University Hospitals of Leicester NHS
NHS Trust

Trust Board Paper E

Meeting title:	Trust Board					
Date of the meeting:	9 October 2025					
Title:	Integrated Performance Report and Executive Summary					
Report presented by:	Jon Melbourne, 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	Operations and Performance Committee – 25 September 2025 Quality Committee – 25 September 2025					

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: AUGUST 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** 	August 2025 saw an increase of 181 Emergency Department attendances to plan with a year-to-date overperformance of 916 attendances. Paediatric ED saw an increase of 28 attendances compared to August 2024 year to date though they are under by 1718 thereby overall significant increase in the adult department. Eye Casualty in August 2025 has seen a year-to-date overperformance of 1083 attendances. 4-hour performance in August achieved the trajectory of 59.73% with a performance of 63.2% LRI monthly ambulance handovers continues to be challenged but we have seen a deterioration compared to August 2024. The 12-hour performance (total time in dept) for August 2025 was 11.56% failing trajectory by 0.66% Emergency admissions were over plan by 424 admissions and over the number of admissions seen in August 2024 by 617, year to date is 1701 admissions over plan. This has been a key component in driving the deterioration in ambulance handover and 12 hour performance. Actions for improvement – Achievements in August • Increased the number Same Day Emergency Care services –achieved trajectory. • Develop our direct access pathways for our GP and Ambulance colleagues • Developed the Trust's Winter plan • Increase the call volume through clinical bed bureau. • Opened additional capacity in the community – Preston Lodge • Collaborated with the digital team to prioritise the UEC plan. • Commenced the ward improvement programme
Elective Care **Referrals and Outpatient performance** **Elective activity** **Pathway** **Improvements** 	Performance across Elective Care remains significantly challenged, particularly in relation to waiting list size, RTT standards, and long waiters (65 week and 52 week waits). Theatre utilisation continues to be below the 85% GIRFT target, however, performs well compared to peers and nationally. PIFU is progressing but remains off trajectory, requiring further operational embedding. **Elective Care (RTT)** • **Waiting List**: At the end of July 2025, the waiting list remains materially above the operational plan, with circa 120,000 patients (including those awaiting e-triage).

- **18-week RTT**: Compliance stands at 56.6% (peer median 59%), placing the Trust in the lower third of peers.
- **Long Waiters**: 2.9% of patients are waiting over 52 weeks, against a target of 1.3%. Specialties most affected include Maxillofacial, Orthopaedics/Spines, ENT, and General Surgery.
- **Root Causes**: Demand growth, workforce shortages in theatres, emergency pressures leading to cancellations, and PAS implementation impacts.
- **Actions**:
    - Increased validation sprint activity.
    - Super-clinics to expand outpatient capacity.
    - Engagement with Independent Sector providers to reduce long waiters.
    - Additional focus on PIFU and DNA process improvements.
    - Plan developed with CMGs to undertake additional work funded by the region to support RTT and Cancer performance improvement.

Theatre Utilisation

- **Current Performance**: Theatre utilisation remains below target, primarily due to cancellations linked to emergency pressures, workforce gaps, and estate limitations.
- **Impact**: Lost theatre sessions are directly impacting RTT performance and long-wait trajectories.
- **Actions**:
    - Theatre productivity programme focusing on list scheduling, job planning, and workforce cover.
    - Exploring cross-cover and flexible staffing models to minimise late cancellations.
    - Auto-send of the first patient on each theatre list at the LRI site, implement and monitor.

Patient-Initiated Follow-Up (PIFU)

- **Current Performance**: PIFU remains below national trajectory, with uptake not yet embedded at the required scale across specialties.
- **Root Causes**: Variation in clinical adoption, digital process challenges, and delays in pathway redesign.
- **Actions**:
    - Specialty-level action plans to increase PIFU conversion.
    - Enhanced clinical engagement and training.
    - Strengthened monitoring through outpatient transformation programme.

Impact of PAS implementation: PAS implementation continues to affect performance and elective recovery, with many missing outcomes still under review by admin teams. Teams are adjusting to new processes, which has reduced productivity for both clinical and administrative staff. Key issues remain unresolved by the Nervecentre team, such as slow e-triage from interface problems, missing procedure options, and unavailable PIFU choices for some scenarios.

Cancer **Referrals** **2 week wait** **Faster Diagnosis Standard** **62-day referral to treatment** 	Referrals year to date have seen an increase of 1.8% compared to previous year. Conversion rates remain at 7%. The Trust was unable to deliver the FDS standard of 75% in July, the first time since September 2023 due to an unexpected loss of capacity in Breast, Skin and H&N in June/July which significantly delayed time to first appointment. FDS would have delivered 78% without the loss of locum capacity within these services. August FDS performance is also likely to fall below the standard, with improvements in performance not expected until late September/October. There is a capacity gap within these services reliant on locums or WLIs, where uptake of additional clinics has reduced. This requires addressing into 26/27 to support the fragility of these services. 62-day performance in July achieved 54.5%. The impact from capacity losses in Skin, H&N and Breast will have a detrimental impact on 62 day performance next month, with recovery unlikely until November. For 31-day performance, improvements are not anticipated to impact until Q4. Radiotherapy recovery is on track, with breast radiotherapy backlog due to reach zero by the end of September and recovery of prostate by the end of Q4. Recovery and performance meetings identifying targeted actions, with EMCA and NHSE cancer recovery funds supporting. Risks to improve performance continue to be the ability to have sustainable and sufficient capacity to meet demand. UHL remains in Tier 1 for cancer performance.
Quality 	Overall operational and quality performance remains stable, with no material deterioration across our core Board metrics. Healthcare-Associated Infections (HAI) remain a key focus. Actions are being driven through our Fundamentals of Care work and infection prevention programme—strengthening everyday practice at ward level, reinforcing audit and hygiene standards, and supporting teams with practical tools and coaching. These actions align with the wider IPC improvement work and audit standardisation already underway and will remain a prominent strand of our clinical quality agenda into Q3. Complaints performance continues to improve. The Complaints and PALS teams are working to agreed recovery actions to enhance timeliness and the quality of responses, with stronger divisional ownership and clearer During the period, two Never Events were reported. Duty of Candour has been completed in both cases, and organisational learning is in progress.
Finance 	The month 5 YTD position for the Trust is a deficit of £14.1m which is £5m adverse to plan. The main drivers are reduced patient care income excluding EDD £7mA (mainly elective care) impact of PAS implementation £1.6mA, under-recovered other operating income excluding donated assets of £2.6mA, offset by pay/non-pay underspend of £7mF (excluding EDD) and industrial action in M4 of £1.3mA, increased interest receivables £0.5mF. The Trust reported a year-to-date deficit of £47.1m at the end of August excluding deficit support. Further substantial improvement to the run-rate are required to match the increasing monthly CIP targets over the remaining months of the financial year.

	The Trust committed net capital expenditure of £14m in Month 5 after deducting charitable donations/capital grants, resulting in an underspend of £10.8m against CDEL target of £24.8m for M5. The cash position at the end of Month 5 was £44.9m, which is an increase of £11.3m from M4
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 Month 5 we recorded an overall workforce of 18,470 wte, which is 64 wte over the planned position of 18,406 wte (a performance of 0.35% above plan). • Agency wte usage decreased to 24 wte which reflects a 67% (48 wte) below the plan. • While Bank wte usage decreased compared to previous month's usage, M5 recorded usage above plan of 191 wte which is 27% above plan. Bank usage was mostly high within ESM for Registered and Unregistered Nursing staff and also W&C and E&F for Cleaning, Portering and Catering staff. • Substantive staff was recorded at 17,562 wte which is 0.44% below the plan. However, the expected reductions in substantive workforce from M6 onwards pose a significant risk of performance remaining above the plan if these reductions are not realised through the remaining months of the financial year ending 31 March 2026. There is continued work on workforce control programmes to ensure alignment with the submitted Workforce and Finance plans while ensuring the delivery of safe patient care. Weekly workforce reporting via the Results Delivery Office (RDO) is in place to track and monitor workforce performance against the plan and highlight possible risks. NHSE continues to monitor levels of grip and control on workforce utilisation and spend via the monthly workforce and financial returns against the submitted workforce plan, which is a statutory, Board-approved document used to assess UHL's workforce delivery performance. Workforce turnover remains stable at 7% against the 10% target. Adult Nursing and Midwifery vacancies are at 5% against the 7% target. Pediatric Nursing vacancies are on target at 10%, and HCSW are above the 5% target at 11%. All nursing roles now comply with the general nursing agency price cap. Nationally all medical posts are above the agency price cap. NHSE have acknowledged the West Midlands medical agency rate card as an acceptable interim rate cap for Trusts to apply; which UHL has implemented since June 2025 for all new medical agency bookings without exception. There remain some long line workers who remain over the price cap, but these are acknowledged to be in specialist fragile services.

	We are over price cap only in specialist roles in Sonography and Cardiorespiratory for AHP/ST&T. There are 3 Project officers in capital projects which meet the special projects exemption. We have seen a 1% reduction in Statutory and Mandatory training at 94% against the target of 95% Appraisals performance has further declined to 83.4% against the 95% target. The focus remains on both improving performance and the quality of appraisals, with the appraisal process and documentation currently under review through engagement with key stakeholders. Sickness absence is reported a month in arrears, and we have seen a 0.05% reduction in July. Over the last 12 months, the highest levels of absence are in E&F (6.17%), W&C (5.58%), RRCV (5.21%) 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 2.03% in 25/26 M4. 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**	Theatres • In August, overall theatre utilisation slightly declined to 80.7%, down from 80.9% in July. With three out of five sites achieved utilisation rates above 80%. • Late starts and Cancellations remained consistent with the previous month, with OTDC rates at 8% and late theatre starts at 25%. • Day case data within the Model Health System (MHS) has not been updated since the previous month, with the last reported rate at 83.5% in May. Our internal BADS report shows a rapid decline in performance, 73.1% in August. Since the implementation of PAS, Day case performance has declined, this is due to data quality issues in the Intended Management field, including entries marked as "NA", blanks, and "delivery facilities". These issues have led to misclassification and underreporting of day case activity, particularly for zero-night stays incorrectly recorded as inpatient. The issue has been logged within Neurons and escalated. Outpatients. • The Did Not Attend / Was Not Brought rate has improved from the previous month, now standing at 6.6%. However, further progress is needed, and ongoing projects are in place to support continued improvement

	• Appointment Reminders: Work is underway to strengthen the Accurx reminder system, with a new tiered schedule (14, 7, and 3–1 day prior to appointments) due to go live by mid-October to help improve attendance rates. • The current PIFU rate has increased to 4.9%, showing improvement from the previous month, but it remains below the 5.5% target. Challenges with the PAS system, particularly around clinic outcome recording, continue to limit the ability to apply PIFU in certain scenarios. On-going improvement work is underway to identify additional opportunities for increasing uptake. UEC • 4969 Monthly SDEC attendance delivered in Aug (6% above target) • 1935 calls received to Clinical Bed Bureau which is a 15% reduction to monthly average. Comms Plan enacted to increase calls. • The ED Transport Tender now completed and in standstill period awaiting award. • UEC PAS development work completed, and post go live review underway. • GI Surgical Criteria for Direct Conveyance with EMAS board for approval • HPB direct conveyance for VW patients agreed – Criteria being revised by EMAS • Discussions ongoing re Paediatric Single Front Door via SPOA to support flow and Safeguarding • Orthopaedic Criteria in review. Meetings began to formalise service as and SDEC. • Discussion regards to slot booking in SDEC progressed (enables ED to send patients home and return them next day OOH) • Specialist Medicine Project Begun to reduce time of Discharge following PA consulting recommendations • GIRFT Action Plan being progressed. Access to Hotclinc and SDEC as priority.

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

UHL Oversight Framework Metrics

August 2025

Oversight Framework

Key Performance Indicator	Target	Jun-25	Jul-25	Aug-25	YTD	Assurance	Variation	Trend	Data Quality Assessment	Local or National Target?	Exec Lead
Clostridium Difficile per 100,000 Bed Days	167 Cases	22.3	21.6	19.5	17.1	?			Mar-24	Local	Chief Nurse and Medical Director
Methicillin Resistant Staphylococcus Aureus	0	0	0	1	5	?			Mar-24	Local	Chief Nurse and Medical Director
E-Coli per 100,000 Bed Days		26.8	28.1	36.7	22.7		H		TBC	No Target	Chief Nurse and Medical Director
Hospital Acquired Pressure Ulcers - All categories per 1000 bed days	1.7	1.7	1.6	1.4	1.6	?			Jun-21	Local	Chief Nurse and Medical Director
Sickness Absence	3%	4.8%	4.7%		4.6%	F			Mar-25	Local	Chief People Officer
30 Day Readmission Rate		9.9%	11.3%		9.9%		H		TBC	No Target	TBC
Published Summary Hospital-level Mortality Indicator (SHMI)	100	99	99		99 (Latest figure)	Assurance and variance not applicable			May-21	National	Chief Nurse and Medical Director
Emergency Department 4 hour waits UHL *	61%	60.8%	64.7%	63.1%	60.7%	?	H		Mar-23	National	Chief Operating Officer
% of 12 hour waits in the Emergency Department	10.3%	9.0%	8.4%	11.6%	9.6%	?			Mar-23	National	Chief Operating Officer
Referral to Treatment (RTT) 18 wk performance *	62.3%	56.6%	53.4%	51.9%		F	L		TBC	Local	Chief Operating Officer
Referral to Treatment (RTT) 52+ weeks as a % OF Total Incompletes *	0.9%	2.4%	2.9%	3.1%		F	H		TBC	Local	Chief Operating Officer
6 Week Diagnostic Test Waiting Times *	5%	22.7%	26.5%	24.6%		F			Jul-23	National	Chief Operating Officer
28 Day Faster Diagnosis Standard *	80%	75.2%	69.5%		75.4%	?	L		May-24	National	Chief Operating Officer
Cancer 62 Day Combined *	70%	56.2%	54.5%		58.8%	F			May-24	Local	Chief Operating Officer
Trust level control level performance	-£9.1m	-£1.6m	-£1.4m	-£3.9m	-£14.1m				Jun-22		Chief Financial Officer
Capital expenditure against plan	£24.8m	£2.9m	£4.5m	£4.5m	£14m				Jun-22		Chief Financial Officer

*Please note the indicators marked with * are RAG rated based on monthly plan trajectories (see slide 14 of the Integrated Performance Report for more details).*

Oversight Framework

Key Performance Indicator	
CQC inpatient survey satisfaction rate	Data TBC
National maternity survey score	Data TBC
NHS Staff Survey - raising concerns sub-score	Data TBC
NHS staff survey engagement theme score	Data TBC
National Education and Training Survey overall satisfaction score	Data TBC
CQC safe inspection score (if awarded within the preceding 2 years)	Data TBC
Implied productivity level	Data TBC
Under 18s elective waiting list growth	Data TBC

We are currently working with the relevant teams and data owners to source the outstanding metrics.

