services 7. Share Missed Appointment questionnaire responses with services to review and action as appropriate	• All actions, plus many others, are happening imminently to help reduce the number of DNAs. • An improvement in the DNA rate should continue over the next 3 months providing the actions are carried out.

Responsive Cancer – Cancer 31 Day Combined



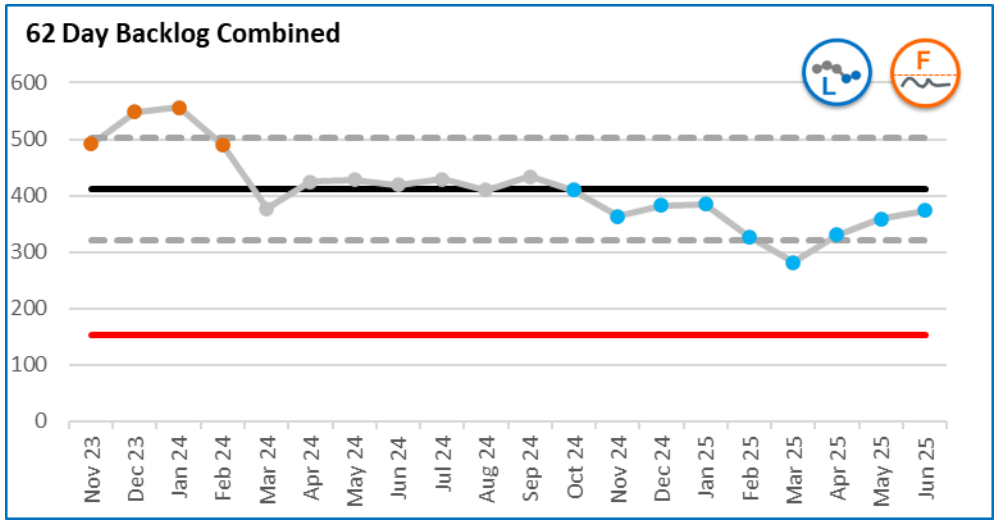
Current Performance			
May 25	YTD	May 25 Plan	Target
72.4%	74.6%	79.1%	96%

National Position & Overview

In May, UHL ranked 138 out of 137 Acute Trusts. The National average was 91.0%. 56 out of the 137 Acute Trusts achieved the target. UHL ranked 18 out of the 18 UHL Peer Trusts. The best value within our peer group was 98.0%, the worst value was 72.4% and the median value was 88.6%.

Root Cause	Actions	Impact/Timescale
• Insufficient capacity within surgery, chemotherapy and radiotherapy to meet current demand • Radiotherapy demand has exceeded capacity – affecting prostate and breast category 2 patients • Patient readiness to proceed with surgery impacting in addition to capacity constraints (physical and workforce including case mix) • 31 day anti-cancer drug regimes capacity is constrained mainly within pharmacy provision	• Increased emphasis at PTL meetings to bring forward patients within target - weekly • Radiotherapy 5th linac • Radiotherapy mutual aid • Radiotherapy efficiency workstream • Oncology OPD and SACT efficiency • Oncology OPD review • Surgical dating for availability to improve • Pharmacy workforce review to support increased SACT capacity • EMAP - Oncology regional review of mutual aid and workforce opportunities (East Midlands Acute Providers). • Collaboration with UHN	• Radiotherapy; - 5th linac – in place - mutual aid continuing in Q2 - D&C east midlands review - August - Review of workflow opportunities to increase capacity. Phase 1 completed in July, phase 2 – September 25 • CWT surgical dates – improvement delivered in June in Breast • Oncology OPD review of schedule – complete, impact anticipated from 1-3months • Digital opportunities and pathway efficiencies to be scoped including for Onc/SACT – Jul 25 • UHN oncology collaboration work commenced

Responsive Cancer – Cancer 62 Day Backlog

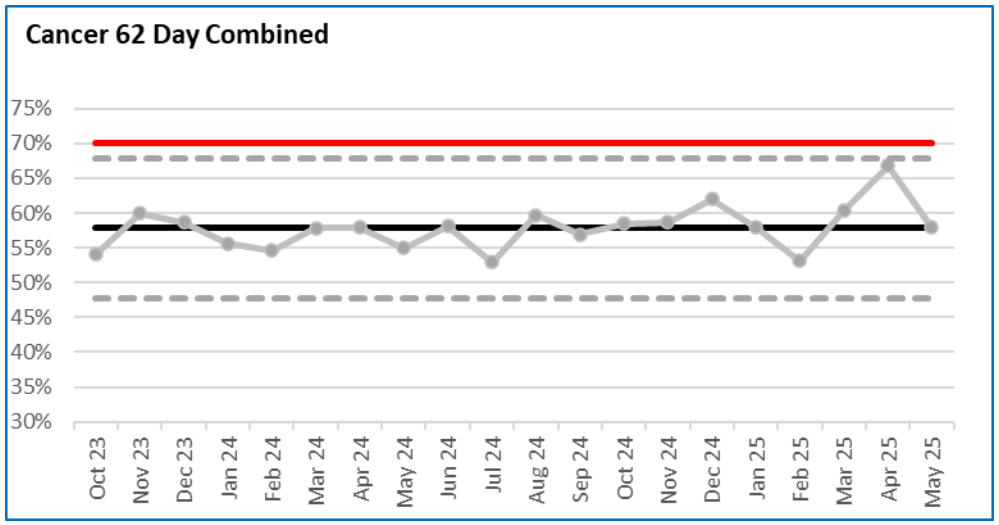


Current Performance		
Jun 25	YTD	Target
374	-	152 (by Mar26)

