Meeting title:	Trust Board
Date of the meeting:	13 November 2025
Title:	Integrated Performance Report and Executive Summary
Report presented by:	Helen Hendley, Chief Operating Officer
Report written by:	Sarah Taylor, Deputy COO Emergency Care and Kully Kaur, Assistant Director of BI and Information

Action – this paper is for:	Decision/Approval		Assurance	X	Update	
Where this report has been discussed previously						

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

Impact assessment

Acronyms used

Purpose of the Report

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

The executive summary is split into 3 parts

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

Recommendation

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

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

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

Summary

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

Main report detail

Key headlines in performance are summarised below:

Summary of UHL Performance: SEPTEMBER 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**	September 2025 saw an increase of 455 Emergency Department attendances to plan with a year-to-date overperformance of 1888 attendances. Paediatric ED saw an increase of 30 attendances compared to September 2024 year to date though they are under by 1688 thereby overall significant increase in the adult department. Eye Casualty in September 2025 has seen a year-to-date overperformance of 809 attendances. 4-hour performance in August achieved the trajectory of 59.16% with a performance of 62.19% LRI monthly ambulance handovers continues to be challenged but we have seen an improvement compared to September 2024 with 1627 less hours lost. The 12-hour performance (total time in dept) for September 2025 was 9.15% achieving trajectory by 1.46% Emergency admissions were over plan by 965 admissions and over the number of admissions seen in September 2024 by 1204, year to date is 2560 admissions over plan. Length of stay has improved in September achieving trajectory. Actions for improvement – Achievements in September • Increased the number Same Day Emergency Care services –achieved trajectory. • Develop our direct access pathways for our GP and Ambulance colleagues • Implement the Trust's Winter plan • Increase the call volume through clinical bed bureau - achieved. • Planning for Phase 2 of Preston Lodge • Commenced the ward improvement programme – diagnostic phase completed
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 September 2025, the waiting list remains materially above the operational plan, with circa 121,000 patients (including those awaiting e-triage).

- **18-week RTT**: Compliance stands at 52% (peer median 59%), placing the Trust in the lower third of peers.
- **Long Waiters**: 3.3% 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 and sourcing mutual aid within the region to reduce long waiters for suitable patient cohorts.
  - 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 3.1% compared to previous year. Conversion rates remain at 7%. The Trust was unable to deliver the FDS standard of 75% in August for the second time since September 2023, due to the unexpected loss of capacity in Breast, Skin and H&N in Q2 delaying time to first appointments. Without this loss of capacity, FDS would have delivered above 78%. FDS performance is also likely to fall below the standard in both September and October, however improvements have been seen in H&N & Skin. Breast performance is not expected to start to recover until late November. The capacity gap, reliant on locums or additional WLIs requires addressing in 26/27 planning to support the fragility of these services. 62-day performance in August fell to 43.9% following the loss of capacity predominately in Skin. This has placed the Trust in the bottom quartile of performance in England. The impact from capacity losses in Skin, H&N and Breast earlier in Q2 will continue to impact, with recovery unlikely until November. 31-day performance improvement is expected within Q4, with Radiotherapy recovery on track. All services have actions in place to support recovery and performance, 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, but there has been a slight deterioration in the FFT score within some admission areas at the LRI and Glenfield Hospital in September 2025 with plans in place to understand the feedback in more detail. The continued collaborative approach between the fundamentals of care programme and infection prevention workstream has focussed on identifying and addressing specific themes across all staff groups since the initiative commenced at the end of September. Timely individual and team coaching, bedside teaching and constructively challenging practice appears to have had a positive impact on improving ward audits, enhancing knowledge and skills, and improving professional and clinical standards. In the admission areas where there has been a slight deterioration in the FFT score at both the LRI and Glenfield Hospital, Co-Pilot will be used to analyse all the September non-positive FFT comments to identify the key areas and themes of concerns to support CMGs to target improvements in a more efficient and timely way
Finance	The month 6 YTD position for the Trust is a deficit of £13.4m which is £4m adverse to plan. The main drivers are reduced patient care income excluding EDD £5mA (mainly elective care) impact of PAS implementation £2.1mA, under-recovered other operating income excluding donated assets of £2.9mA, offset by pay/non-pay underspend of £6.7mF (excluding EDD) and industrial action in M4 of £1.3mA and other £0.6mF. The Trust reported a year-to-date deficit of £52.3m at the end of September excluding deficit support. Further substantial improvement to the run-rate is required to match the increasing monthly CIP targets over the remaining months of the financial year.