Integrated Performance Report

August 2025

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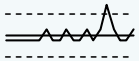
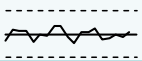
- Performance Overview
- Exception Reports
- Finance
- Appendix - Data Quality Assessment

Performance Overview (Safe)

Domain	Key Performance Indicator	Target	Jun-25	Jul-25	Aug-25	YTD	Assurance	Variation	Trend	Data Quality Assessment	Local or National Target?	Exec Lead
Safe	Never events	0	0	0	2	2	?	H		Nov-22	National	Chief Nurse and Medical Director
	Clostridium Difficile per 100,000 Bed Days	167 Cases	22.3	21.6	19.5	17.1	?			Mar-24	Local	Chief Nurse and Medical Director
	Methicillin Resistant Staphylococcus Aureus	0	0	0	1	5	?			Mar-24	Local	Chief Nurse and Medical Director
	Methicillin-susceptible Staphylococcus Aureus	40	6	5	2	22	?			Mar-24	Local	Chief Nurse and Medical Director
	All falls reported per 1000 bed days	4.0	3.0	3.2		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	0.09	0.16		0.10	P			Aug-22	Local	Chief Nurse and Medical Director
	Hospital Acquired Pressure Ulcers - All categories per 1000 bed days	1.7	1.7	1.6	1.4	1.6	?			Jun-21	Local	Chief Nurse and Medical Director
	% of all adults Venous Thromboembolism Risk Assessment on Admission	95%	97.5%	97.8%	96.3%	97.7%	P	L		Oct-21	National	Chief Nurse and Medical Director
	Number of Patient Safety Incident Investigations (PSIIs) commissioned		1	0	5	8	Awating more data for assurance and variance			Nov-24	No Target	Chief Nurse and Medical Director
	Number of reported Patient Safety Incidents		2374	2501	2338	12160				Nov-24	No Target	Chief Nurse and Medical Director
	Rate of reported Patient Safety Incidents (per 1000 inpatient, outpatient and ED attendances)		18.1	23.2	18.7	19.3		H		Nov-24	No Target	Chief Nurse and Medical Director

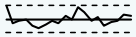
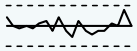
Performance Overview (Caring)

Domain	Key Performance Indicator	Target	Jun-25	Jul-25	Aug-25	YTD	Assurance	Variation	Trend	Data Quality Assessment	Local or National Target?	Exec Lead
Caring	Single Sex Breaches		24	7	22	88				Jul-22	No Target	Chief Nurse and Medical Director
	Inpatient and Day Case Friends & Family Test % Positive	95%	96%	96%	95%	96%	P	L		Jul-22	Local	Chief Nurse and Medical Director
	A&E Friends & Family Test % Positive	81%	84%	82%	85%	84%	?			Jul-22	Local	Chief Nurse and Medical Director
	% Complaints Responded to in Agreed Timeframe - 25 Working days	90%	67%	80%		68%	?			Jul-23	Local	Chief Nurse and Medical Director
	% Complaints Responded to in Agreed Timeframe - 60 Working days	90%	80%			82%	?			Jul-23	Local	Chief Nurse and Medical Director

Performance Overview (Well Led)

Domain	Key Performance Indicator	Target	Jun-25	Jul-25	Aug-25	YTD	Assurance	Variation	Trend	Data Quality Assessment	Local or National Target?	Exec Lead
Well Led	Turnover Rate	10%	7.1%	6.9%	7.0%		P	H		Aug-22	Local	Chief People Officer
	Sickness Absence	3%	4.8%	4.7%		4.6%	F			Mar-25	Local	Chief People Officer
	% of Staff with Annual Appraisal	95%	85.1%	85.1%	83.4%		F			Mar-25	Local	Chief People Officer
	Statutory and Mandatory Training	95%	95%	95%	94%		?			Dec-22	Local	Chief People Officer
	Adult Nursing Vacancies	7%	4.3%	5.3%	5.1%		?			Dec-23	Local	Chief People Officer
	Paed Nursing Vacancies	10%	10.3%	10.3%	10.9%		F	L		Dec-23	Local	Chief People Officer
	Midwives Vacancies	7%	6.0%	5.2%	5.4%		?			Dec-23	Local	Chief People Officer
	Health Care Assistants and Support Workers Vacancies - excluding Maternity	5%	11.4%	10.6%	9.5%		?	L		Dec-23	Local	Chief People Officer
	Health Care Assistants and Support Workers Vacancies - Maternity	5%	-0.4%	-5.1%	-2.3%		P	L		Dec-23	Local	Chief People Officer
	% Bank spend of Pay Bill	8%	5.4%	6.5%	6.9%		P			TBC	National	Chief People Officer
	% Agency spend of Pay Bill	3.2%	0.4%	0.2%	0.2%		P	L		TBC	National	Chief People Officer
	Agency Off Framework activity- No. of shifts	0	0	0	0		Awating more data for assurance and variance			May-25	National	Chief People Officer
	Non Clinical Agency- No. of Staff	0	3	3	3		Awating more data for assurance and variance			May-25	National	Chief People Officer
	Agency Staff above Price cap	0	30	21	21		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	Jun-25	Jul-25	Aug-25	YTD	Assurance	Variation	Trend	Data Quality Assessment	Local or National Target?	Exec Lead
Effective	Published Summary Hospital-level Mortality Indicator (SHMI)	100	99	99		99 (Latest figure)	Assurance and variance not applicable			May-21	National	Chief Nurse and Medical Director
	12 months Hospital Standardised Mortality Ratio (HSMR)	100	102	102		102 (Latest figure)	Assurance and variance not applicable			May-21	National	Chief Nurse and Medical Director
	Crude Mortality Rate		0.9%	1.1%	1.0%	1.0%				May-21	No Target	Chief Nurse and Medical Director
	DNA Rate - IMD Deciles 1 and 2	5%	8.8%	9.5%	9.5%	9.2%				Feb-24	Local	Director of Health Equality and Inclusion
	DNA Rate - IMD Deciles 3 - 10	5%	5.7%	6.3%	5.7%	5.7%				Feb-24	Local	Director of Health Equality and Inclusion
	Gestation at Booking 71+ days, IMD Deciles 1 and 2						Awating more data for assurance and variance			Dec-24	No Target	Director of Health Equality and Inclusion
	Gestation at Booking 71+ days, IMD Deciles 9 and 10						Awating more data for assurance and variance			Dec-24	No Target	Director of Health Equality and Inclusion
	Gestation at Booking 71+ days, White British						Awating more data for assurance and variance			Dec-24	No Target	Director of Health Equality and Inclusion
	Gestation at Booking 71+ days, Black African or Black Caribbean						Awating more data for assurance and variance			Dec-24	No Target	Director of Health Equality and Inclusion
	Gestation at Booking 71+ days, Asian Indian, Bangladeshi or Pakistani						Awating more data for assurance and variance			Dec-24	No Target	Director of Health Equality and Inclusion

Performance Overview (Responsive Emergency Care)

Domain	Key Performance Indicator	Target	Jun-25	Jul-25	Aug-25	YTD	Assurance	Variation	Trend	Data Quality Assessment	Local or National Target?	Exec Lead
Responsive (Emergency Care)	Emergency Department 4 hour waits LLR	78%	75.9%	79.3%	78.5%	77.1%	?	H		Mar-23	National	Chief Operating Officer
	Emergency Department 4 hour waits UHL	61%	60.8%	64.7%	63.1%	60.7%	?	H		Mar-23	National	Chief Operating Officer
	Mean Time to Initial Assessment	15	16.9	7.3	7.8	9.6	P			Nov-24	National	Chief Operating Officer
	% 12 hour trolley waits in Emergency Department (DTA)	10.3%	2.4%	2.7%	4.2%	3.0%	?			Mar-23	National	Chief Operating Officer
	% of 12 hour waits in the Emergency Department	10.3%	9.0%	8.4%	11.6%	9.6%	?			Mar-23	National	Chief Operating Officer
	Average Clinical Handover time for ambulance handovers (Minutes)	30	40	33	56	42	Awating more data for assurance and variance			Data sourced externally	Local	Chief Operating Officer
	Non Elective Average Length of Stay	7.2	7.0	7.1	7.6	7.3	?			Aug-25	Local	Chief Operating Officer
	% of Patients Discharged on Discharge Ready Date	88.3%	89.2%	87.5%	88.2%	88.3%	?			Aug-25	Local	Chief Operating Officer
	Average Delay (Post Discharge Ready Date)	3.8	3.7	3.5	4.2	4.0	?			Aug-25	Local	Chief Operating Officer
	Trust Bed Occupancy	92.0%	86.5%	89.5%	85.2%		?			Dec-23	National	Chief Operating Officer
	Long Stay Patients (21+ days) as a % of G&A Bed Occupancy	10%	13.9%	18.3%	18.1%		F	H		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	Jun-25	Jul-25	Aug-25	YTD	Assurance	Variation	Trend	Data Quality Assessment	Local or National Target?	Exec Lead
Responsive (Elective Care)	Referral to Treatment Incompletes	105,500	109,601	109,635	110,728		F	L		Jun-23	Local	Chief Operating Officer
	Referral to Treatment (RTT) 18 wk performance	62.3%	56.6%	53.4%	51.9%		F	L		TBC	Local	Chief Operating Officer
	Referral to Treatment (RTT) – First Attendance - % waiting less than 18 weeks	68.1%	64.9%	63.3%	62.6%		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%	2.4%	2.9%	3.1%		F	H		TBC	Local	Chief Operating Officer
	6 Week Diagnostic Test Waiting Times	5%	22.7%	26.5%	24.6%		F			Jul-23	National	Chief Operating Officer
	Theatre Utilisation	85.0%	82.7%	81.3%	80.7%	82.1%	F	H		Dec-23	National	Chief Operating Officer
	Patient Initiated Follow Up	5.5%	5.3%	4.4%	4.9%	5.3%	?			Oct-23	Local	Chief Operating Officer
	% Outpatient Did Not Attend rate	4.9%	6.3%	6.9%	6.6%	6.5%	F			Apr-23	Local	Chief Operating Officer
	% Outpatient Non Face to Face	25%	27.9%	26.0%	24.6%	27.5%	?	L		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	Jun-25	Jul-25	Aug-25	YTD	Assurance	Variation	Trend	Data Quality Assessment	Local or National Target?	Exec Lead
Responsive (Cancer)	28 Day Faster Diagnosis Standard	80%	75.2%	69.5%		75.4%	?	L		May-24	National	Chief Operating Officer
	Cancer 31 Day Combined	96%	75.3%	75.9%		75.1%	F			May-24	National	Chief Operating Officer
	62 Day Backlog Combined	152	374	511	590		F	H		Dec-24	Local	Chief Operating Officer
	Cancer 62 Day Combined	70%	56.2%	54.5%		58.8%	F			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	Jun-25	Jul-25	Aug-25	YTD	Assurance	Variation	Trend	Data Quality Assessment	Exec Lead
Finance	Trust level control level performance	-£9.1m	-£1.6m	-£1.4m	-£3.9m	-£14.1m				Jun-22	Chief Financial Officer
	Capital expenditure against plan	£24.8m	£2.9m	£4.5m	£4.5m	£14m				Jun-22	Chief Financial Officer
	Cost Improvement (Includes Productivity)	£20.4m	£3.4m	£6.4m	£4.9m	£20.7m				Dec-23	Chief Financial Officer
	Cashflow	No Target	£35.1m	-£41.9m	£11.3m	£44.9m				Jun-22	Chief Financial Officer
	Aged Debt	No Target	£15.4m	£15.7m	£13.1m					Feb-24	Chief Financial Officer
	Invoices paid within 30 days (value)	95%	98%	98%	98%					Feb-24	Chief Financial Officer
	Invoices paid within 30 days (volume)	95%	97%	97%	97%					Feb-24	Chief Financial Officer

Performance Overview (Activity)

Domain	Activity Type	Plan 25/26	Plan in Month (M5)	Activity In Month (M5)	Variance In Month (M5)	Plan YTD	Actual YTD	Variance YTD	YTD Variance to 19/20
Activity	New Outpatients (inc. NFTF)	270,077	21,563	20,312	-1,251	111,351	105,558	-5,793	-6,764
	Follow Up Outpatients (inc. NFTF)	601,725	48,313	43,353	-4,960	250,001	224,534	-25,467	-23,235
	Outpatient Procedures	220,367	18,202	18,315	113	92,375	83,591	-8,784	20,445
	Daycase	137,582	11,066	8,701	-2,364	58,825	45,918	-12,907	276
	Inpatient	22,053	1,798	2,010	211	9,151	9,346	195	952
	Emergency	114,624	9,140	10,080	940	46,412	48,103	1,691	7,054
	Non Elective	22,843	1,941	2,127	186	9,578	9,857	280	851
	Emergency Department (inc. Eye Casualty)	282,655	22,050	22,827	777	115,646	117,506	1,860	8,938
	Diagnostic Imaging (inc. Direct Access)	398,464	33,764	30,584	-3,179	157,373	160,923	3,551	91,738
	Other	11,473,688	942,562	957,175	14,613	4,661,158	5,050,174	389,017	1,319,800
	TOTAL	13,544,078	1,110,398	1,115,485	5,086	5,511,870	5,855,511	343,642	1,420,056

The DM01 plan for imaging activity for M5 was 3,723 below plan in month (27,805 vs 24,082) and was 10,590 below plan YTD (138,165 vs 127,575).

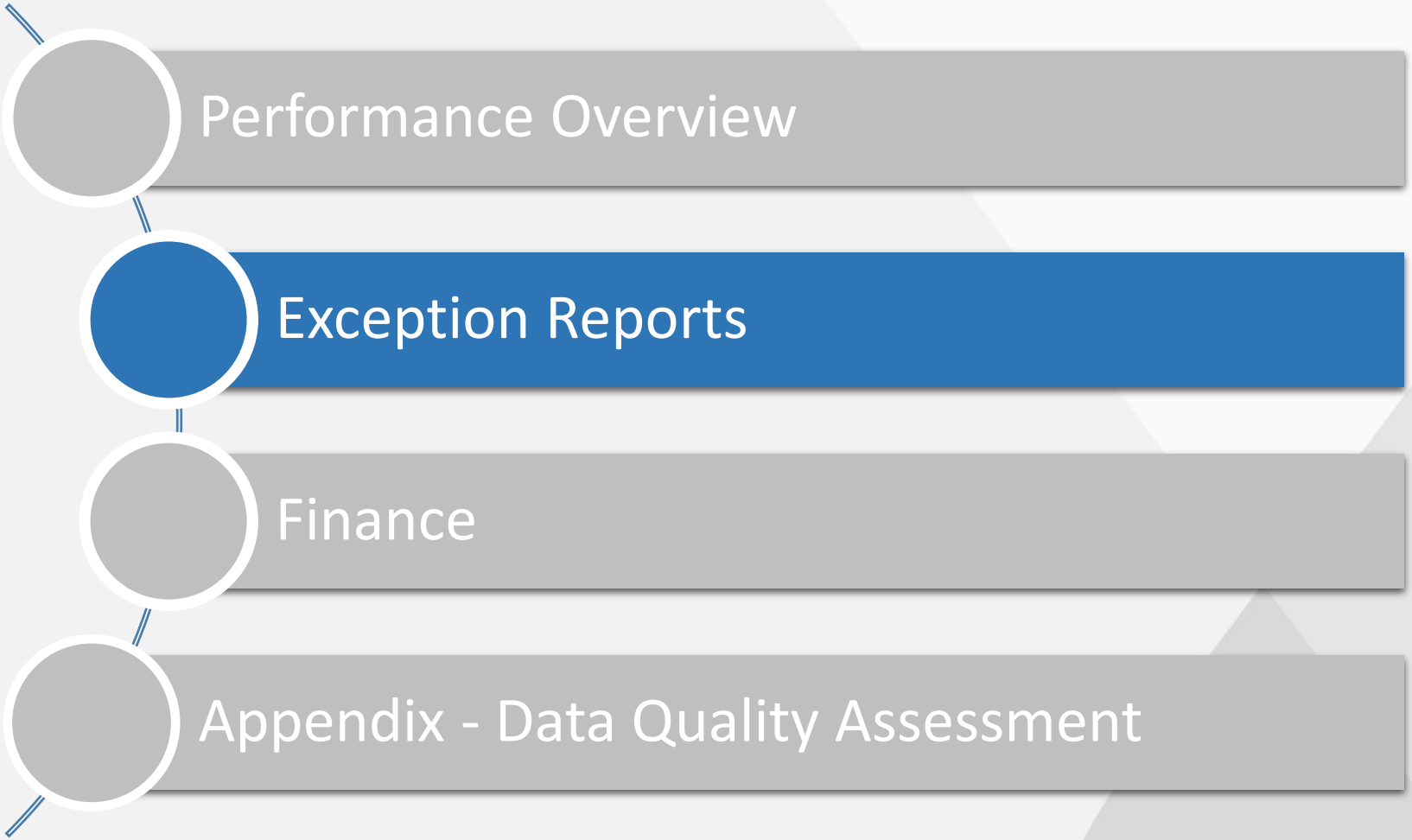
Performance Overview (Workforce Performance Overview)

Key Performance Indicator	Target (National KPI cap)	Apr 25	May 25	Jun 25	Jul 25	Aug 25
% Bank spend of Pay Bill	8%	6.48%	5.80%	5.39%	6.54%	6.90%
% Agency spend of Pay Bill	3.20%	0.51%	0.39%	0.44%	0.20%	0.21%

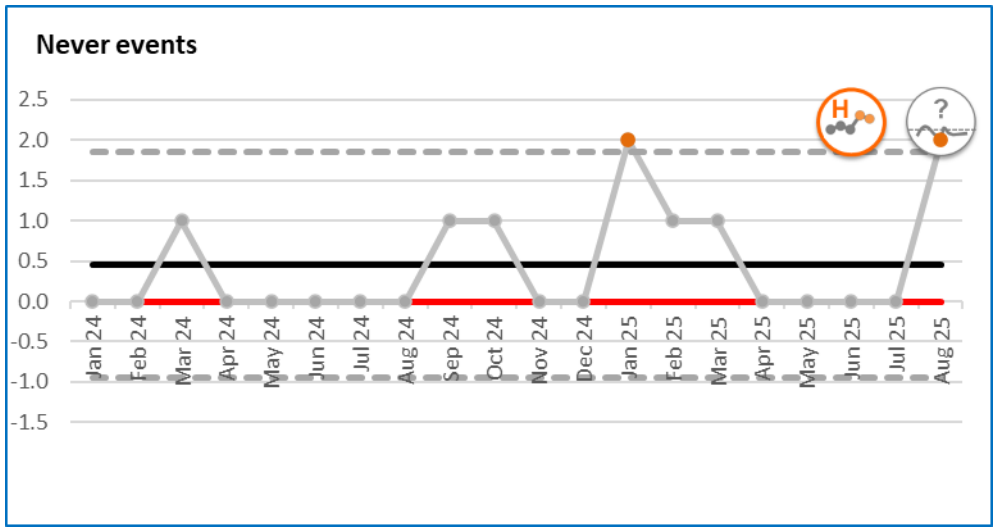
Planned data is from the NHSE submitted 25/26 workforce plan and the actuals are from a combination of the ESR and finance ledger figures.