National Position & Overview

Root Cause	Actions	Impact/Timescale
• Post pandemic increase in patients waiting more than 62 and 104 days • Constraints include capacity, specifically outpatient, diagnostic and workforce. • Increase in diagnostic tests required and patient factors impacting. • Oncology OPD capacity and waits contribute	• Clinical prioritisation of all cancer patients and clinical review of patients over 104 days. • Daily & weekly reviews • Internal trajectories agreed with services • LD/Autism and SMI flags on PTL • Pre-diagnosis nurse support for patient engagement. • Digital solutions to support pathway progression • Request for additional cancer activity	• Recovery and performance action plans in place with increased frequency for those behind plan. • Additional capacity required –services exploring options to support (Skin, H&N, Breast) – ongoing. • Oncology review of OPD capacity complete, anticipate 1-3months to implement – Q3 • Expansion of PSFU opportunities scoped – review of workforce options to enable expansion – Sept 25 • Discussion on sequential ordering continuing at Cancer Board – ongoing

Responsive Cancer – Cancer 62 Day Combined

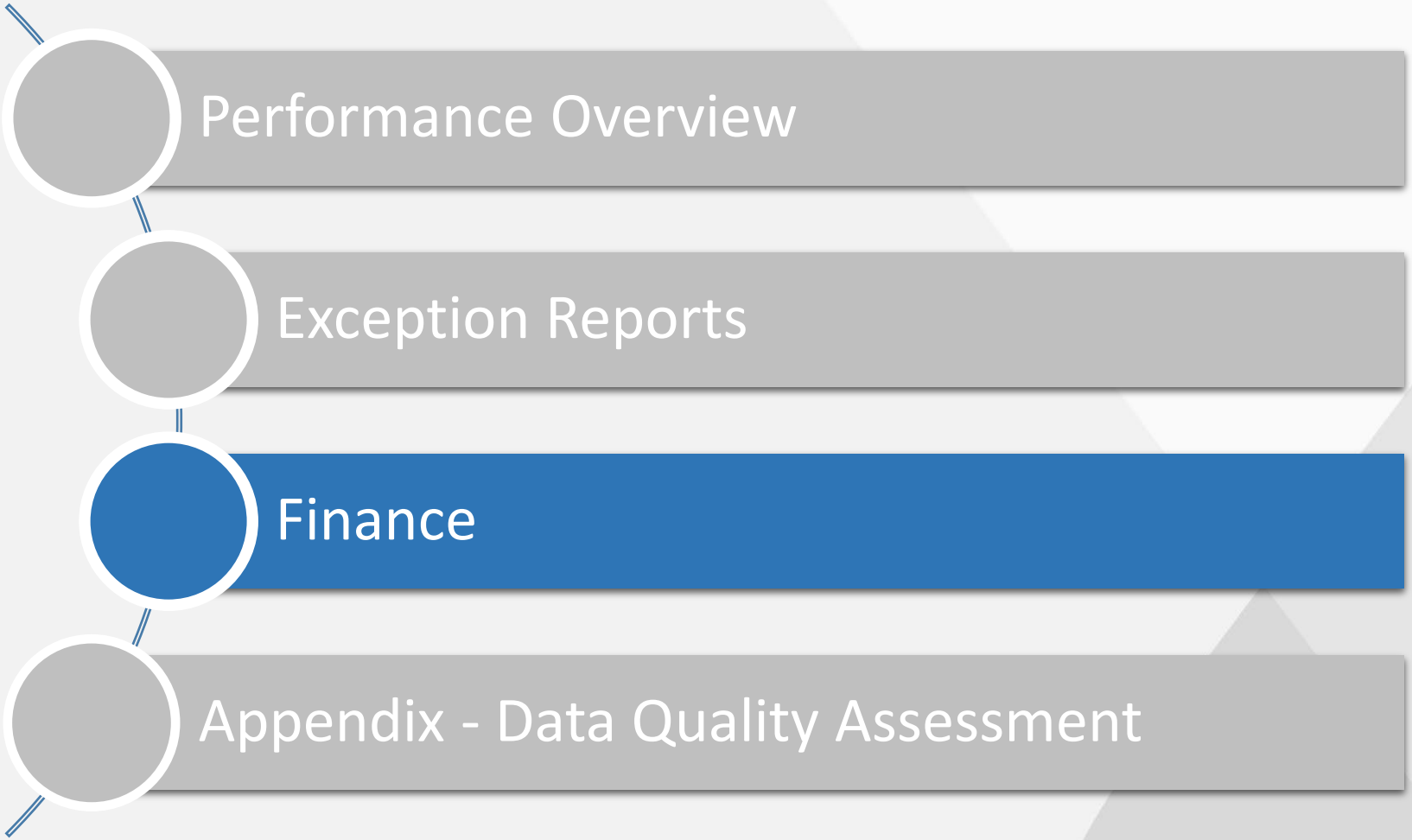


Current Performance			
May 25	YTD	May 25 Plan	Target
58.0%	62.5%	60.1%	70%

National Position & Overview

In May, UHL ranked 128 out of 145 Acute Trusts. The National average was 67.8%. 80 out of the 145 Acute Trusts achieved the target. UHL ranked 13 out of the 18 UHL Peer Trusts. The best value within our peer group was 75.5%, the worst value was 46.3% and the median value was 63.3%.

Root Cause	Actions	Impact/Timescale
• Capacity constraints across various points of the pathways • Focus on treating patients in order of clinical priority and longest waits impact performance • Increase in diagnostic tests required and patient factors • Oncology OPD and radiotherapy capacity contribute to longer wait times • Risks for H&N, Skin and Breast capacity due to workforce challenges	• Clinical prioritisation of patients and increased emphasis at PTL meetings to bring confirmed cancers within target - weekly • Escalation process in place • Recovery & Performance (RAP) in place • Review of pathways in line with Best Practice Timed Pathways (BPTP). • Additional capacity required – Urology, Breast, H&N and Skin • EMCA 25.26 funding SDF of £1.5m plus £403k allocated for Tier 1 support in Q1 and £704k confirmed for Q2. • Pre-diagnosis nursing team supporting PTLs	• Focus on time to 1st appointment, FDS, reducing backlogs and improved utilisation across all pathways – monthly • Risks for 1st appointment capacity in Skin/H&N/breast services working to resolve including opportunities for mutual aid. • Joint skin/plastics clinic – once a month in place • Locum support for H&N and Skin – July/ August • Breast improvement project - pathway mapping – August - D&C review for appointments - complete - Review of processes, opportunities for further one stop diagnostics – scoping August