	The Trust committed net capital expenditure of £20m in Month 6 after deducting charitable donations/capital grants, resulting in an underspend of £10m against CDEL target of £30m for M6. The cash position at the end of Month 6 was £17.6m, which is a decrease of £27m from M5. The Trust made a PDC Dividend payment in month of £10m, payments to creditors were higher by £11m and PCI income reduced by £6m.
Workforce	In Month 6 wte recorded an overall workforce of 18,187 wte, which is 71 wte below the planned position of 18,406 wte (a performance of 0.35% under plan). • Agency wte usage continues to positively perform below plan and recorded 34 wte which is 48.07% below the planned position. Although it should be noted that this was an increase to the M5 position by 10wte. • Bank usage decreased from the previous month (M5) by 238 wte and is below plan for M6. Bank wte is recorded at 646 wte for M6 against a planned position of 665 wte (-19wte and 2.88% under plan) • Substantive staff is recorded at 17,507 wte which is 0.12% below the plan. However, the expected reductions in substantive workforce from M7 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 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. The MARS programme has concluded, and 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 through 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 marginally above the 10% target at 10.7%, and HCSW are above the 5% target at 10.6% with a plan to convert some HCSW posts to RN. 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 with plans to reach the price cap by April 2026.

	We are over price cap with some AHP specialist roles in Sonography, Radiography and Cardiac Physiotherapists, but across the region we have the lowest rates. There are 3 Project officers in capital projects which meet the special projects exemption. Statutory and Mandatory training remains stable at 94% against the target of 95% Appraisal performance has improved by 1.3% taking us to 84.7% 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. Sickness absence is reported a month in arrears, and we have seen a 0/24% % reduction in August. Over the last 12 months, the highest levels of absence are in E&F (6.01%), W&C (5.57%), RRCV (5.14%). A key area of focus moving forward is winter support and the launch of the flu vaccine from 1 October 2025. As of 22 October 2025, 25.7% of our workforce have been vaccinated against the 41% target to achieve by 31 March 2026. Workforce performance is reviewed through CMG Performance Review meetings, CMG Boards, Senior Leadership Teams, and Specialty Reviews. An amber rating remains in place.
Tranformation & Productivity **Key Overview** **e.g Urgent and Emergency Care, Elective, digital, Estates etc**	**<u>Theatres</u>** • In September, overall theatre utilisation showed a slight improvement, rising to 81.1% compared to 80.7% in August. The year-to-date position stands at 82% • Late starts and cancellations remained consistent with the previous month, with OTDC rates at 8.3% and late theatre starts at 23%. A focused drive is reinforcing the no TCI before confirmed fitness policy for non-urgent patients, and the feasibility of automated theatre text reminders is being explored to reduce patient-related cancellations. • The day case rate, as reported by the Model Hospital System, was last updated in June, showing a recorded rate of 80.4%. The rollout of NC -migration has impacted Intended Management selection and outpatient coding, contributing to a drop in performance. A specialty-level review is planned for November 2025. **<u>Outpatients</u>** • Did Not Attend (DNA): The DNA rate remains above target, with September's performance at 6.3%. Continued improvement is needed, and several on-going projects and interventions are underway to support this • Appointment Reminders: Work is underway to strengthen the Accurx reminder system, with a new tiered schedule (14, 7, and 3–1 days prior to appointments) due to go live by the end of October to help improve attendance rates.

	• Patient Initiated Follow-Up (PIFU): The PIFU rate for September was 5%, with a year-to-date position of 5.3%. This remains below the target of 5.5%. Persistent challenges with the PAS system—particularly in accurately recording clinic outcomes continue to restrict the application of PIFU in certain scenarios. Improvement efforts are on-going to identify further opportunities for increasing uptake. Additionally, a PAS update is planned to reinstate previously supported scenarios, with implementation expected by December 2025. **UEC** • 5642 monthly SDEC attendance delivered in September (20% above target) • 2316 calls received to Clinical Bed Bureau(CBB) which is a 16% increase to previous month following the initiation of communications plan to increase calls. And is a 1% increase to average calls per month compared to the previous year). Further communications with PCNs planned for November. • The ED Transport Tender now complete and successful bidder has been awarded. Contract to begin 1st December 25. • GIRFT Action Plan progressing with a focus on enhancing SDEC Streaming • On-going discussions to establish **two new direct streaming pathways** via the CBB with **EPAU** and **MaxFax**. • A process has been agreed to use Accurx within CBB, enabling patients to share images that support consultant conversations—aimed at reducing diversions to ED.