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 – Never Events



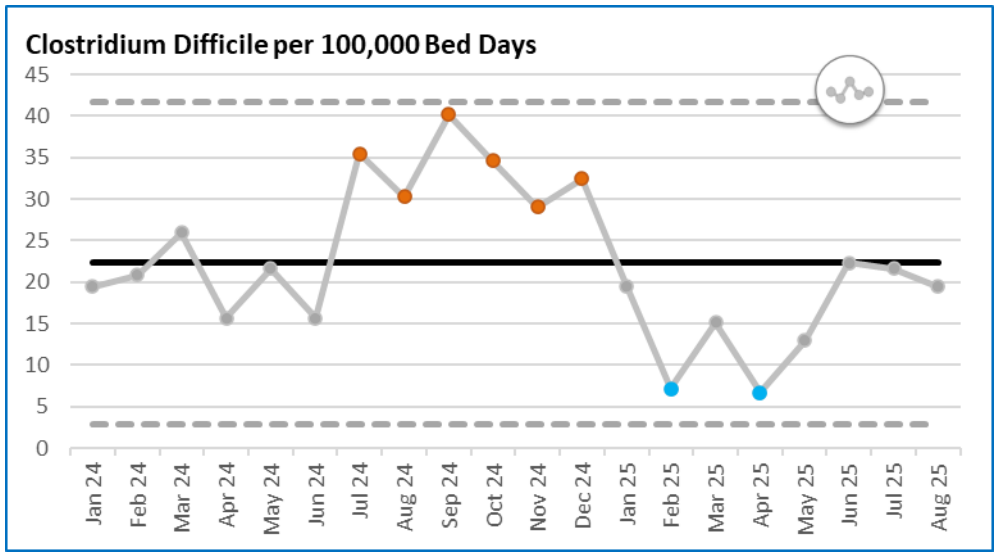
Current Performance		
Aug 25	YTD	Target
2	2	0

National Position & Overview

UHL reported 8 Never Events in 2022/2023
UHL reported 4 Never Events in 2023/2024
UHL reported 6 Never Events in 2024/2025

Root Cause	Actions	Impact/Timescale
• **Wrong site surgery**	Appropriate clinical care provided to patient Apology given to patient and informed of investigation into events and is engaged and involved in the investigation Never Events are now integrated within the PSIRF governance framework Patient Safety Incident Investigation (PSII) will incorporate review of previous similar incidents at same hospital site for learning and actions	Complete Complete Ongoing Ongoing
• **Retained foreign object procedure**	Appropriate clinical care provided to patient Apology given to patient and informed of investigation into events and is engaged and involved in the investigation Never Events are now integrated within the PSIRF governance framework Patient Safety Incident Investigation (PSII) will incorporate review of previous similar incidents for learning and actions	Complete Complete Ongoing Ongoing

Safe – Clostridium Difficile



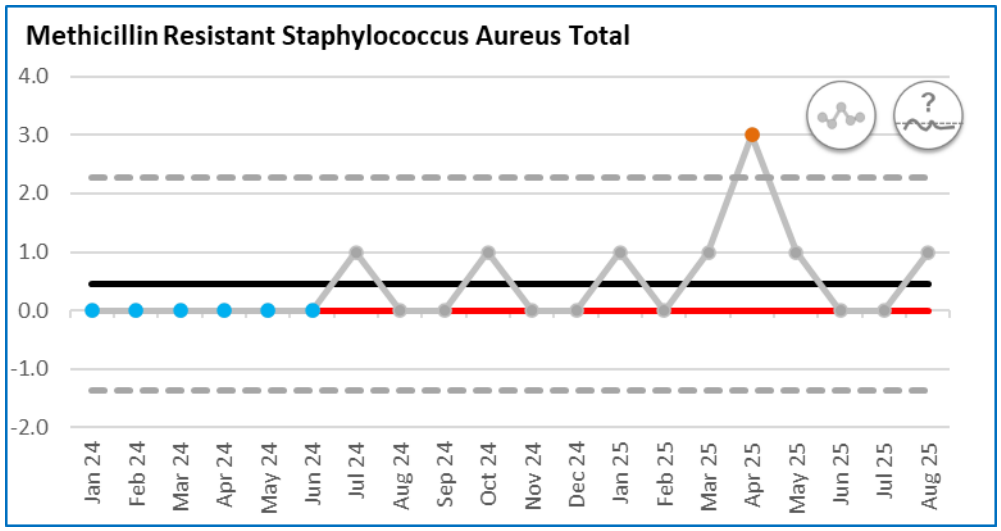
Cases			Cases per 100,000 Bed Days		
Aug 25	YTD	Target	Aug 25	YTD	Target
16	63	167	19.45	17.06	

National Position & Overview

	August	Total	
CDIFF NHSE Threshold 25/26	14	167	
* Actual Infections (HOHA) 25/26	9	30	
* Actual Infections (COHA) 25/26	7	17	
* **Actual Infections Total (HOHA & COHA)** 25/26	16	47	
UHL 100,000 Bed Days (HOHA) 25/26	19.45	**17.06**	*YTD UKHSA Report
National Average	23.04		
National Highest	96.78		
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 • Re iterate in all training sessions the importance of early isolation • Ward staff to review patients presentation and isolation requirements on a daily basis • A revised CDI action programme will be managed via TIPOG during Q3 and presented to TIPAC at the Q3 meeting	• Any immediate actions to be taken will be raised in TIPOG and the wards accordingly

Safe – Methicillin Resistant Staphylococcus Aureus



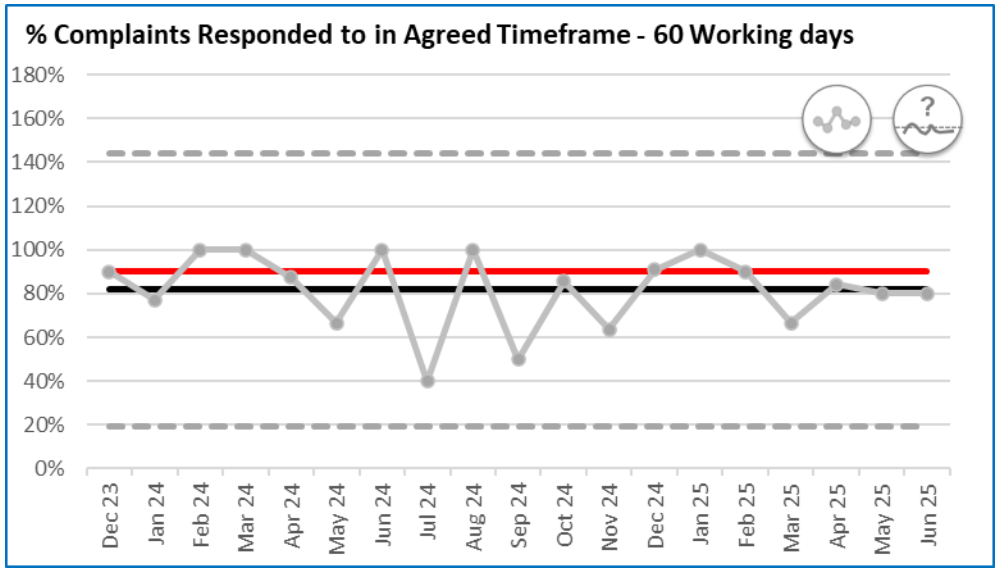
Current Performance			Cases per 100,000 Bed Days		
Aug 25	YTD	Target	Aug 25	YTD	Target
1	5	0	2.03	2.07	

National Position & Overview

	August	Total	
CDIFF NHSE Threshold 25/26	0	0	
* Actual Infections (HOHA) 25/26	1	5	
* Actual Infections (COHA) 25/26	0	0	
* **Actual Infections Total (HOHA & COHA)** 25/26	1	5	
UHL 100,000 Bed Days (HOHA) 25/26	2.03	**2.07**	*YTD UKHSA Report
National Average	0.77		
National Highest	7.99		
National Lowest	0		

Root Cause	Actions	Impact/Timescale
• Initial review of Trust wide MRSA policy audit indicate improvement in compliance with the MRSA policy is required. • Please note this data refers to HOHA cases only, which are in the sphere of UHL review	• Trust wide MRSA audit results are currently being reviewed and report compiled • Stellisept usage audit has been undertaken and these results are also being reviewed. • A TIPOG dedicated to review of the requirements of the MRSA policy and patient management is planned for early October • Revised IP PSIRF (Patient Safety Incident Response Framework) for HCAI, including MRSA bloodstream infections, has been developed and is now being used	• For completion within October 2025

Caring – % Complaints Responded to in Agreed Timeframes



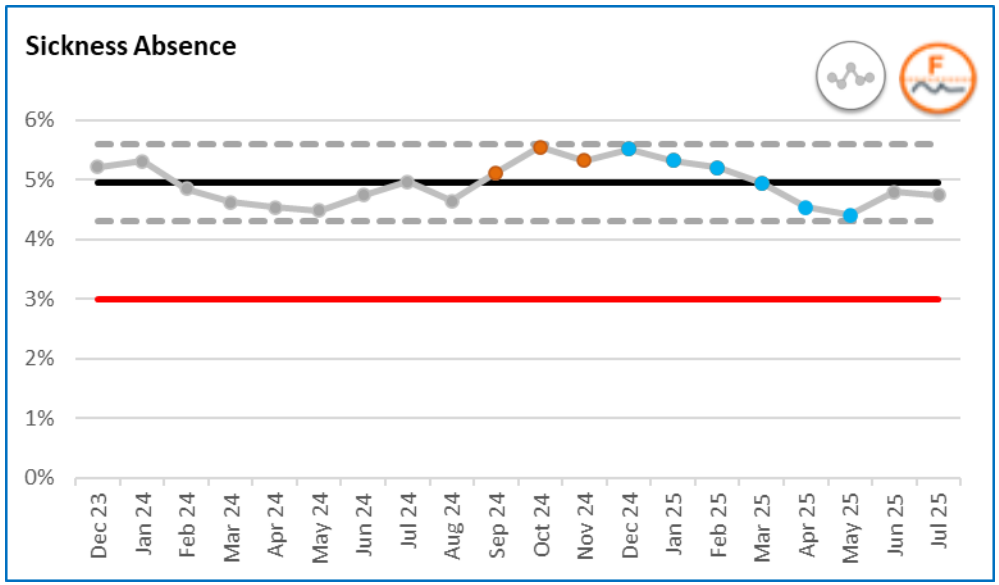
25 Working Days		
Jul 25	YTD	Target
80.0%	68.1%	90%

60 Working Days		
Jun 25	YTD	Target
80.0%	81.8%	90%

National Position & Overview

Root Cause	Actions	Impact/Timescale
• 80% target achieved April- June 25 for 60 working day complaint responses (these are complex / meetings)	• B2 complaints meeting coordinator / administrator has been redeployed from CHUGGS to support the Complaints team	• Anticipate timelier complaint meetings (& achieve 60 working day target)
• 80% target achieved for 25 working days complaint responses	• PALS / Complaints team working weekly with areas of highest concerns to prevent formal complaints e.g. Ophthalmology, Gynaecology etc	• Anticipate reduction in number of formal complaints for Gynaecology, Ophthalmology etc

Well Led – Sickness Absence



Current Performance		
Jul 25	YTD	Target
4.7%	4.6%	3%

National Position & Overview

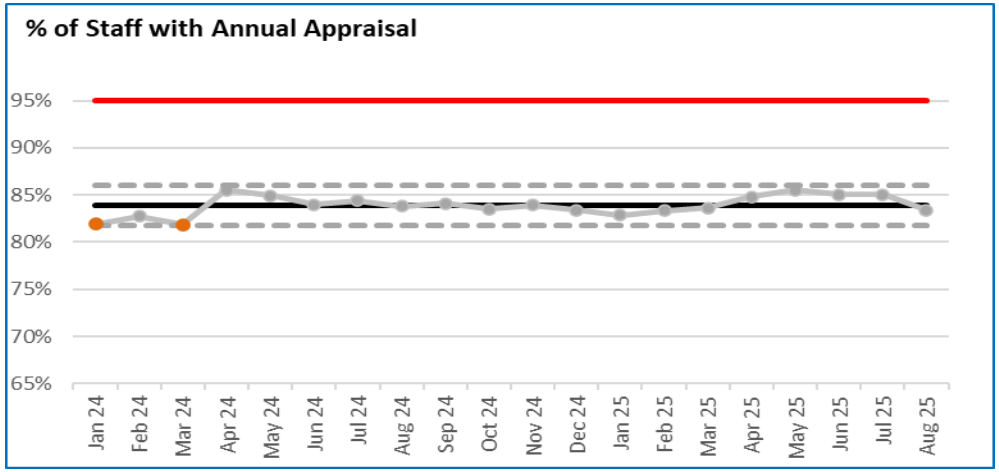
The overall sickness absence rate for England was 4.8%. This has fallen slightly since March 2025 (4.9%) and is the same as April 2024 (4.8%)

Anxiety/stress/depression/other psychiatric illnesses was the most reported reason for sickness, accounting for over 580,400 full time equivalent days lost and 27.7% of all sickness absence in April 2025. This has increased slightly since March 2025 (27.5%).

Data source: NHS Sickness Absence Rates, April 2025 - NHS England Digital

Root Cause	Actions	Impact/Timescale
•Clinical CMG's have seen a decrease of 0.1% this month, whereas Corporate Directorates have increased 0.1.6%. •Over the last 12 months, the highest levels of absence are in E&F (6.17%), W&C (5.58%), RRCV (5.21%). •The areas achieving the 3% target are within the Corporate Directorates (5 areas) •The top 3 reasons for sickness absence are anxiety/stress/depression (24.91%), Other & Unknown (18.59%) and musculoskeletal (10.61%) (which has replaced cold/flu).	•The Electronic Rostering team continue to work to improve reporting reasons for sickness as this is essential for CMG's assurance and oversight regarding management and support of sickness absence cases. •Wellbeing information continues to be 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, W&C and E&F have prioritized training for managers, implemented 'making it all happen' meetings for hot spot areas. There has been a particular focus on long term sickness, and accurate reporting. •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. • Training was run this month by the Employee Relation Team for the Occupational Health Team on the new sickness policy. Training included the new indicators, the importance of stages and reasonable adjustments plus the introduction of disability leave. The policy received excellent feedback.	•The new sickness policy continues to be received well and helps embed one of the NHS Long Term Workforce Plan key pillars, which includes supporting staff to stay well. •The launch, and subsequent results of the 2025 Staff Survey will build on the People Promise Theme "We are safe and healthy". Actions arising from this year's survey will be highlighted in future exception reporting. • Several long-term sickness cases are concluding due to staff returning to work, exiting the Trust, retirement and MARS.

Well Led – % of Staff with Annual Appraisal



Current Performance		
Aug 25	YTD	Target
83.4%	-	95%

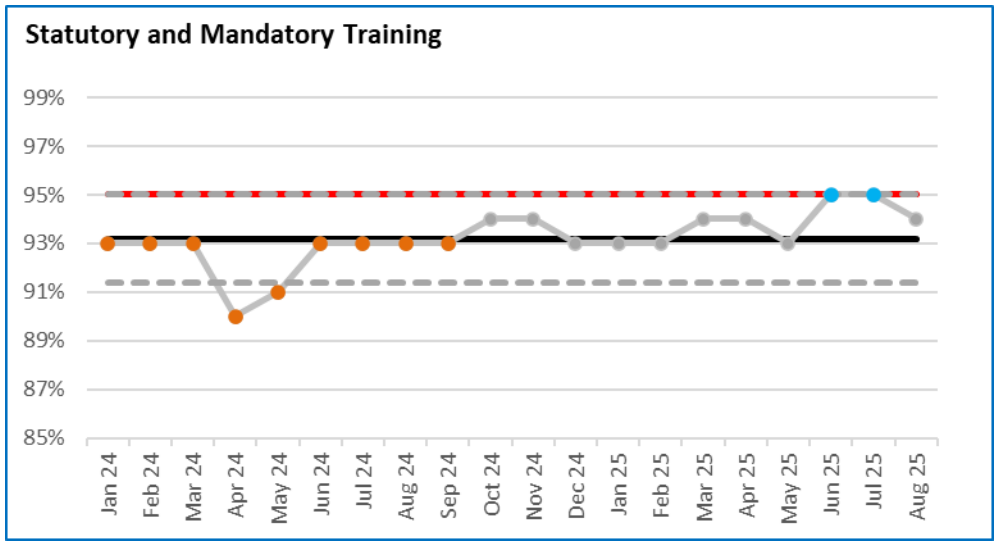
National Position & Overview

Peer data not available.

The August figure shows a decreased position on the previous month. We are 11.6% 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 continued plans are underway to support capturing this across services • In month, the appraisal average for UHL has decreased and may be linked to increased annual leave periods. • The Trust's compliance in month has been due to decreases in all clinical and corporate areas, bar MSK with a 2% increase and only Research CRN meeting the target at 95.7%, across all services.	• 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..	• In August 2024 Appraisal performance was at 83.8% which was an decrease in compliance on the previous month of July 2024; this year we also see a slightly decreased position compared to the Aug 2024 figure. • Appraisals are reviewed through regular line management and Board oversight meetings. • CMG/ Directorate leadership are 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 – Statutory and Mandatory Training



Current Performance		
Aug 25	YTD	Target
94%	-	95%

National Position & Overview

Peer data not available.