Performance Overview
Exception Reports
Finance
Appendix - Data Quality Assessment

Executive Summary

- The month 3 position for the Trust is a deficit of £8.8m which is £2.8m adverse to plan. The main drivers are reduced patient care income £3.4mA (mainly elective care), under-recovered other operating income excluding donated assets of £1.9mA, offset by pay/non-pay underspend of £3mF and other £0.5mA.

- The Trust committed net capital expenditure of £5m in Month 3 after deducting charitable donations/capital grants, resulting in an underspend of £9m against CDEL target of £14m for M3.

- The cash position at the end of Month 3 was £75.5m, which is an increase of £35m from M2, which is mainly driven by the timing of the payroll, which took place after the closure of ledger for M3 reporting. The payroll value was £49.1m therefore the closing balance would have been £26.4m leading to a reduction of £14m from M2

Summary Financial Position – YTD M3

	I&E YTD		
	Plan	Actual	Variance to Plan
	£'000	£'000	£'000
NHS Patient-Rel Income	405,507	401,335	(4,172)
Other Operating Income	45,230	42,365	(2,865)
Total Income	**450,737**	**443,701**	**(7,037)**
Pay	(284,177)	(282,022)	2,155
Non Pay	(149,283)	(148,428)	854
Total Expenditure	**(433,459)**	**(430,450)**	**3,009**
EBITDA	**17,278**	**13,250**	**(4,028)**
Non Operating Expenditure	(22,162)	(21,915)	247
Surplus/Deficit	**(4,884)**	**(8,664)**	**(3,781)**
Donated Assets Adjustment	(1,134)	(108)	1,026
Control Total Surplus/Deficit	**(6,018)**	**(8,772)**	**(2,755)**

Comments – YTD Variance to Plan

Total Income: £7mA:

- Under recovery of PCI income of £3.4m (Exc. EDD) which includes an assumption of £1m impact of PAS implementation. (see income slide for more detail).
- Other income includes reduced donated income £1mA offset by donated asset adjustment, CSI £0.8mA (mainly relating to pathology, pharmacy, imaging), reduced private patients £0.1mA, reduced E&F income £0.8mA mainly relating to car parking/catering and other income £0.1mA.
- Passthrough **excluded drugs and devices** lower than plan £0.8mA offset by expenditure.

Pay: £2.2mF:

- Medical and dental £1.1mA. Mainly linked to medical locum covering gaps in RRCV and CHUGGS.
- Nursing, midwife and health visitor staffing is £2.2mF driven mainly by increased bank usage controls across most CMGs.
- Other clinical £0.7mF.
- Non-clinical £0.4mF.

Bank (£16.6m) and Agency (£1.3m) spend YTD amounts to £17.9m which is 6.3% of total pay. June saw a £0.4m reduction from May.