Supporting documentation

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

The key changes to the IPR are:

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

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

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

No.	NHS Oversight Framework national mandated KPIs
1	Proportion of patients discharged from hospital to their usual place of residence
2	Available virtual ward capacity per 100k head of population

3	National Patient Safety Alerts not completed by deadline
4	Potential under-reporting of patient safety incidents
5	Overall CQC rating
6	Performance against relevant metrics for the target population cohort and five key clinical areas of health inequalities
7	Proportion of acute or maternity inpatient settings offering smoking cessation services
8	Proportion of patients who have a first consultation in a post-covid service within six weeks of referral
9	Proportion of people over 65 receiving a seasonal flu vaccination
10	Acting to improve safety - safety culture theme in the NHS staff survey
11	CQC well-led rating
12	Aggregate score for NHS staff survey questions that measure perception of leadership culture
13	Staff survey engagement theme score
14	Staff survey bullying and harassment score
15	Proportion of staff in senior leadership roles who are from a) a BME background or b) are women

UHL Oversight Framework Metrics

September 2025

Oversight Framework

Key Performance Indicator	Target	Jul-25	Aug-25	Sep-25	YTD	Assurance	Variation	Trend	Data Quality Assessment	Local or National Target?	Exec Lead
Clostridium Difficile per 100,000 Bed Days	167 Cases	21.6	19.5	15.6	16.8				Mar-24	Local	Chief Nurse and Medical Director
Methicillin Resistant Staphylococcus Aureus	0	0	1	0	5				Mar-24	Local	Chief Nurse and Medical Director
E-Coli per 100,000 Bed Days		28.1	36.7	11.2	20.8				TBC	No Target	Chief Nurse and Medical Director
Hospital Acquired Pressure Ulcers - All categories per 1000 bed days	1.7	1.6	1.4	1.3	1.6				Jun-21	Local	Chief Nurse and Medical Director
Sickness Absence	3%	4.8%	4.6%		4.6%				Mar-25	Local	Chief People Officer
30 Day Readmission Rate		11.2%	11.3%		10.2%				TBC	No Target	TBC
Published Summary Hospital-level Mortality Indicator (SHMI)	100	99	99		99 (May 24 to Apr 25)	Assurance and variance not applicable			May-21	National	Chief Nurse and Medical Director
Emergency Department 4 hour waits UHL *	61%	64.7%	63.1%	62.2%	60.8%				Mar-23	National	Chief Operating Officer
% of 12 hour waits in the Emergency Department	10.3%	8.4%	11.6%	9.2%	9.5%				Mar-23	National	Chief Operating Officer
Referral to Treatment (RTT) 18 wk performance *	62.3%	53.4%	51.9%	51.6%					TBC	Local	Chief Operating Officer
Referral to Treatment (RTT) 52+ weeks as a % OF Total Incompletes *	0.9%	2.9%	3.1%	3.3%					TBC	Local	Chief Operating Officer
6 Week Diagnostic Test Waiting Times *	5%	26.5%	24.6%	23.1%					Jul-23	National	Chief Operating Officer
28 Day Faster Diagnosis Standard *	80%	69.5%	64.9%		73.2%				May-24	National	Chief Operating Officer
Cancer 62 Day Combined *	70%	54.5%	43.9%		55.9%				May-24	Local	Chief Operating Officer
Trust level control level performance	-£9.4m	-£1.4m	-£3.9m	£0.6m	-£13.4m				Jun-22		Chief Financial Officer
Capital expenditure against plan	£30m	£4.5m	£4.5m	£6.3m	£20m				Jun-22		Chief Financial Officer

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*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

September 2025

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

Performance Overview (Safe)