Root Cause	Actions	Impact/Timescale
It is recognised that performance for some CMG's, departments or staff groups has been, and is being, affected by: • Operational pressures • Operational demand • Staffing Levels. Although the RAG rating is red, it should be noted that the compliance of 94% is higher than many other NHS organisations nationally and is not an immediate risk, however the target of 95% is desirable. Mandatory training knowledge modules are one of many tools to support patient and staff safety.	Performance against trajectories is being monitored via Trustwide Performance Reviews. Access to compliance data and emailed reports to 2950 staff. 10,000+ direct reminder emails per month. Some colleagues cannot get online. Mandatory training booklets have been updated with SME's for Estates and Facilities Colleagues. Workforce, Training and Education Steering Group are looking at Essential Training. NHS England are conducting a review of Mandatory Training topics/frequency; both aims are to ensure a balance between minimising incidents, mitigating risks and releasing staff time into the workforce.	Reviewed through the Making it All Happen reviews chaired by CMG / Directorate leadership teams with support from HR. This is a meeting with each line manager to review sickness, appraisals and S&MT compliance. Drive towards improving the overall percentage of UHL throughout the financial year has been implemented with renewed chasing on non-compliant with organisational support. Review of ESR and HELM data alignment is ongoing as business as usual. Ad hoc Challenges to this data alignment are under consistent scrutiny.

Well Led – Non Clinical Agency- No. of Staff

Awaiting more data for SPC chart

Current Performance		
Aug 25	YTD	Target
3	21	0

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.	The service has confirmed that these workers are assigned to working on delivery of the capital programme which has been approved by NHSE. A large proportion of the projects are NHSE funded projects, eg Estates Safety and OFH No exit plans are in place for these workers for the foreseeable future as they are only half way through delivering this year's capital plan for Backlog spend, and without these workers the completion of the current projects are at risk. These workers are funded from the capital and not revenue. The capital programme always evolves and expands throughout the year as extra funding is received across the organisation and the team has to respond and deliver the projects relating to this funding and cannot do this without the flexibility of the use of agency workers. These roles are supported by the Director of Estates & Facilities

Well Led – Agency Staff above Price cap

Awaiting more data for SPC chart

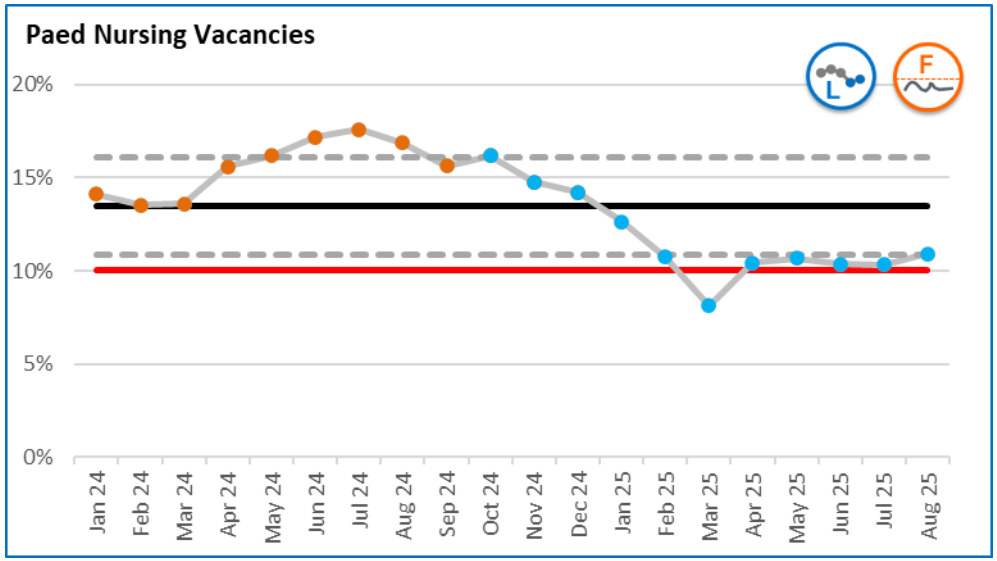
Current Performance		
Aug 25	YTD	Target
21	121	0

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.	•NHSE have acknowledged the West Midlands medical agency rate card as an acceptable interim rate cap for Trusts to apply and UHL have implemented this since June 25 for all new medical agency bookings without exception. There remains some long line workers who remain over the price cap but these are acknowledged to be in specialist fragile services. •We are over price cap only in specialist roles in Sonography and Cardio respiratory for AHP/ST&T. Attendance at regional group by Chief AHP.

Well Led – Paed Nursing Vacancies



Current Performance		
Aug 25	YTD	Target
10.9%	-	10%

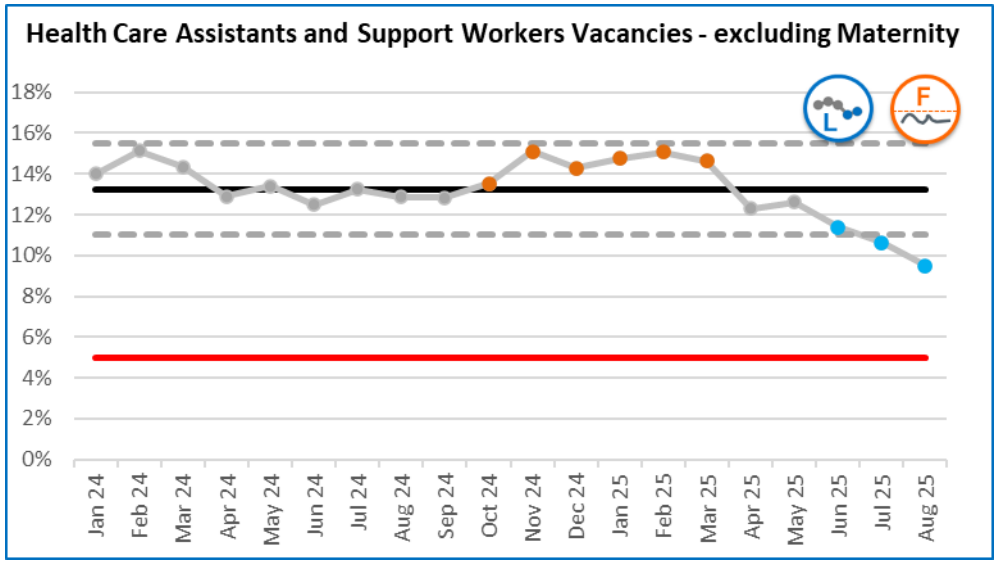
National Position & Overview

- There are regional differences in Registered Nurse shortfalls. In particular, specialised areas of children's nursing face unique challenges that require tailored solutions to address these gaps.

Root Cause	Actions	Impact/Timescale

This shortfall is primarily driven by two factors:
• The previous high vacancy rate, which created a backlog in recruitment.
• The implementation of the 3-year Children's Hospital Workforce Plan, which increased the budgeted WTE and therefore raised the overall establishment requirement.
	• We have confirmed offers for 29.46 WTE newly qualified Registered Nurses (Children's).
	• The recruitment campaign targeted candidates nationwide, not just local HEIs. In addition, 8 Internationally Educated Nurses (IENs) have been recruited, with 5 expected to complete their OSCE programme by October 2025.
	• The Nursing and Midwifery Annual Establishment Review for the Children's Hospital is scheduled for 25 September 2025, chaired by the Chief Nurse. This review will confirm the required staffing for FY 2026–27 and align with the trajectory set out in the 3-year Children's Hospital Workforce Plan.
		• The following data set has been submitted direct from the Children's Hospital Matron for Safe Staffing, Recruitment and Retention for Sept-25 (AfC Band 5):
		  • Vacancies: 35.16 wte
		  • Non-NQN pipeline: 12.48 wte
		  • NQN pipeline: 29.46 wte
		  • Leavers: 1.29 wte
		  • Projected vacancy: -5.49 wte
		• Planning underway to reorientate funding from AfC Band 4/ 6 to address national NQN recruitment direction.

Well Led – HCA and Support Workers Vacancies – excluding Maternity



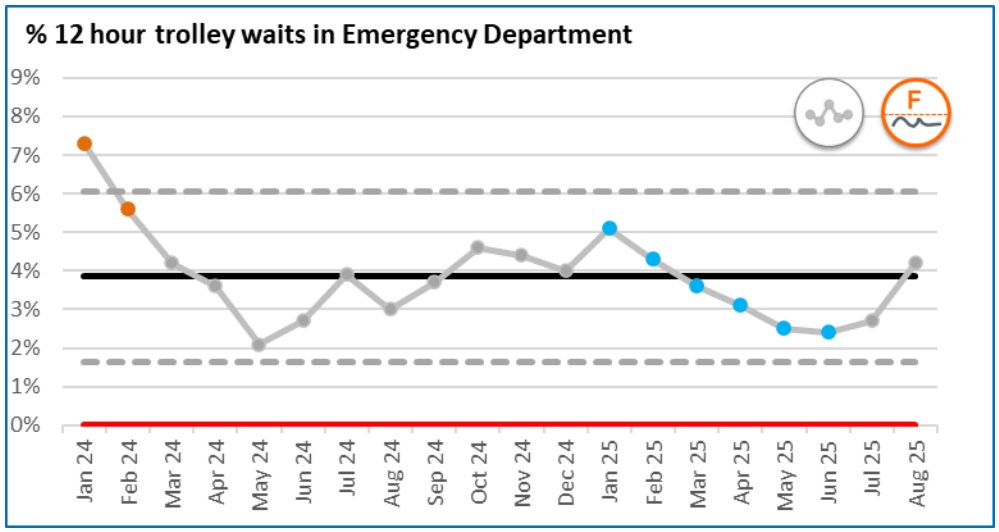
Current Performance		
Aug 25	YTD	Target
9.5%	-	5%

National Position & Overview

- Model Hospital is reporting the "Support to Nurses" role vacancy at 10.6% (Jul-25).
- This suggests that UHL is outperforming the national average.
- The current UHL position is showing a downward trajectory

Root Cause	Actions	Impact/Timescale
• Workstream completed for bank to substantive workforce • Retention has been maintained for HCSW • Small number of HCSW transitioned to TNA programme	• Bank to substantive HCSW resulted in 60 posts offered • Recent HCA recruitment drive for Aug-25; 44 applicants successful at interview are currently undergoing HR checks. • We are converting some Healthcare Assistant (HCA) posts into Registered Nurse (RN) posts across the organisation to increase the percentage of RNs on duty. These changes are being reviewed and approved as part of the Nursing and Midwifery Annual Establishment Reviews (NMAER), chaired by the Chief Nurse, to confirm the required staffing for FY 2026–27. • As a result of these decisions, we expect the overall RN vacancy rate to decrease.	• Once all HCSW have commenced in post the trajectory remains downward • NMAER meetings are ongoing with annual report completion in Q3.

Responsive (Emergency Care) – % of 12 hour waits in the Emergency Department



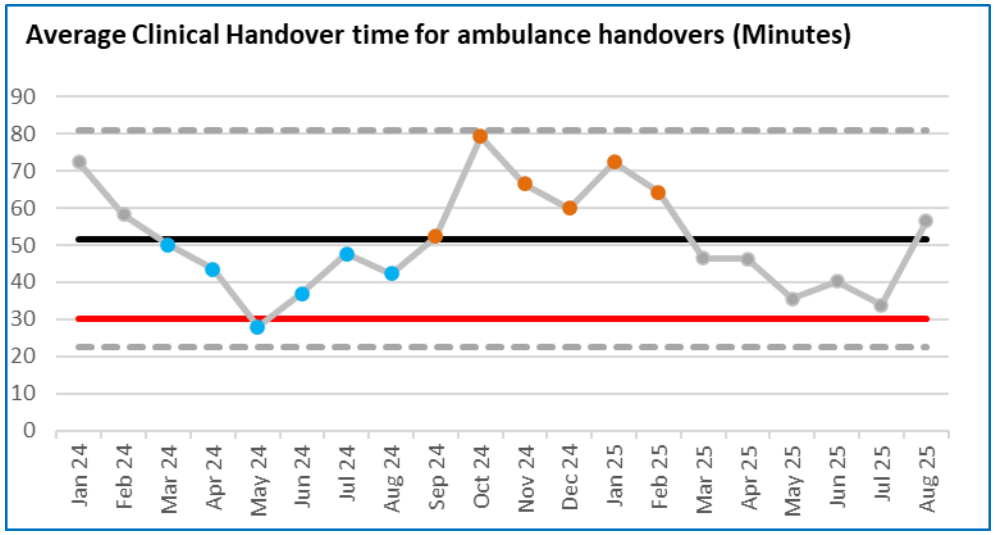
Current Performance		
Aug 25	YTD	Target
11.6%	9.6%	10.3%

National Position & Overview

In August, UHL ranked 97 out of 121 Major A&E NHS Trusts. UHL ranked 14 out of the 18 UHL Peer Trusts. The best value nationally was 0 and the worst value was 12%. 118 out of the 121 Acute Trusts achieved the target.

Root Cause	Actions	Impact/Timescale
• Poor outflow across the emergency care pathway • Inability to create early capacity across the emergency care pathway due to lack of early discharges	• Ward improvement programme with ESM • Refresh of release to respond • Daily breach validation • Pilot of non bedding in SDEC to support early flow	• Diagnostic phase commenced in August – due to be complete in February 2026 • September 2026 • In place • October 2026

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



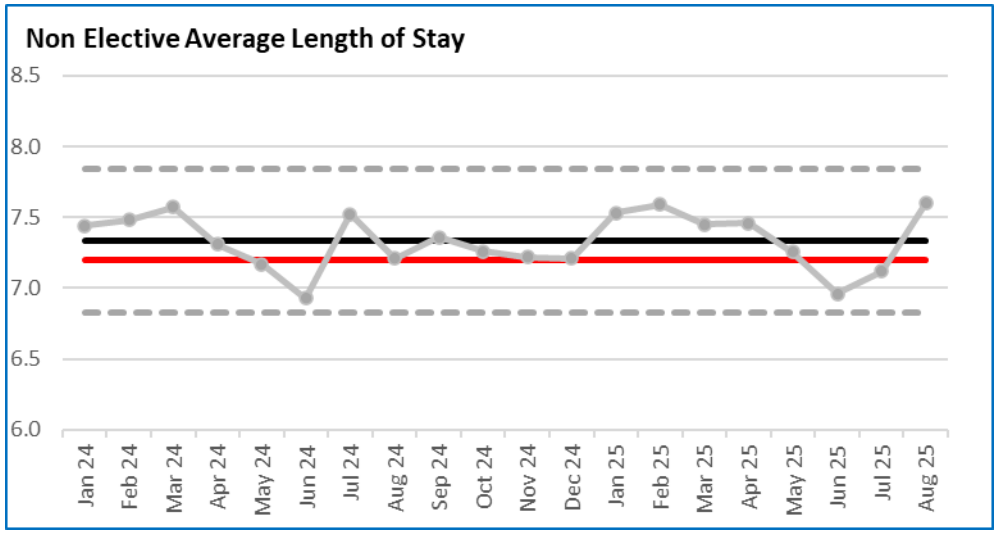
Current Performance			
Aug 25	YTD	Aug Plan	Target
56	42	33	30

National Position & Overview

The LRI had the highest Average Clinical Handover time in the East Midlands in August out of 24 hospital sites (Source EMAS monthly turnaround 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 due to POA's meaning prioritization of patient in walk in assessment	• Utilisation of pre-transfer unit at LRI • Utilisation of EDU for bed waits • Rapid flow and Boarding • Refresh of release to respond • Explore call before convey • Explore further escalation capacity • Implement Trust Winter plan	• In place • In place • In place • September 2026 • October 2026 • October 2026 • December 2026

Responsive (Emergency Care) – Non Elective Average Length of Stay

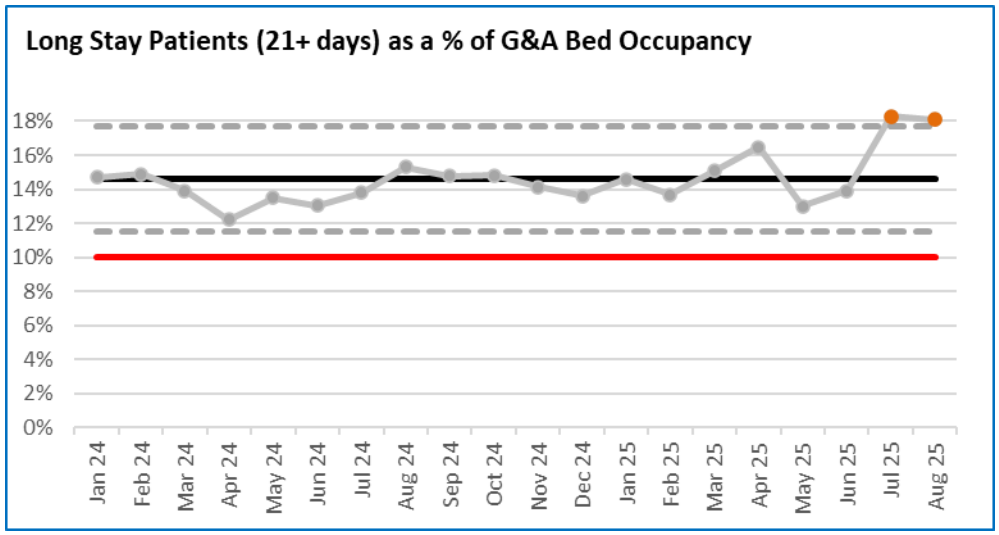


Current Performance			
Aug 25	YTD	Aug Plan	Target
7.6	7.3	7.0	7.2

National Position & Overview

Root Cause	Actions	Impact/Timescale
• Process delays internally relating to ward processes, diagnostics, discharge delays (TTO's etc) • Process delays externally to provide timely plans for discharge	SDEC plans to avoid admission Frailty working group –implement action plan Diagnostic board to develop inpatient actions to support process improvement Ward improvement programme with ESM	• From April – project plan available – target of 11% increase set for 2/26 • Ongoing • September 2025 • Diagnostic phase commenced in August – due to be complete in February 2026

Responsive (Emergency Care) – Long Stay Patients as a % of G&A Bed Occupancy



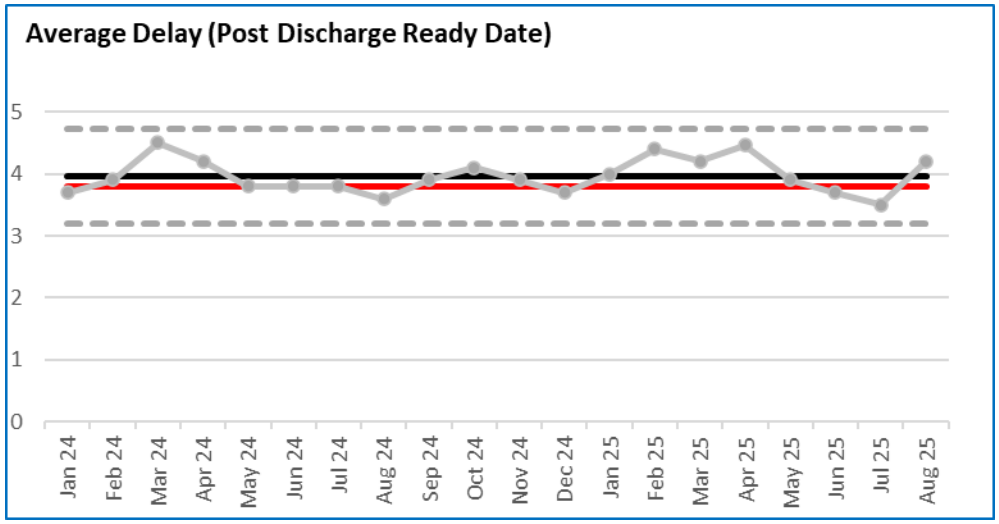
Current Performance		
Aug 25	YTD	Target
18.1%	-	10%

National Position & Overview

- 57 (344) Patients (17 %) are receiving appropriate care/ treatment on a neuro rehabilitation /brain injury pathway or on an Intensive Care Unit, Infectious Diseases Unit or in UHL at Preston Lodge (13 patients).
- 86 Patients (25%) are medically optimised complex patients awaiting discharge with no reason to stay in an Acute Trust.