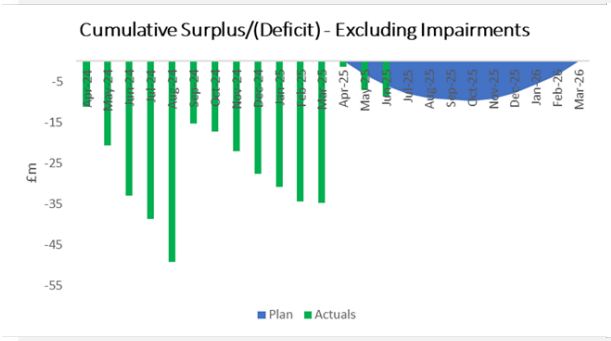
Non-Pay: £0.9mF:

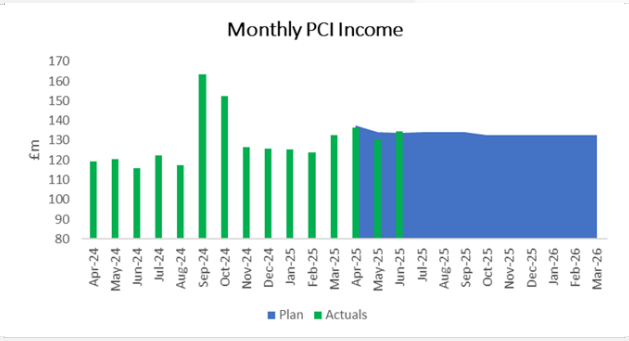
- Clinical supplies and services £1.3mA is mainly driven by CHUGGS and ITAPs – robotic surgery consumables, prior year insourcing/sleep monitoring invoices and undelivered CIP.
- Drugs £1.5mA - mainly due to CHUGGS block baseline drugs in Haematology/Oncology and undelivered CIP.
- Premises and Fixed Plant £0.9mF mainly driven by energy/utilities, credit notes and software underspend in corporate services.
- Excluded drugs and devices underspend covered by income. Expenditure/Income variance difference driven mainly by Vat reclaims

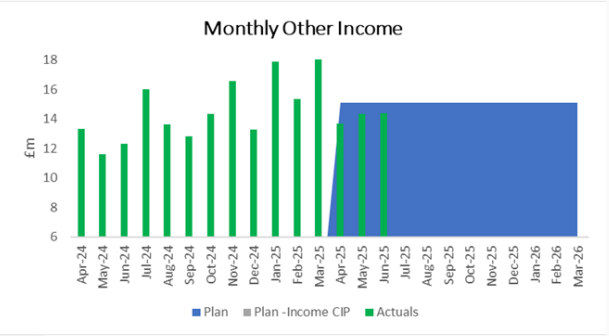
Non-Operating Costs £0.2mF relating to increased interest receivable.

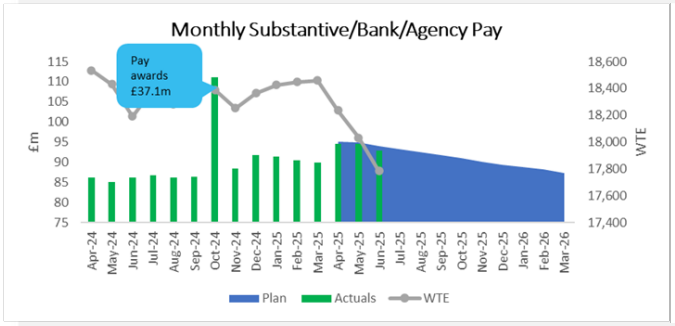
Donated assets variance is driven by lower donations than planned (this is offset in other income).