Root Cause	Actions	Impact/Timescale
• Since the end of June we have seen an increase of 108 patients with a > 21 day length of stay across the CMG's. • We have seen a doubling in the number of a Complex patients > 21 day awaiting a discharge outcome from 31 in June to 62 at the end of August. • Data quality issues arising from change to PAS have had an impact too.	Continue to work with health and social care system partners during September 2025 to: • Maximise the use of P1/ P2 capacity in LLR. • Embed/ refine weekly long wait for outcome escalation meetings with Adult Social Care. Work with CMG's to: • Promote the early referral of patients to the discharge hub prior to being MOFD. (Currently 34%). • Undertake weekly >100 day patient reviews • Undertake deep dive review of LLOS list to ensure it is pulling the correct patients • Plan process for moving to a weekly in depth review of > 60 day patients. • Commence discovery phase of Specialist Medicine Discharge Project.	• Aim to reduce number of MOFD patients waiting for discharge in UHL beds. • Increase numbers of patients discharged on a Pathway 0/ pathway 1. • Reduce time to discharge from MOFD identification. • Staff feel better equipped to manage and coordinate the safe discharge and transfer of Patients

Responsive (Emergency Care) – Average Delay (Post Discharge Ready Date)



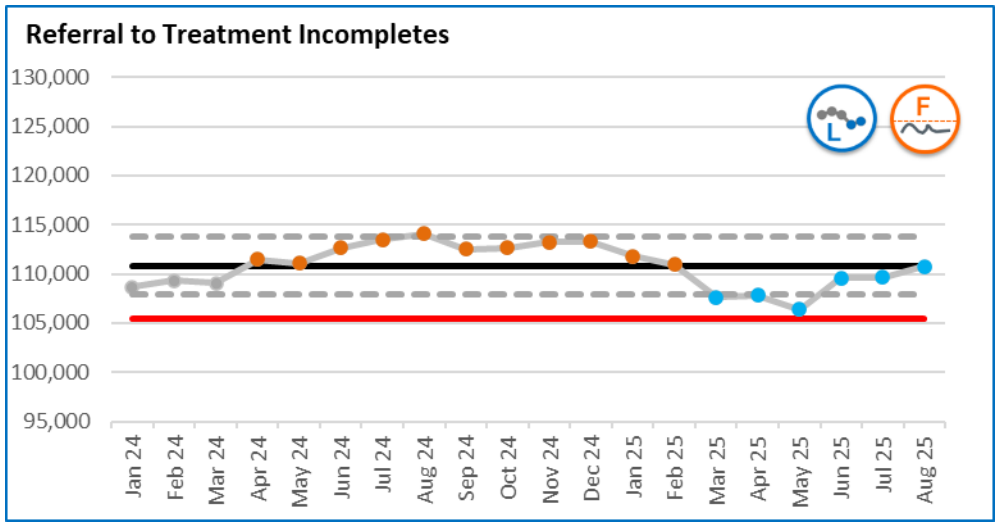
Current Performance		
Aug 25	YTD	Target
4.2	4.0	3.8

National Position & Overview

In July, UHL ranked 20th out of 117 Acute Trusts that submitted acceptable data. The National average was 6.1. 21 out of the 117 Acute Trusts achieved the target. UHL ranked 4th out of the 18 UHL Peer Trusts. The best value within our peer group was 2.7 and the worst value was 9.9.

Root Cause	Actions	Impact/Timescale
Poor outflow from inpatient wards due to: • Internal ward based process delays (Discharge medication, transport , family communication etc.) • External partner interface or capacity delays for Pathways 1-3	• Incomplete discharge monitoring for Pathways 1-3. Monthly review of themes and actions taken to resolve. (10% improvement target set, monitored through Improving Patient Discharge Meeting) • Specialty Medicine Discharge Intervention Project commenced – discovery phase in progress. • Weekly partner >1 week delay escalation meeting in progress.	• Aim to reduce the number of medically optimised patients waiting for discharge in UHL • Reduce time to discharge from medically optimised identification • Reduce the number of incomplete discharges each month. • Work with health and social care partners to right size capacity/ transform ways of delivering intermediate care Actions monitored and delivered through: Improving Patient Discharge, Step down and Intermediate care meetings and System Discharge Operational and UEC meetings.

Responsive (Elective Care) – RTT Incompletes



Current Performance		
Aug 25	August Plan	Target
110,728	109,387	105,500

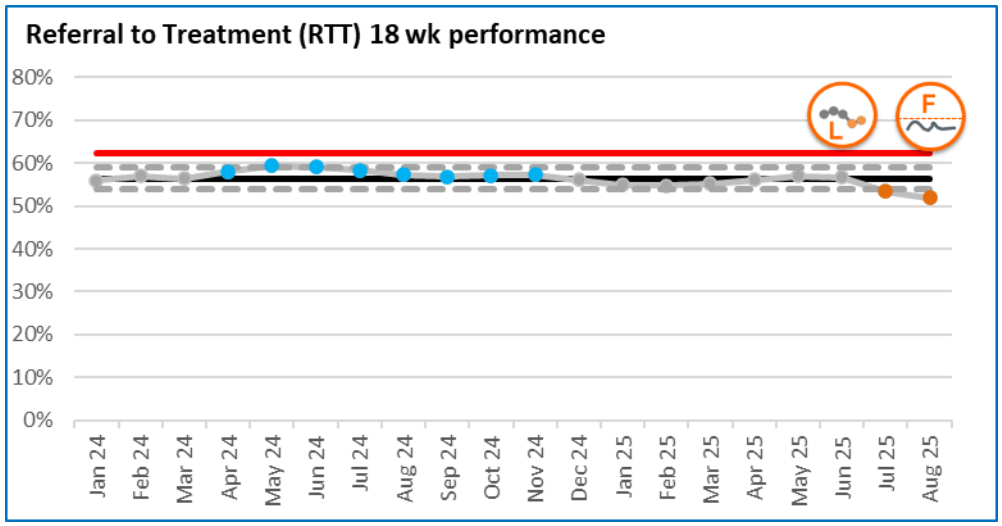
National Position & Overview

At the end of July, UHL ranked 15th out of 18 trusts in its peer group with a total waiting list size of 109615 patients. The best value within our peer group was 65637, the worst value was 186088 and the median value was 87495.5. (Source: NHSE published monthly report)

Root Cause	Actions	Impact/Timescale

• Continued growth in demand against a significant number of specialities
• Industrial action- loss of activity
• 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.
• 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 continues to exclude those pathways awaiting triage.
• PAS productivity – the PAS roll out has had a bigger impact on productivity than expected and has led to decreased activity in some areas. The estimate is being finalised and in some areas is ongoing. This was also impacted by the 2-week delay to PAS go live.
• Workforce controls impacting on ability to maintain baseline and undertake additional activity through WLIs
	• 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
	• CDC opened end of May- focused actions to ensure filling capacity
	• Continued learning and fix finding in new PAS
	• Project to implement FDP (Federated Data Platform) RTT Validation module- to improve speed and efficacy of validation efforts
	• 12 week improvement plan to reduce total WL with 4 workstreams: Validation, Appointment Outcomes, Triage and Increased activity
	• Plan developed with CMGs to undertake additional work funded by the region to support RTT and Cancer performance improvement.
		• Above baseline for validation sprint in Q1. Participating in Q2 sprint July-Sept 25 and cumulatively above baseline.
		• Increased ACPL on theatre lists- improving activity through existing resource- ongoing.
		• Outpatient clinic template standardisation- to increase the number of new and follow-up appointments within clinic templates- ongoing.
		• CDC will support an increase in diagnosis and therefore, supporting an increase in clock-stops (FYE additional 89,000 tests)
		• Increased volumes of validation, better visibility across corporate and clinical services of clean PTL.
		• Reduction of total WL by 6-10k by end of October 2025.
		• Additional regional funds to support key actions to deliver:
		  • Zero 65+ by the end of December 25
		  • 52+ back to <1% of TWL March 26
		  • FDS back to plan December 25
		  • 31 day to plan by March 26
		  • 62 day to plan by March 26

Responsive (Elective Care) – RTT 18 Week Performance



18 Week Performance			First Attendance - 18 Week Performance		
Aug 25	Aug Plan	Target	Aug 25	Aug Plan	Target
51.9%	57.2%	62.3%	62.6%	62.5%	68.1%

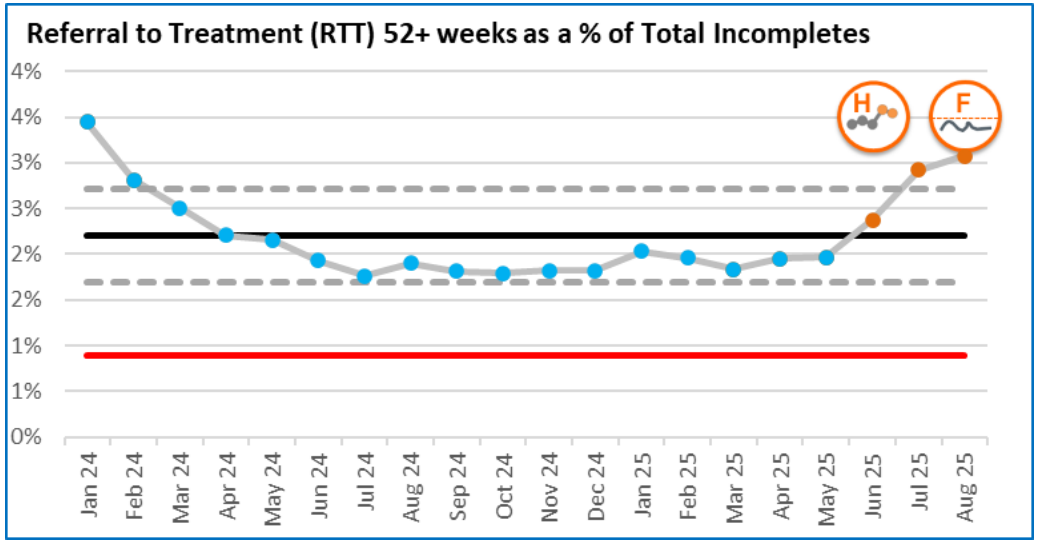
National Position & Overview

At the end of July, UHL ranked 17th out of 18 trusts in its peer group with RTT 18 Week Performance at 53.4%. The best value within our peer group was 73.7%, the worst value was 53.3% and the median value was 58.2%. (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.
• Trustwide roll out of e-triage through eRS in Q3 and 4 of 24/25 led to a 'false' reduction in total waiting list, those waiting under 18 weeks and in turn, our <18 wk performance. The reported waiting list size continues to exclude those pathways awaiting triage.
• PAS productivity – the PAS roll out has had a bigger impact on productivity than expected and has led to decreased activity in some areas. The estimate is being finalised and in some areas is ongoing. This was also impacted by the 2-week delay to PAS go live.
• Workforce controls impacting on ability to maintain baseline and undertake additional activity through WLIs
	• 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.
	• To establish escalation fortnightly escalation meetings chaired by DCOO for Planned Care with specialties that have potential to go further against the 18w target and will positively contribute to overall Trust total (high volume).
		• Targeted validation in the sprint periods and month end processes to maximise removals of the longest waiters and those waiting over 18 weeks.
		• Increased ACPL on theatre lists- improving activity through existing resource- ongoing.
		• Outpatient clinic standardisation plan agreed at TLT in July will support an increase in outpatient clinic appointments supporting improved 18ww performance.
		• CDC will support an increase in diagnosis and therefore, supporting an increase in clock-stops (FYE additional 89,000 tests)
		• Additional regional funds to support key actions to deliver:
		  • Zero 65+ by the end of December 25
		  • 52+ back to <1% of TWL March 26
		  • FDS back to plan December 25
		  • 31 day to plan by March 26
		  • 62 day to plan by March 26

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



Current Performance		
Aug 25	August Plan	Target
3.1%	1.3%	0.9%

National Position & Overview

At the end of July UHL ranked 11th out of the 18 Trusts in it's peer group with 2.1% of patients on the waiting list waiting over 52+ weeks. The best value within our peer group was 1.4%, the worst value was 5.4% and the median value was 2.7%. (Source: NHSE published monthly report).
Long waiter performance continues to deteriorate. 52 week waits are increasing rather than reducing, with the bulk of waiters in Maxfax, Orthopaedics/Spines, ENT/Paeds ENT and General Surgery. 65 week waits have also increased this year.

Root Cause

- 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.
- Nervecentre implementation: Reduction in activity due to PAS rollout. Activity and administrative actions including validation not yet up to pre-roll out levels.
- High levels of administrative vacancies and reduction of bank due to workforce controls has led to a reduction in staff able to book clinics, reducing productivity and activity levels.

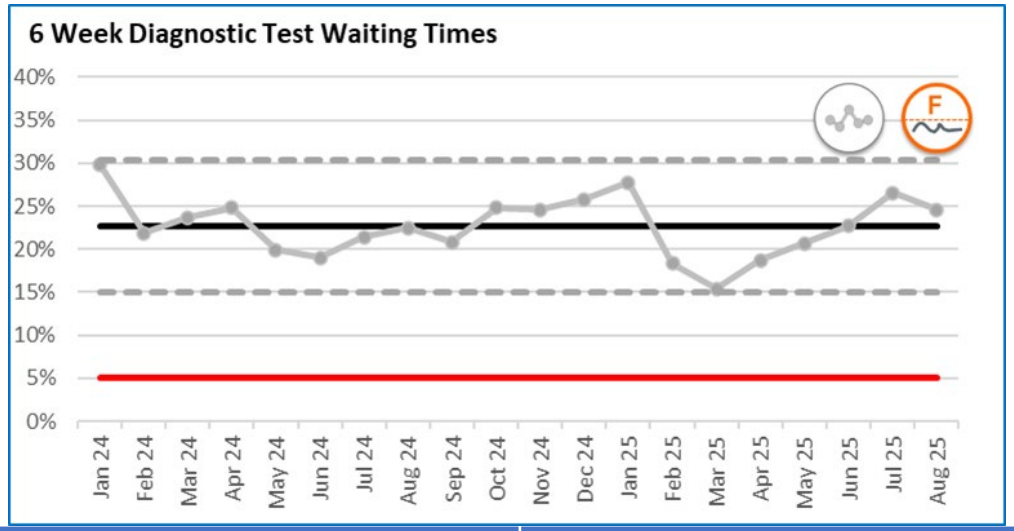
Actions

- 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.
- Successful Paediatric ENT superweek of elective operating held w/c 21/7, with further plans in September.
- Fortnightly escalation meetings chaired by COO/System Director for Planned Care with CMGs with the bulk of long waiters (65ww)
- Increased use of mutual aid and independent sector support
- Paper to be taken to RDO on the impact of administrative workforce controls.
- 52ww and 65ww forecasting models for specialties with large volumes of long waiters
- Plan developed with CMGs to undertake additional work funded by the region to support RTT and Cancer performance improvement.

Impact/Timescale

- All actions taken with the intention of reducing long waits faster than current performance.
- Forecasts shared with CMG leads fortnightly and monitored to provide challenge and support where needed.
- Additional regional funds to support key actions to deliver:
  - Zero 65+ by the end of December 25
  - 52+ back to <1% of TWL March 26
  - FDS back to plan December 25
  - 31 day to plan by March 26
  - 62 day to plan by March 26

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



Current Performance		
Aug 25	YTD	Target
24.6%	-	5.0%

National Position & Overview

Published National data at the end of July 25 shows 1.7 m patients on the diagnostic waiting list with 21.9% waiting over 6 weeks. For August 25, UHL with 27,100 patients would comparatively rank as the 6th highest waiting list. The 6-week trajectory for August was set to deliver 10.6%, the actual was 24.6%, 13% behind plan, driven by NOUS, Endoscopy, Audiology and Echo. There were 6,663 patients waiting >6 weeks an improvement of 787 from July 25.

Root Cause

Diagnostics pressure areas are in the main:

- NOUS
- Endoscopy
- Audiology
- Echo
- MRI for complex long waiters

Root cause

- Clinical workforce gaps
- Admin recruitment
- Reporting and coding errors
- Overall NOUS and Echo waiting list growth
- Pressure from emergency, cancer and elective long wait pathways

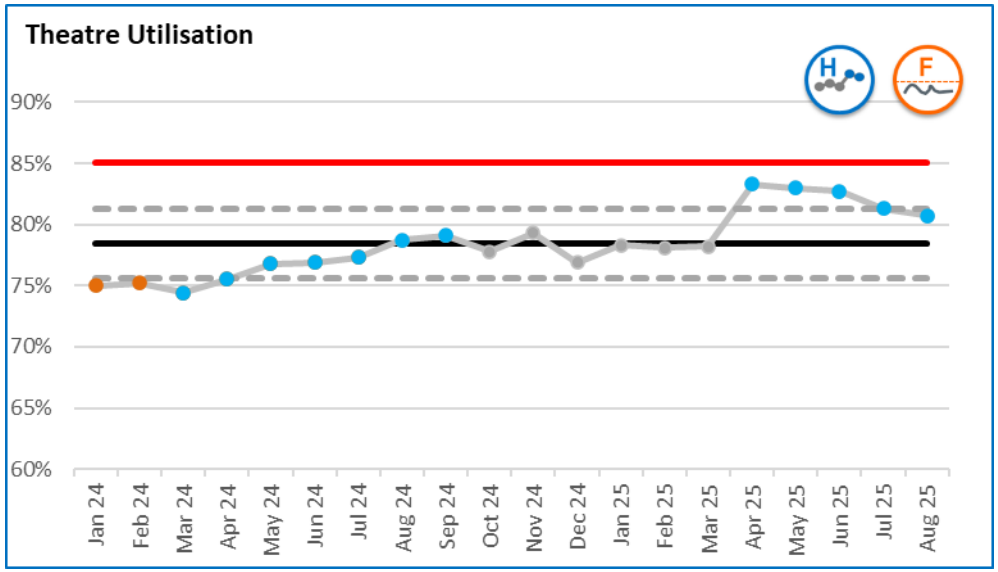
Actions

- QLIK & PAS WLMDS training
- Increased productivity of resources
- Increase capacity
  - New endoscopy unit – Oct 25
  - Hinckley Community Diagnostics Centre – opened June 25
  - NOUS – ERF to return to plan
  - Echo – ERF to return to plan
- Review demand data with ICB for further opportunities
- Expand direct access diagnostics 25/26
- 5year MRI/CT D&C plan – complete, next steps to discuss recommendations and £ evaluation with TLT – Oct 25.
- Sleep to increase capacity and review workforce sustainability

Impact/Timescale

- Training following PAS upgrade – Oct25
- Validation – ongoing, Aug improvement in MRI.
- Productivity metrics Aug - improvements in DNA for CT and improved session utilisation in Endoscopy. Outpatients modalities added from Q2 and showing Cystoscopy and Urodynamics utilisation above 90%.
- MRI recovery on track vans x2 on site supporting recovery - Q4
- Sleep reduction in waits continue to be seen – Q2
- NOUS recovery expected by end of Q3
- Echo recovery progress noted in month and delivery on track for Q3
- Review of 5year MRI & CT D&C – Complete Sept 25, to discuss recommendations with TLT – Oct 25.
- Audiology recovery – Q3
- Endoscopy recovery - Q3

Responsive (Elective Care) – Theatre Utilisation



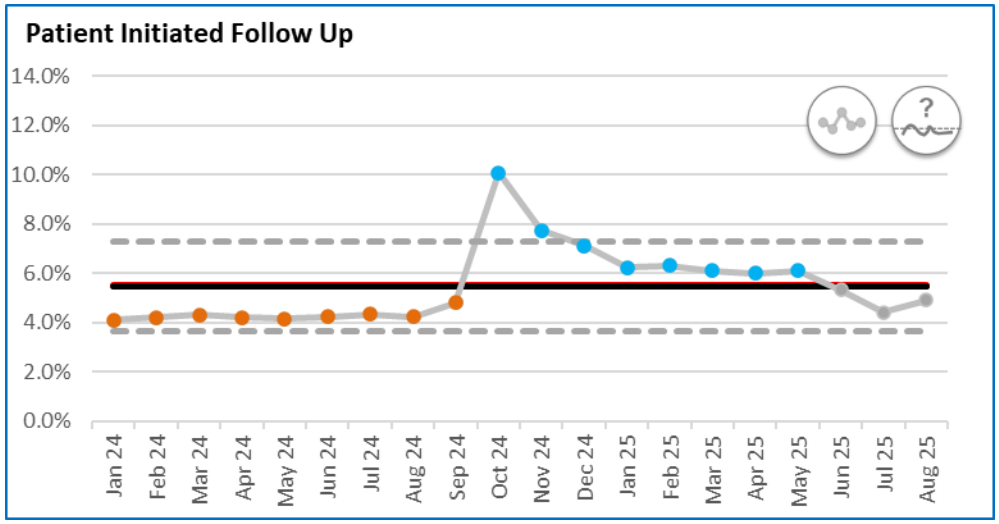
Current Performance		
Aug 25	YTD	Target
80.7%	82.1%	85%

National Position & Overview

For the week ending 24/08/2025, the MHS system value for theatre utilisation was 82.4%, outperforming both peer systems (81.5%) and the national average (81.3%). The system is currently rated Green, Quartile 3.

Root Cause	Actions	Impact/Timescale
• LRI (74.4%) below target: Issue with late starts (42%) and high number of OTDC (11%). The main reason for both is the emergency pressures on this site which impacts elective activity in terms of bed pressures or needing to convert elective lists to emergency. • EMPCC (74.5%): Below target, Issue with scheduling process; procedure times are taking less than planned. Therefore, lists are underrunning. • LGH (82.3%): Just below target, moderate late starts (14.6%) and OTDC (6.21%) contribute to underperformance.	• Golden patient assignment – confirmation that each list has a clinician-assigned golden patient (All sites) • Clinicians to review and approve list in advance, ensuring appropriate preparation and case complexity (All sites) • Each specialty do a review of procedure timings within the EMPCC and adapt scheduling accordingly • Trialing a new complex LA clinic to reduce OTDC rates within local anaesthetic procedures within Urology at the EMPCC and LGH. • Auto-send of the first patient on each theatre list at the LRI site, implement and monitor.	• Reduction in late starts and ensures the first case is confirmed and prepared in advance – Aug 25. • Anticipate the time required for each case, reducing the likelihood of under & overruns and ensuring all investigation have been undertaken in readiness – Aug 25. • Improve scheduling accuracy and reduce under-runs, improving utilisation – Sep 25. • Improve patient planning and reduces OTDC % - October 25. • Reduce late starts and improve cancellations due to lack of session time - Sep 25.

Responsive (Elective Care) – PIFU



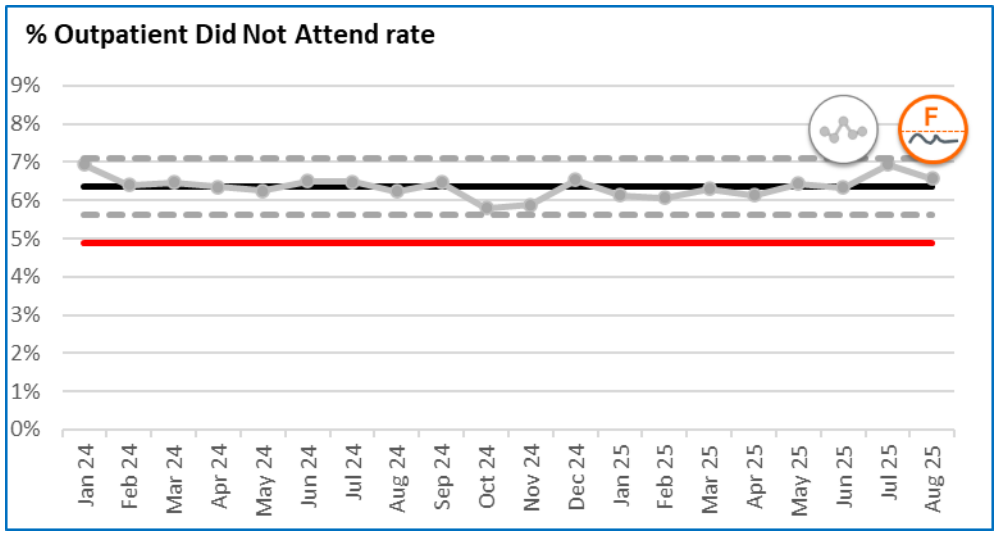
Current Performance		
Aug 25	YTD	Target
4.9%	5.3%	5.5%

National Position & Overview

National Expectation: NHS England has set a target for **5%** of outpatient activity to result in a PIFU outcome.
UHL Ambition: UHL has committed to a more ambitious target of **5.5%** as part of its operational plan.
Performance (July 2025): UHL achieved a ranking of 21 out of 143 NHS Trusts for the proportion of outpatient appointments resulting in a PIFU outcome. This ranking reflects the percentage of episodes transitioned to a PIFU pathway following patient attendance.
Data Source: Provider E-ROC

Root Cause	Actions	Impact/Timescale
• The implementation of the new PAS system has resulted in inconsistencies in how PIFU pathways are recorded in certain scenarios. Consequently, PIFU cannot be applied in some cases. **Other Contributing Factors:** • Limited clinical engagement in specialty-level rollout. • Challenges in identifying suitable patient groups. • Inconsistent communication across teams. • Concerns about increased follow-up demand. • Additional increase in administrative workload due to unclear processes and documentation requirements.	**System & Process Issues:** Recording challenges in PAS require timely Neurons ticket resolution and collaboration between the service , outpatient leadership and PAS teams. **Performance & Targets**: Specialty-level targets are in place, with stretch goals for high performers; underperforming areas are supported through focused meetings. **Monitoring & Benchmarking**: Weekly reports and national benchmarking (Further Faster, GIRFT) guide progress and best practice sharing. **Expansion & Efficiency**: Opportunities to grow PIFU via helplines and post-discharge pathways are being explored, alongside consistent reporting and digital solutions to streamline triage and reduce admin burden	**Governance Oversight**: PIFU performance is monitored through established governance forums including the Outpatient Transformation Board, specialty-level meetings, and access performance reviews—enabling timely issue identification and responsive planning. **Strategic Workshops**: Outpatient transformation workshops with all CMGs are scheduled for September and October 2025, led by the Deputy Chief Operating Officer and Deputy Medical Director. These will position PIFU as a key strategy to reduce avoidable follow-ups and improve outpatient efficiency across specialties.

Responsive (Elective Care) – Outpatient DNA Rate

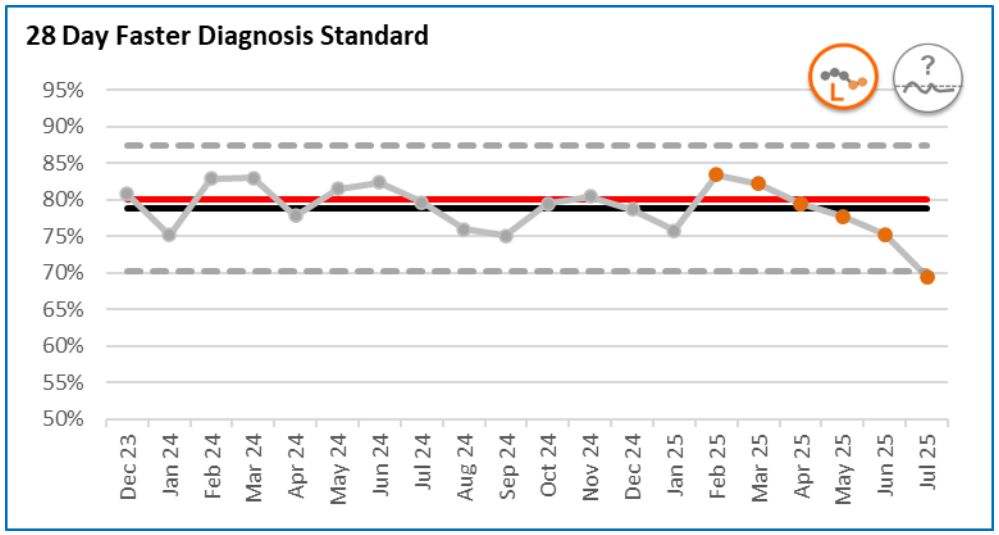


Current Performance		
Aug 25	YTD	Target
6.6%	6.5%	4.9%

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. There has also been an issue with the location field and patients have attended the wrong location. 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. Location issue has been escalated. 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 28 Day Faster Diagnosis Standard



Current Performance			
Jul 25	YTD	Jul Plan	Target
69.5%	75.4%	78.0%	80%

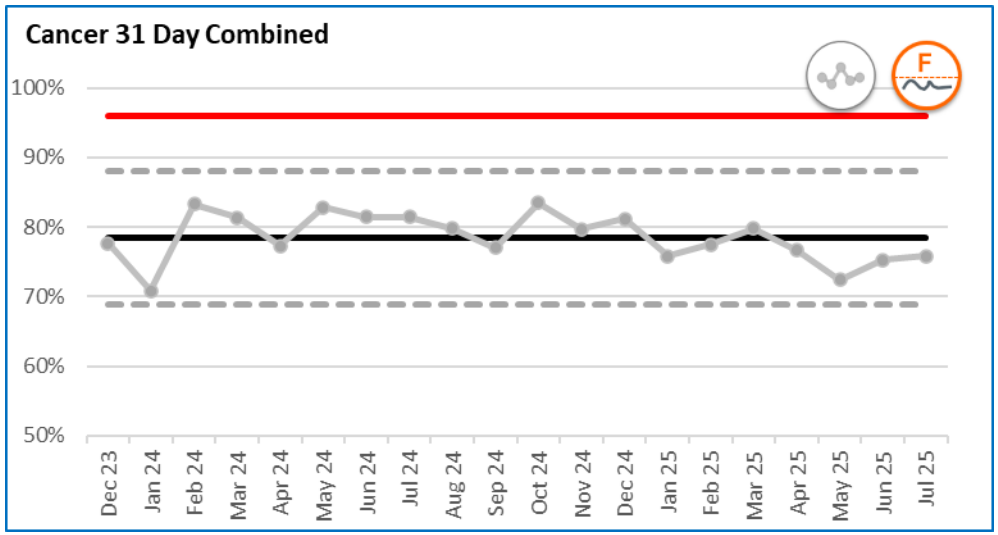
National Position & Overview

In July, UHL ranked 125 out of 140 Acute Trusts. The National average was 76.6%. 81 out of the 140 Acute Trusts achieved the target. UHL ranked 16 out of the 18 UHL Peer Trusts. The best value within our peer group was 83.7%, the worst value was 50.8% and the median value was 75.6%. UHL have previously performed above national average. Unexpected loss of capacity in Breast, Skin, H&N in July & August has caused the Trust to have deteriorated FDS performance for the first time below the national standard since September 2023.