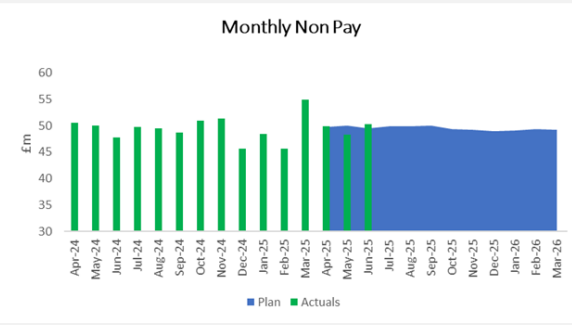
Month 3 I&E Dashboards

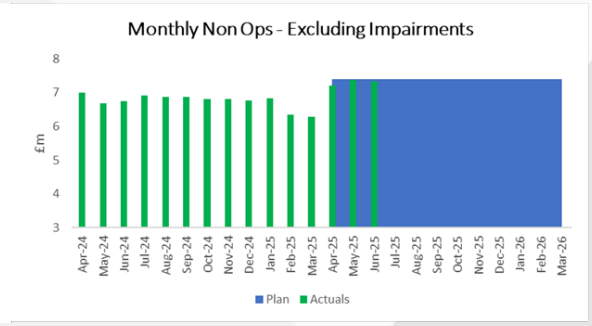


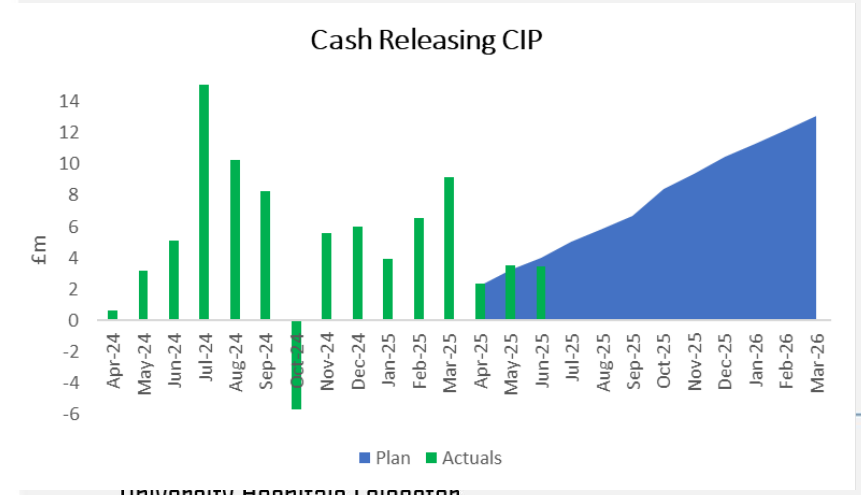


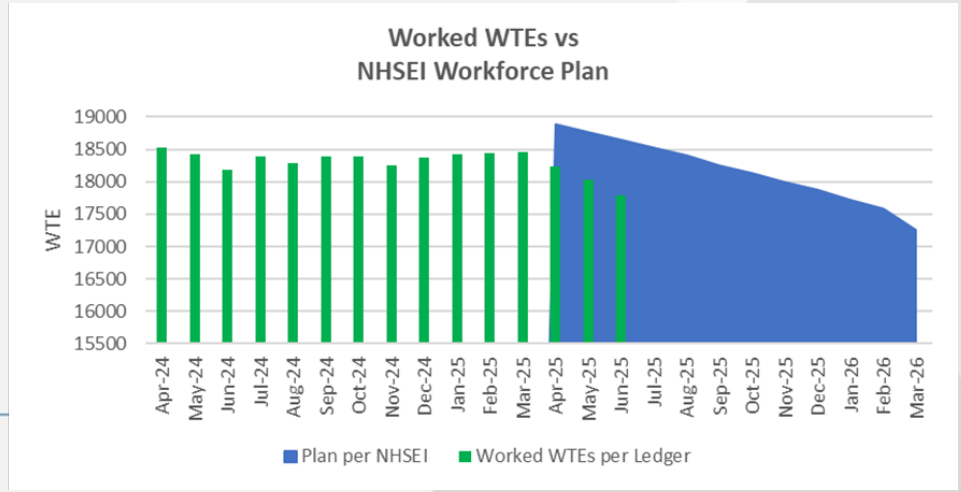




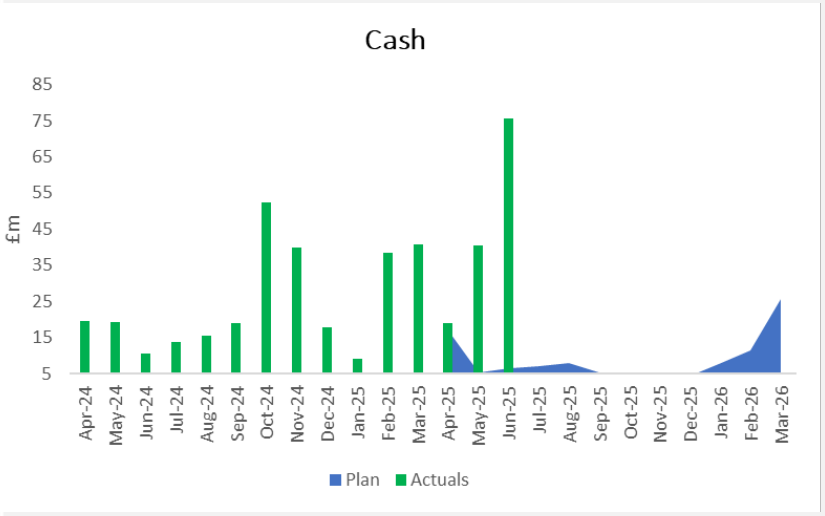


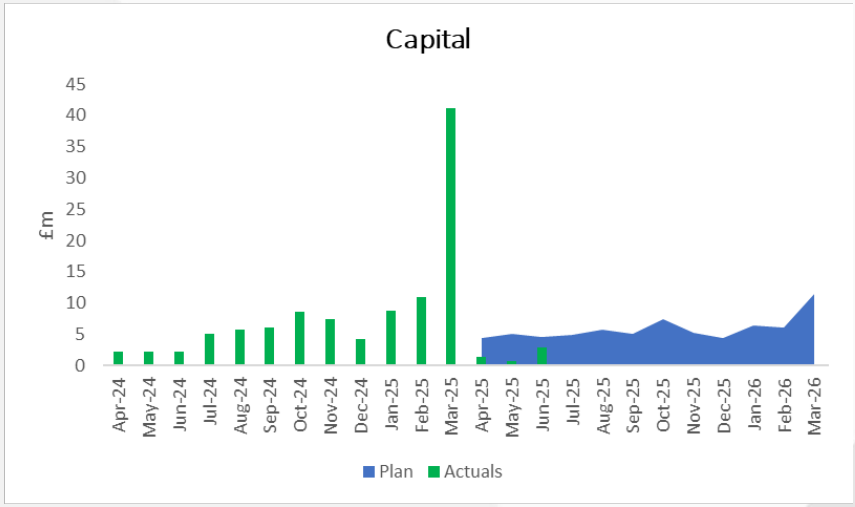


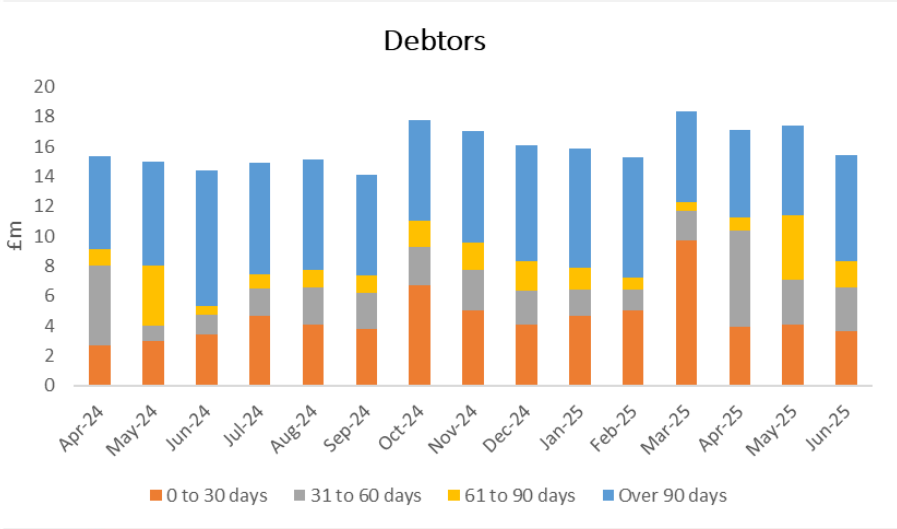


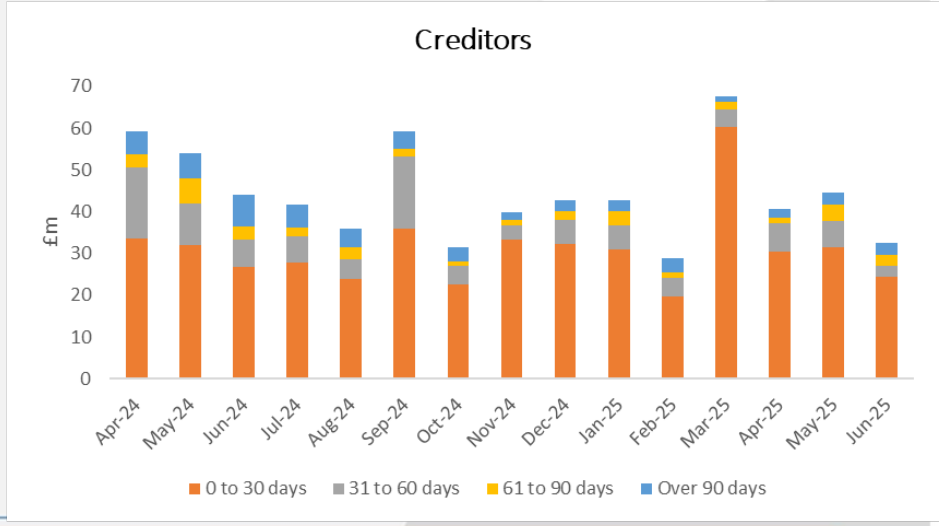


Month 3 Balance Sheet Dashboards









Statement of Financial Position

£m	31-Mar-25	31-May-25	30-Jun-25	In Month Movement	YTD Movement
Fixed Assets	807.1	799.2	796.8	(2.3)	(10.2)
Other non-current assets	4.4	4.5	4.4	(0.1)	(0.0)
Total non-current assets	**811.5**	**803.6**	**801.2**	**(2.4)**	**(10.3)**
Current Assets					
Inventories	28.6	28.6	29.1	0.6	0.5
Trade and other receivables	41.2	55.2	63.7	8.5	22.5
Cash and cash equivalents	40.7	40.4	75.5	35.1	34.8
Total Current Assets	**110.4**	**124.1**	**168.3**	**44.2**	**57.9**
Current Liabilities					
Trade and other payables	(147.8)	(123.0)	(163.4)	(40.5)	(15.6)
Leases < 1 Year	(9.0)	(8.8)	(8.6)	0.2	0.3
Accruals	(19.8)	(32.8)	(34.3)	(1.5)	(14.5)
Deferred income	(4.7)	(26.6)	(27.5)	(0.8)	(22.8)
Dividend payable	0.0	(3.8)	(5.6)	(1.9)	(5.6)
Provisions < 1 year	(9.3)	(9.3)	(9.0)	0.3	0.3
Total Current Liabilities	**(190.6)**	**(204.3)**	**(248.5)**	**(44.2)**	**(57.9)**
Net Current Assets / (Liabilities)	**(80.1)**	**(80.2)**	**(80.2)**	**0.0**	**(0.0)**
Leases > 1 Year	(43.3)	(42.3)	(41.6)	0.7	1.6
Provisions for liabilities & charges	(3.6)	(3.6)	(3.6)	0.0	0.0
Total non-current liabilities	**(46.9)**	**(45.9)**	**(45.3)**	**0.7**	**1.6**
Total Assets/(Liabilities)	**684.5**	**677.5**	**675.8**	**(1.7)**	**(8.7)**
Public dividend capital	(924.8)	(924.8)	(924.8)	0.0	0.0
Revaluation reserve	(223.7)	(223.7)	(223.7)	0.0	0.0
Income and expenditure reserve	464.0	471.0	472.7	1.7	8.7
Total Capital & Reserves	**(684.5)**	**(677.5)**	**(675.8)**	**1.7**	**8.7**

The Statement of Financial Position (SOFP) at the end of Month 3 is presented in the table opposite. The key month on month movements are explained as follows:

Non-Current Assets - Non-current assets reduced by £2.4m as capital additions of £2.9m were offset by M3 depreciation and amortisation of £5.3m.

Trade and other receivables – Increased by £8.5m in month, mainly as a consequence of; VAT claim (£3.9m), which will be recovered in M4; patient care (PCI) accrued income (£2.9m) reflective of activity performance; and timing of quarterly contract prepayments (£2.1m).

Cash Balances – Cash balances increased by £35.1m to £75.5m.