Root Cause	Actions	Impact/Timescale

• Unexpected loss of capacity in
  • Breast (decline WLI + Sickness June/July)
  • Skin (loss of locum short notice 11/7)
  • H&N (loss of locum short notice + decline in WLIs)
• D&C gap for 1st appointments in Breast (50 slots per week) & H&N (244 slots per month) usually covered with WLI/Insourcing
• Decline in uptake of WLIs
Has caused time to first appointment to extend resulting in a decline in FDS performance for the first time since Sep23.
Without this loss of capacity performance would have been at 78%.
	Breast
	• Use of insourcing radiology support
	• Request temporary exception to apply ERF rates for Admin/Nursing until year end.
	• Sustainable plan required for 26.27
	Skin
	• Locum required – in place Mid Aug
	• Increase first appointment capacity
	H&N
	• Locum required – in place Aug
	• Conversion of routine slots to increase cancer capacity
	• Review of referral criteria
	• Sustainable plan required for 26.27 (use of alt workforce).
		Breast
		• YMS radiology support in place, limitations with admin/nursing uptake. Request exception for ERF rates – Sept 25 and plan required for 26.27. Waits have reduced from initial 8 weeks (July) to average 4 weeks. Further capacity required.
		H&N
		• Locum in place, time to 1st appt reduced from 9 weeks in June to 2-3 weeks
		Skin
		• Waits in August reduced to 10 days
		• Increase in capacity UHLiC (date TBC)
		• Increase in OPD capacity from 1st Oct (linked to changes in Skin AI pathway)

Responsive Cancer – Cancer 31 Day Combined



Current Performance			
Jul 25	YTD	Jul Plan	Target
75.9%	75.1%	78.1%	96%

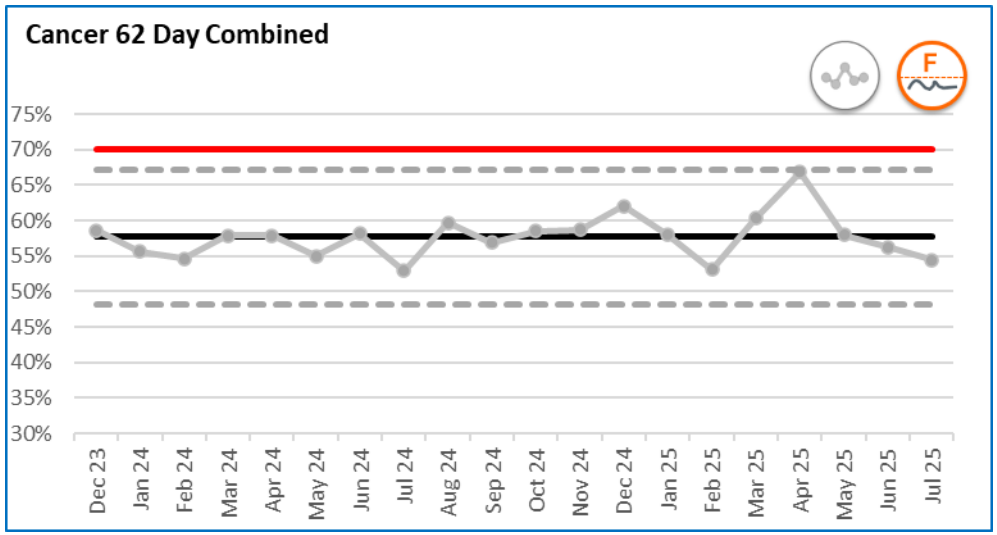
National Position & Overview

In July, UHL ranked 137 out of 137 Acute Trusts. The National average was 92.4%. 64 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 98.2%, the worst value was 75.9% and the median value was 92.1%.

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
  • Robotic capacity (Urology, Gynaecology)
  • Theatre capacity constraints
  • 31 day anti-cancer drug regimes capacity is constrained mainly within pharmacy provision
• Patient readiness to proceed with surgery impacting ability to date within 31days
	• Increased emphasis at PTL meetings to bring forward patients within target - weekly
	• Ensuring unused robotic time is released to other CMGs – ongoing
	• Radiotherapy 5th linac, mutual aid & efficiency workstream
	• Oncology OPD and SACT efficiency 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
	• Collaboration with UHN - ongoing
		• Radiotherapy
		  • 5th linac –breast backlog to be 0 by end of Sept, prostate reducing – delivery by end of Q4. Mutual aid continuing until Q4. D&C EM review & EM GIRFT - a/w recommendations.
		  • Workflow rescheduling time to maximise patient throughput – Sept 25
		• Surgical dating – improvements in Breast noted, further work others by Q4.
		• Oncology
		  • OPD review– impact unclear due to PAS reporting shift updated reports due Sept 25.
		  • Digital opportunities - first form to be implemented by Oct.

Responsive Cancer – Cancer 62 Day Combined



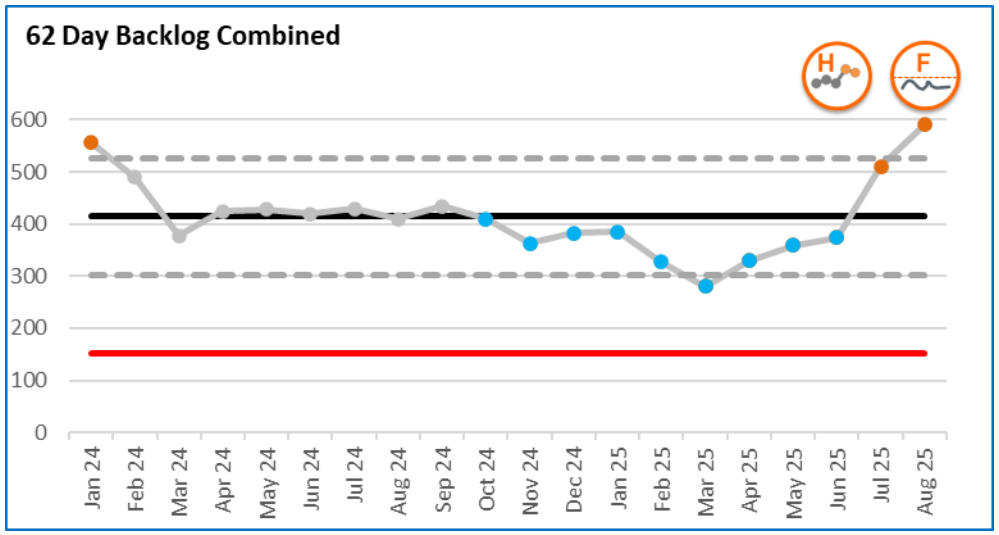
Current Performance			
Jul 25	YTD	Jul Plan	Target
54.5%	58.8%	62.1%	70%

National Position & Overview

In July, UHL ranked 136 out of 144 Acute Trusts. The National average was 69.2%. 79 out of the 144 Acute Trusts achieved the target. UHL ranked 17 out of the 18 UHL Peer Trusts. The best value within our peer group was 78.7%, the worst value was 48.5% and the median value was 63.1%.

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 the number of required diagnostic tests per patient, adding 1+ weeks to a pathway • Oncology time to OPD contribute to longer wait times • Ongoing 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 – tighten timescales • Recovery & Performance (RAP) in place with frequency adjusted when off plan • Review of pathways in line with Best Practice Timed Pathways (BPTP) – supported by EMCA. • Additional capacity required – Urology, Breast, H&N and Skin • Increased communication to move away from sequential diagnostic ordering and agree next steps ahead of MDTs • EMCA & NHSE additional funding supporting increased activity/mutual aid	• Audits to identify areas for improvement with focus on time to 1st appointment, FDS, reducing backlogs and improved utilisation – monthly. • Capacity challenges in Skin/H&N/Breast whilst 1st waits have reduced, knock on negative impact to 62 days. Improvement not expected until Oct 25. • Breast improvement project – first improvements expected to impact Q3. • Extending PTLs to capture 'likely' cancers notifications to support earlier prioritisation – Oct 25. • Escalation process to tighten timescales – Oct 25.

Responsive Cancer – Cancer 62 Day Backlog



Current Performance		
Aug 25	YTD	Target
590	-	152 (by Mar26)

National Position & Overview

National data is not available.
Midlands trend – increases in backlog seen in 2/11 systems this month.

> 62 day 293 behind plan.
> 104 day 68 behind plan.
PAS implementation has impacted on PTL size, backlog and speed of tracking/service actions

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 • Introduction of new PAS system impacted PTL size and speed of tracking/actioning escalations.	• Clinical prioritisation of all cancer patients and clinical review of cancer patients treated over 104 days. • Internal trajectories agreed with services • LD/Autism/Dementia/Carer and SMI flags on PTL • Pre-diagnosis nurse support for patient engagement. • Digital solutions to support pathway progression – requested • Increase PSFU pathways to support capacity within services • Request for additional cancer activity, utilising EMCA/NHSE additional cancer recovery funds.	• Additional capacity required –services exploring options to support (Skin, H&N, Breast and Gynaeology) – ongoing. • Requested clinical validation to support – Sept 25 • Expansion of PSFU opportunities scoped – agreed to commence Skin and High-risk bladder a/w start date. • Audit of breaches showing length of breach distribution reduced with more patients breaching by 0-7 days. Use of audits to streamline and increase out of decision MDT steps – some reduction seen beginning of September.

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

Executive Summary

- The month 5 YTD position for the Trust is a deficit of £14.1m which is £5m adverse to plan. The main drivers are reduced patient care income excluding EDD £7mA (mainly elective care) impact of PAS implantation £1.6mA, under-recovered other operating income excluding donated assets of £2.6mA, offset by pay/non-pay underspend of £7mF (excluding EDD) and industrial action in M4 of £1.3mA, increased interest receivables £0.5mF.

- The Trust reported a year-to-date deficit of £47.1m at the end of August excluding deficit support. Further substantial improvement to the run-rate are required to match the increasing monthly CIP targets over the remaining months of the financial year.

- The Trust committed net capital expenditure of £14m in Month 5 after deducting charitable donations/capital grants, resulting in an underspend of £10.8m against CDEL target of £24.8m for M5.

- The cash position at the end of Month 5 was £44.9m, which is an increase of £11.3m from M4

Summary Financial Position – YTD M5

I&E

	I&E YTD		
	Plan	Actual	Variance to Plan
	£'000	£'000	£'000
NHS Patient-Rel Income	677,714	667,262	(10,452)
Other Operating Income	75,384	72,491	(2,893)
Total Income	**753,098**	**739,753**	**(13,345)**
Pay	(474,422)	(469,794)	4,628
Non Pay	(248,932)	(246,033)	2,899
Total Costs	**(723,353)**	**(715,826)**	**7,527**
EBITDA	**29,745**	**23,927**	**(5,818)**
Non Operating Costs	(36,936)	(36,444)	492
Retained Surplus/(Deficit)	**(7,191)**	**(12,517)**	**(5,326)**
Donated Assets	(1,890)	(1,559)	331
Control Total Surplus/(Deficit)	**(9,081)**	**(14,076)**	**(4,995)**

Total Income: £13.3mA:

- Under recovery of PCI income of £9.1m which includes an assumption of £1.6mA impact of PAS implementation and £0.5mA industrial action impact. EDD is -£1.4m under-recovered.
- Other income includes reduced donated income £0.3mA offset by donated asset adjustment, CSI £1.1mA (mainly relating to pathology, pharmacy, imaging), reduced private/overseas patients £0.3mA, reduced E&F income £1.2mA mainly relating to car parking/catering.

Pay: £4.6mF:

- Medical and dental £2.4mA of which £0.8m is the net industrial action impact and the balance linked to medical gaps in RRCV, CHUGGS and W&C.
- Nursing, midwife and health visitor staffing is driven mainly by increased bank usage controls across CMGs.
- Other clinical driven by vacancy control and increased bank usage controls across most CMGs.
- Non-clinical mainly driven by vacancy control.

Bank (£29.2m) and Agency (£1.6m) spend YTD amounts to £30.9m which is 6.6% of total pay. July saw a £1m increase from June linked mainly to industrial action and switch from weekly bank pay to monthly bank pay.

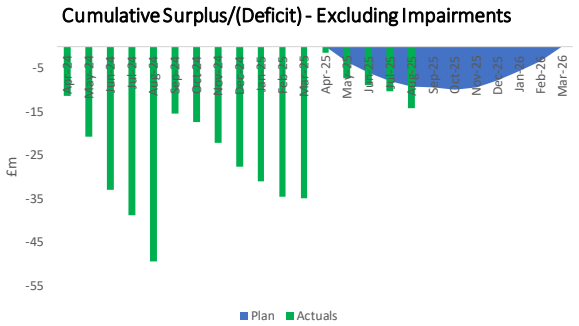
Non-Pay: £2.9mF:

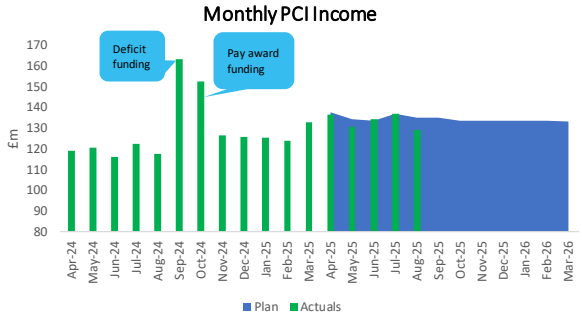
- Clinical Negligence £2.1mF relating to the maternity incentive scheme rebate.
- Clinical supplies and services £2.2mA is mainly driven by CHUGGS oncology contracted services, mutual aid in general surgery, ITAPS linked to prior year insourcing/sleep monitoring invoices, CSI continued use of CDC imaging vans and undelivered CIP across CMGs.
- Drugs £3mA - mainly due to CHUGGS block baseline drugs in Haematology/Oncology, ITAPS mainly baseline drugs in sleep/theatres, RRCV relating to renal and respiratory and undelivered CIP.
- Premises and Fixed Plant £1.3mF mainly driven by energy/utilities, credit notes and software underspend in corporate services.
- Excluded drugs and devices overspend offset by income. Expenditure/Income variance difference driven mainly by Vat reclaims

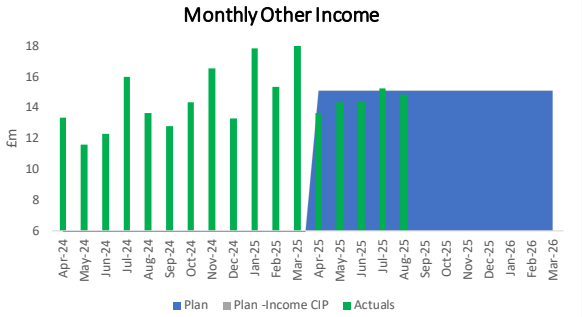
Non-Operating Costs £0.5mF relating to increased interest receivable.

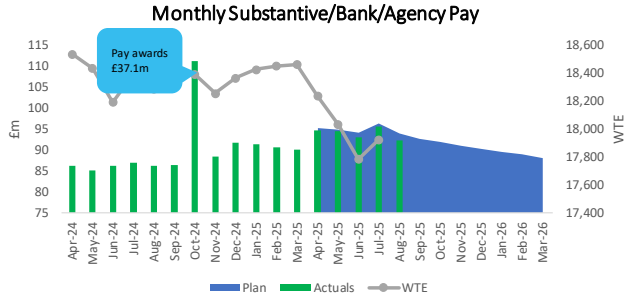
Donated assets variance is driven by lower donations than planned (this is offset in other income).

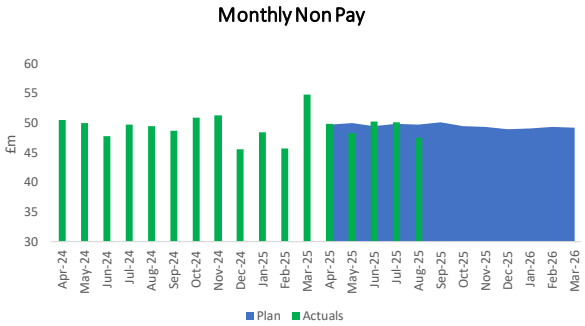
Month 5 I&E Dashboards

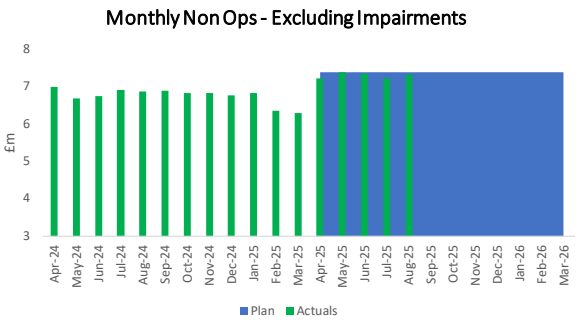


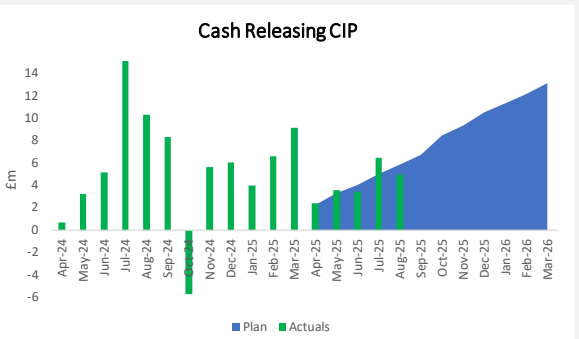


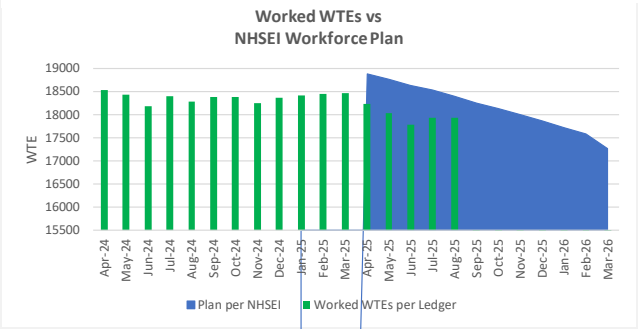




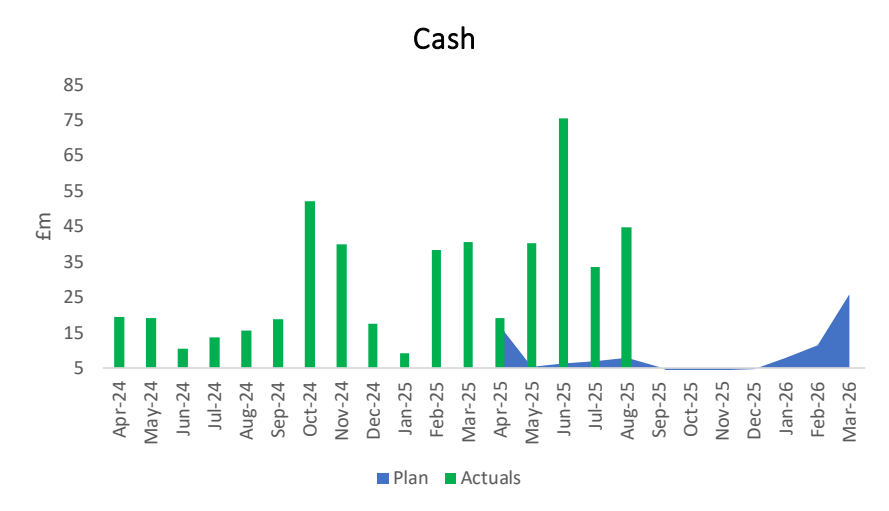


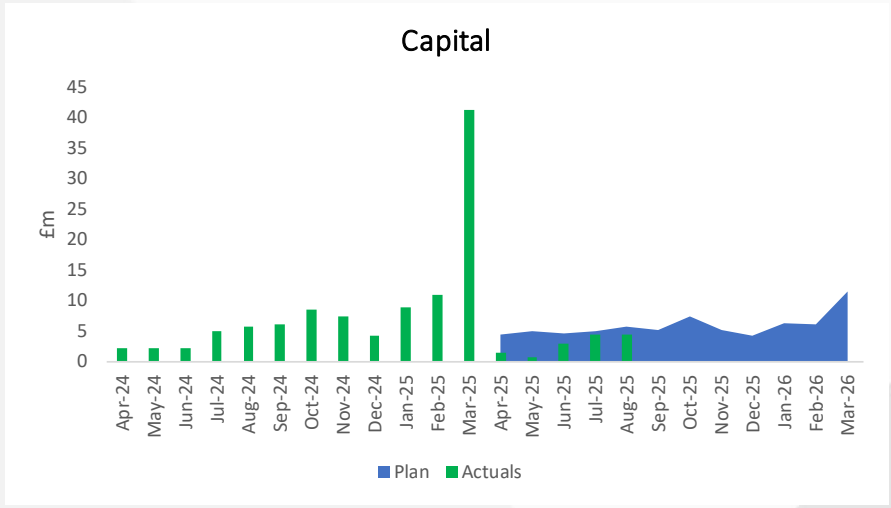


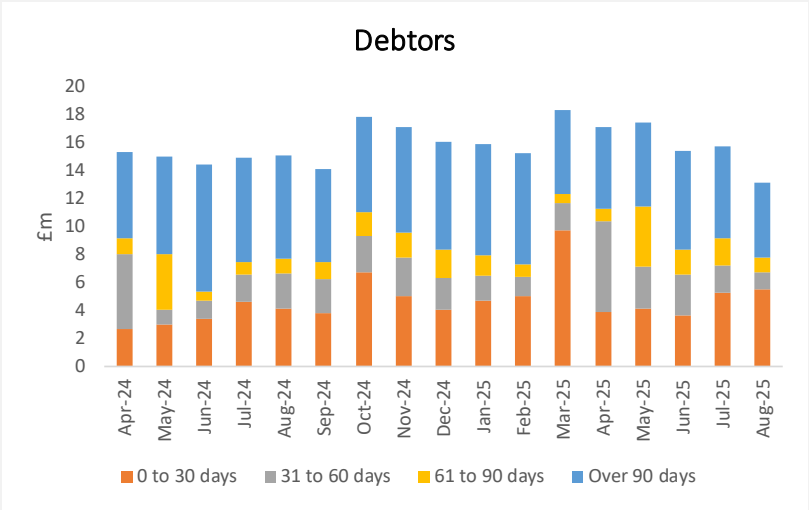


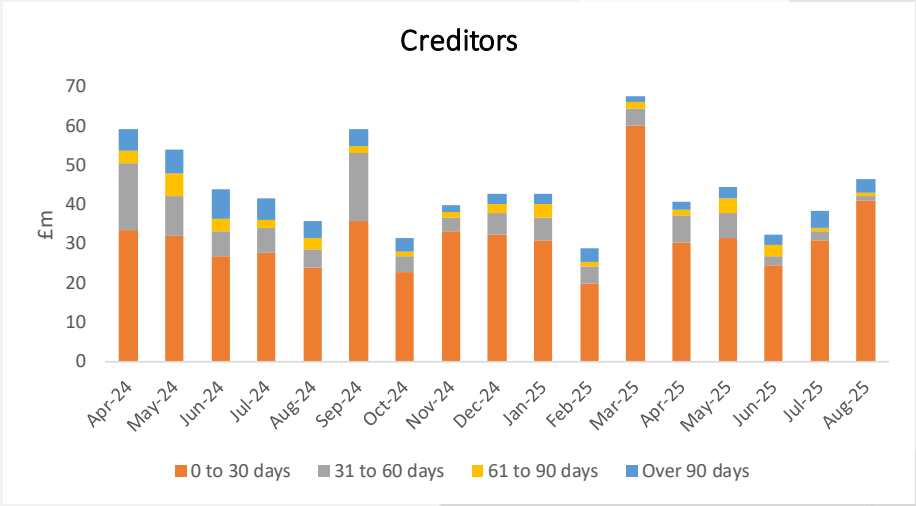


Month 5 Balance Sheet Dashboards









Statement of Financial Position

£m	31-Mar-25	31-Jul-25	31-Aug-25	In Month Movement	YTD Movement
Intangible assets	31.1	32.0	31.5	(0.5)	0.4
Property, plant and equipment	776.0	765.1	765.7	0.6	(10.3)
Fixed Assets	807.1	797.1	797.2	0.1	(9.8)
Other non-current assets	4.4	4.4	4.5	0.1	0.1
Total non-current assets	**811.5**	**801.5**	**801.7**	**0.2**	**(9.8)**
Current Assets					
Inventories	28.6	28.5	28.3	(0.2)	(0.3)
Trade and other receivables	41.2	73.9	59.9	(14.0)	18.7
Cash and cash equivalents	40.7	33.6	44.9	11.3	4.2
Total Current Assets	**110.4**	**136.0**	**133.1**	**(2.9)**	**22.6**
Current Liabilities					**0.0**
Trade and other payables	(147.8)	(117.2)	(136.3)	(19.2)	11.5
Leases < 1 Year	(9.0)	(7.8)	(7.7)	0.1	1.2
Accruals	(19.8)	(43.4)	(27.8)	15.6	(8.0)
Deferred income	(4.7)	(32.6)	(28.2)	4.4	(23.5)
Dividend payable	0.0	(7.5)	(9.4)	(1.9)	(9.4)
Provisions < 1 year	(9.3)	(9.0)	(9.0)	(0.0)	0.3
Total Current Liabilities	**(190.6)**	**(217.4)**	**(218.4)**	**(1.0)**	**(27.8)**
Net Current Assets / (Liabilities)	**(80.1)**	**(81.4)**	**(85.3)**	**(3.9)**	**(5.2)**
Leases > 1 Year	(43.3)	(41.4)	(40.9)	0.5	2.4
Provisions for liabilities & charges	(3.6)	(3.6)	(3.6)	0.0	0.0
Total non-current liabilities	**(46.9)**	**(45.0)**	**(44.5)**	**0.5**	**2.4**
Total Assets/(Liabilities)	**684.5**	**675.1**	**672.0**	**(3.2)**	**(12.5)**
				0.0	0.0
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	473.3	476.5	3.2	12.5
Total Capital & Reserves	**(684.5)**	**(675.1)**	**(672.0)**	**3.2**	**12.5**

The Statement of Financial Position (SOFP) at the end of Month 5 is presented in the table opposite. The key month on month movements are explained as follows:

- **Non-Current Assets -** Non-current assets increased by £0.2m as capital additions of £5.5m were offset by M5 depreciation and amortisation of £5.3m.
- **Trade and other receivables –** Trade and other receivables reduced by £14m in month of which £11m relates to a reduction in PCI income performance. This is due to a reduction in EDD income expected reflective of lower EDD costs in month (£4.5m) and a reduction of £6m on the PCI core contract, as payment has been received. In addition, the trade debtors showed an improved position, as aged debtors being were settled most notably £1.4m from University of Leicester.
- **Cash Balances –** Cash balances increased by £11.3m to £44.9m
- **Trade and other payables and accruals** – Trade and other payables increased by £19.2m, comprised of; £9m increase in trade payables due to timing of payments relative to month end close, reflected in the higher cash balance this month; £7.8m of additional tax, social security costs and employers pension contribution associated with pay award; and £1m increase in capital creditors.
- **Accruals** - Reduced by £15.6m largely reflective of the release of the pay award accrual following arrears payment made in month.
- **PDC Dividend** – the increase of £1.9m was reflective of the M5 forecast PDC dividend liability.
- **Deferred Income** – The reduction of £4.4m was due to the release of HEE Income of £5.2m, which is received in previous months, offset by the deferral of PCI income of £0.9m.
- **Income and Expenditure Reserve –** The deterioration in the I&E reserve of £3.2m is consistent with the in year reported income and expenditure position.

Liquidity

Cash
The Trust cash balance at the end of August was £44.9m, representing an in-month increase of £11.3m, as cash receipts of £155.3m, were offset by £145.1m of outgoing payments. The cash balance exceeded the M5 plan by £36.8m, due to the following main factors:

- Lower payments runs (£14m) due to the change in timings of closure of the financial ledger, resulting the last payment run in August being recorded in M6.
- Lower capital spend than plan (£15m) due to timing of costs incurred, in particular PAS and Endoscopy schemes.
- Phasing of other operating income in plan versus actual (£7m)

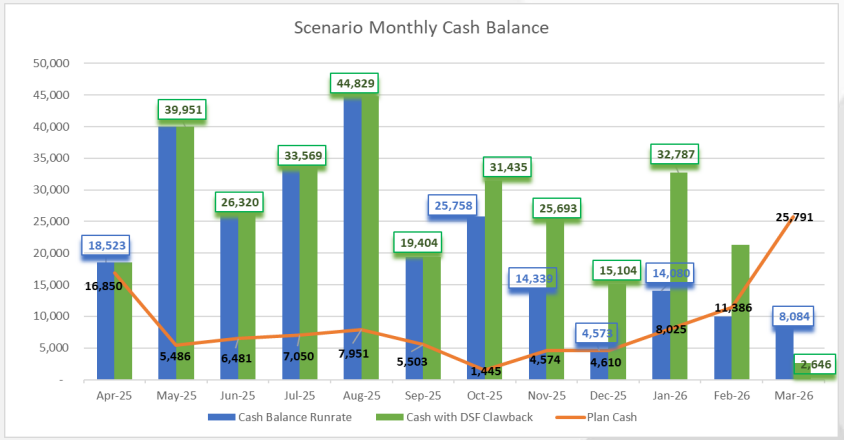
The forecast for year 31 March 26 now shows a lower cash balance of £8m; £17.7m lower than plan. The cash forecast for Q2 25/26 is £19.4m. No PDC revenue cash support requests are planned for 25/26, given that the NHSE are expecting a cash position aligned with a compliant I&E break even plan, supported by non recurrent revenue funding. The Trust may not continue to receive the deficit support in Q3 and Q4 (£26m) if the Trust deviates from plan. Withdrawal of this funding would present a challenge from a cash perspective and would require management of payments runs (a reduction of £32.5m) resulting in a cash position by year end of £2.6m, as shown in the graph opposite. The Trust would dip into negative cash in October for the first time, without deferment of supplier payments, under this scenario.

Receivables
Out of a total debt of £15.7m (£15.4 M4) receivables over 90 days was **£5.1m** (£7.0m in M4) comprised of non-NHS £4.4m and NHS £0.8m. The reduction largely reflects the payment by the University Of Leicester following closure of their year end accounts. Overall, **£4.5m** of over 90 is with debt collection agency, on instalments, pending write off or disputed awaiting instruction.

Overseas Visitors over 90 day was £2.5m, of which; £1.1m has been referred to our credit reference agency; £510k will be put forward for write off; £0.4m is on repayment plans; and £0.1m is going through the credit control process. Private Patients over 90 days was £308k. Sundry Companies over 90 days was £1.1m; £269k of VAT corrections which will be marked for write off for M6, £220k is in query and £452k going through Credit control process.

Salary Overpayments over 90 days was at £455k, of which £216k is with credit reference agency with judgements and enforcements expected. £51k will be put forward for write off and £109k have informal agreements for payment.

	Month 5						Month 4					
	Total	0 to 30 days	31 to 60 days	61 to 90 days	Over 90 days	Percentage over 90 days	Total	0 to 30 days	31 to 60 days	61 to 90 days	Over 90 days	Percentage over 90 days
	£000	£000	£000	£000	£000	%	£000	£000	£000	£000	£000	%
Non-NHS receivables	9,471	3,709	539	530	4,694	38%	11,558	4,499	1,282	1,392	4,385	52%
NHS receivables	3,635	1,786	674	594	582	18%	4,167	2,508	687	219	752	26%
Total receivables	**13,106**	**5,495**	**1,212**	**1,123**	**5,276**	**33%**	**15,725**	**7,007**	**1,969**	**1,611**	**5,137**	**46%**
Non-NHS payables	42,807	38,042	1,186	653	2,926	10%	26,346	20,044	2,038	2,394	1,870	7%
NHS payables	3,820	2,965	52	32	771	19%	6,083	4,339	475	351	918	15%
Total payables	**46,627**	**41,007**	**1,238**	**685**	**3,697**	**11%**	**32,429**	**24,384**	**2,513**	**2,744**	**2,788**	**9%**



Payables – BPPC performance remained high at 98% Value and 97% volume, although total payables increased by £8.4m. This was due to a backlog of invoices that needed to be registered through the introduction of the new invoice registration system. In addition, a number NHS Supply invoices which are paid in month (c £3m) were not approved for payment until after month end.
Over 60 days reduced from £5m to £4.4m. The key blockers for invoices being cleared in this ageing category relate to purchase order invoices; those requiring goods receipt (£1.8m); invoices rejected as no PO quoted (£0.4m); and new PO required £0.2m. A P2P working group has been reestablished to develop and implement an action plan to unblock these issues, on order to improve the automatic 3 way matching percentage (currently 61% on purchase orders) to drive efficiencies and cost reduction in Accounts Payable.

Capital Programme

£million	Annual Plan	Year to Date		
		YTD Plan	M5 Actuals YTD	Variance to Plan
Estates Major Schemes				
LGH Endoscopy	4.2	4.2	3.0	(1.2)
Preston Lodge (UEC)	3.0	1.9	2.8	1.0
CHP	1.4	0.0	0.0	
Mortuary	1.5	0.0	0.1	0.1
Aseptic Lab	1.0	0.8	0.0	(0.8)
UTC	10.2	1.0	0.2	(0.7)
Leicester Diabetes Centre	5.3	3.8	2.2	(1.6)
NHP	1.1	0.8	0.6	(0.2)
Total Estates Major Schemes	**27.7**	**12.4**	**8.9**	**(3.5)**
Other Estates Schemes	10.6	3.2	2.6	(0.6)
IM&T Programme	5.5	3.9	0.8	(3.1)
EPR	5.6	3.1	3.5	0.4
Medical Equipment	7.7	1.3	0.1	(1.2)
MES including enabling works	11.1	1.7	1.0	(0.7)
Other Capital Expenditure	3.4	(0.9)	(2.0)	(1.1)
Contingency	1.9	0.0	0.0	0.0
VAT Credit	(1.4)	0.0	(1.3)	(1.3)
Total Capital Programme	**72.1**	**24.8**	**13.7**	**(11.1)**
Funded by:				
Internally Generated	41.9	18.0	10.7	(7.2)
PDC Funded	23.8	3.9	3.1	(0.8)
Donated/Granted	4.6	4.1	2.4	(1.7)
IFRS 16	7.2	3.0	0.2	(2.7)
Total Funding	**77.5**	**28.9**	**16.5**	**(12.5)**
Donated Income/Grant Rec'd	(4.6)	(4.1)	(2.4)	1.7
Disposals - NBV	0.0	0.0	(0.0)	(0.0)
NET CDEL	**72.9**	**24.8**	**14.0**	**(10.8)**

The Trust committed gross expenditure of £16.5m in M5 against a plan of £28.9m (£11.1m at M4), which netted down to £14.0m, after deducting charitable donations/capital grants and disposals of £2.5m in month. The overall programme is therefore behind the year-to-date plan by £10.8m across all areas at month 5 (£9.4m at M4. All schemes within the programme (with exception of UTC, Aseptic and IFRS16) 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 - £3.8m,Diagnostics - £0.8m; and UEC £10.2m. *'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 than assumed in the original submission. There is a potential underspend/slippage risk of up to £11.1m, with mitigation as set out in the table below, which largely involves the bring forward of 26/27 operational schemes. All Systems have been asked by NHSE to provide an accurate and realistic expenditure forecast for each scheme for 25/26 by 26th September and specifically identify any scheme expenditure that is expected to slip into 26/27; outline any requests for local brokerage to manage identified slippage (where providers have a particular preference to bring forward 26/27 operational capital spend to utilise the expected 25/26 capital underspend); and if applicable, apply for deferral of 25/26 allocations to 26/27..

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.