Trade and other payables and accruals – Trade and other payables increased by £40.5m. The main driver behind this being the earlier close of the ledger to facilitate Day 1 reporting, which has resulted in the month 3 salary payment being assigned to reporting period 4 in cash payment terms. Accruals increased by £1.5m relating to an accrual for the planned pay award cost.

PDC Dividend – the increase of £1.9m was reflective of the M3 PDC dividend due.

Deferred Income – The increase of £0.8m is due to the deferral of PCI income of £5.5m; offset by a reduction of HEE Income of £4.7m, which is received quarterly in advance.

Liquidity

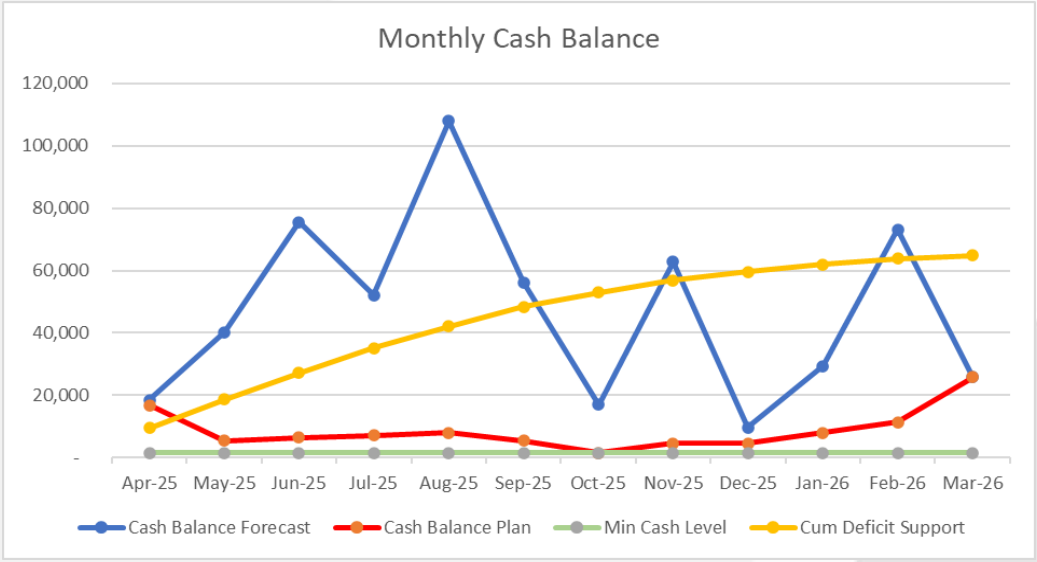
Cash
The Trust cash balance at the end of June was £75.5m, representing an in-month increase of £34.9m, as cash receipts of £147.3m, were offset by £112.4m of outgoing payments. The cash balance exceeded the M3 plan by £69.0m, due to the following main factors:

Monthly payroll payments (£49m) due to the change in timings of closure of the financial ledger, resulting in June salary costs being transacted in the M4 reporting period.
Equal phasing of pay award (£7.6m) in the plan.
Lower capital spend than plan (£12.1m) due to timing of costs incurred, in particular PAS and Endoscopy schemes.

The forecast for year 31 March 26 remains as per plan at a cash balance of £25.8m.

The cash forecast for Q1 25/26 is £56.2m. No PDC revenue cash support requests are planned for 25/26, given that NHSE are expecting a cash position aligned with a compliant I&E break even plan, supported by non recurrent revenue funding. The Trust may not continue to receive the deficit support if the Trust deviates from plan. Withdrawal of this funding would present a challenge from a cash perspective towards the end of Quarter 2 and would result in a cash deficit of c£39m plus any adverse I&E variance by 31 March 2026, which would require an application for cash support in year, in mitigation.

Receivables – Out of a total debt of £15.4m (£17.4 M2) receivables over 90 days were £7.0m (£6.0m in M2) (46%) (comprised of Non-NHS - £6.1m and NHS - £1m). Overall, £5.3m of this is with debt collection agency, on instalments, pending write off or disputed awaiting instruction.. Write offs of £1.4m were approved at the June Audit Committee and will be written off in M4, mainly in relation to irrecoverable overseas debt.



Payables –BPPC performance remained high at 98% Value and 97% volume. Total payables reduced by £12m due to the number of payment runs in month (5 instead of 4). The timing of day one reporting will mean creditors fluctuate monthly. Over 60 days remains a focus to resolve (£5.5m), of which £1.3m sits within NHS.

Capital Programme

£million	Annual Plan	Year to Date		
		YTD Plan	M3 Actuals YTD	Variance to M3 YTD Plan
Estates Major Schemes				
LGH Endoscopy	4.2	3.3	1.1	(2.2)
Preston Lodge (UEC)	3.0	0.7	0.7	(0.0)
CHP	1.4	0.0	0.0	
Mortuary	1.5	0.0	0.0	0.0
Aseptic Lab	1.0	0.5	0.0	(0.5)
UTC	10.2	0.3	0.1	(0.2)
Leicester Diabetes Centre	5.3	2.0	0.6	(1.3)
NHP	1.5	0.5	0.4	(0.1)
Total Estates Major Schemes	**28.1**	**7.3**	**2.9**	**(4.4)**
Other Estates Schemes	10.6	1.4	0.3	(1.0)
IM&T Programme	5.5	2.5	0.3	(2.1)
EPR	5.6	2.1	1.8	(0.3)
Medical Equipment	7.7	0.8	0.2	(0.6)
MES including enabling works	11.1	0.4	0.2	(0.2)
Other Capital Expenditure	3.4	(0.3)	(0.4)	(0.1)
Contingency	1.3	0.0	0.0	0.0
VAT Credit	(1.4)	0.0	(0.3)	(0.3)
Total Capital Programme	**71.9**	**14.0**	**5.0**	**(9.0)**
Funded by:				
Internally Generated	41.3	10.5	4.3	(6.2)
PDC Funded	23.4	1.7	0.5	(1.3)
Donated/Granted	4.6	2.2	0.6	(1.6)
IFRS 16	7.2	1.8	0.2	(1.6)
Total Funding	**76.4**	**16.3**	**5.7**	**(10.6)**
Donated Income/Grant Rec'd	(4.6)	(2.2)	(0.6)	1.6
Disposals - NBV	0.0	0.0	(0.0)	(0.0)
NET CDEL	**71.9**	**14.0**	**5.0**	**(9.0)**

The Trust committed gross expenditure of £5.7m year to date (£2.7m at M2) against a plan of £16.3m which netted down to £5.0m, after deducting charitable donations/capital grants and disposals of £0.7m in month. The overall programme is therefore behind the year to date plan by £9.0m across all areas at month 3 (£7.3m at M2), but most notably IM&T and Endoscopy, which is partly driven by the benefit of VAT credits received. All schemes within the programme will 'catch up' over the coming months and deliver to plan.

National Constitutional Standards allocation (subject to approval of templates or short form business cases) is £21.9m, comprised of; Estates critical infrastructure - £7.2m; Elective Care - £4.8m,Diagnostics - £0.8m; and UEC £10.2m, noting a provisional pre-commitment in 26/27 of £2m against operational capital. 'Local management' of UTC funding across financial years will be required, as the realistic expenditure profile will see a larger proportion of costs incurred in 26/27 (c£8.2m - £6.2m + £2m) than assumed in the original submission.

Performance Overview

Exception Reports

Finance

Appendix - Data Quality Assessment

Data Quality Assessment

The Data Quality Assurance Group (DQAG) panel is presented with an overview of data collection and processing for each performance indicator in order to gain assurance that it is of suitably high quality. DQAG provides scrutiny and challenge on the quality of data presented, via the attributes of:

i. Sign off and Validation
ii. Timeliness and Completeness
iii. Audit and Accuracy and
iv. Systems and Data Capture to calculate an assurance rating.

Assurance rating key: Blue = Substantial Assurance, Green = Reasonable Assurance, Amber = Limited Assurance and Red = No Assurance.