Domain	Key Performance Indicator	Target	Jul-25	Aug-25	Sep-25	YTD	Assurance	Variation	Trend	Data Quality Assessment	Local or National Target?	Exec Lead
Safe	Never events	0	0	2	0	2				Nov-22	National	Chief Nurse and Medical Director
	Clostridium Difficile per 100,000 Bed Days	167 Cases	21.6	19.5	15.6	16.8				Mar-24	Local	Chief Nurse and Medical Director
	Methicillin Resistant Staphylococcus Aureus	0	0	1	0	5				Mar-24	Local	Chief Nurse and Medical Director
	Methicillin-susceptible Staphylococcus Aureus	40	5	2	4	26				Mar-24	Local	Chief Nurse and Medical Director
	All falls reported per 1000 bed days	4.0	3.2	2.7		3.0				Aug-22	Local	Chief Nurse and Medical Director
	Rate of Moderate harm and above Falls per 1,000 bed days	0.19	0.16	0.02		0.09				Aug-22	Local	Chief Nurse and Medical Director
	Hospital Acquired Pressure Ulcers - All categories per 1000 bed days	1.7	1.6	1.4	1.3	1.6				Jun-21	Local	Chief Nurse and Medical Director
	% of all adults Venous Thromboembolism Risk Assessment on Admission	95%	97.8%	97.6%	98.0%	98.0%				Oct-21	National	Chief Nurse and Medical Director
	Number of Patient Safety Incident Investigations (PSIIs) commissioned		0	5	1	9	Awaiting more data for assurance and variance			Nov-24	No Target	Chief Nurse and Medical Director
	Number of reported Patient Safety Incidents		2501	2338	2318	14478				Nov-24	No Target	Chief Nurse and Medical Director
	Rate of reported Patient Safety Incidents (per 1000 inpatient, outpatient and ED attendances)		23.2	18.7	17.0	18.9				Nov-24	No Target	Chief Nurse and Medical Director

Performance Overview (Caring)

Domain	Key Performance Indicator	Target	Jul-25	Aug-25	Sep-25	YTD	Assurance	Variation	Trend	Data Quality Assessment	Local or National Target?	Exec Lead
Caring	Single Sex Breaches		7	22	4	92				Jul-22	No Target	Chief Nurse and Medical Director
	Inpatient and Day Case Friends & Family Test % Positive	95%	96%	95%	95%	96%				Jul-22	Local	Chief Nurse and Medical Director
	A&E Friends & Family Test % Positive	81%	82%	85%	84%	84%				Jul-22	Local	Chief Nurse and Medical Director
	% Complaints Responded to in Agreed Timeframe - 25 Working days	90%	64%	79%		63%				Jul-23	Local	Chief Nurse and Medical Director
	% Complaints Responded to in Agreed Timeframe - 60 Working days	90%	86%			75%				Jul-23	Local	Chief Nurse and Medical Director

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Performance Overview (Well Led)

Domain	Key Performance Indicator	Target	Jul-25	Aug-25	Sep-25	YTD	Assurance	Variation	Trend	Data Quality Assessment	Local or National Target?	Exec Lead
Well Led	Turnover Rate	10%	6.9%	7.0%	7.0%					Aug-22	Local	Chief People Officer
	Sickness Absence	3%	4.8%	4.6%		4.6%				Mar-25	Local	Chief People Officer
	% of Staff with Annual Appraisal	95%	85.1%	83.4%	84.7%					Mar-25	Local	Chief People Officer
	Statutory and Mandatory Training	95%	95%	94%	94%					Dec-22	Local	Chief People Officer
	Adult Nursing Vacancies	7%	5.3%	5.1%	5.0%					Dec-23	Local	Chief People Officer
	Paed Nursing Vacancies	10%	10.3%	10.9%	10.7%					Dec-23	Local	Chief People Officer
	Midwives Vacancies	7%	5.2%	5.4%	4.8%					Dec-23	Local	Chief People Officer
	Health Care Assistants and Support Workers Vacancies - excluding Maternity	5%	10.6%	9.5%	10.6%					Dec-23	Local	Chief People Officer
	Health Care Assistants and Support Workers Vacancies - Maternity	5%	-5.1%	-2.3%	1.5%					Dec-23	Local	Chief People Officer
	% Bank spend of Pay Bill	8%	6.5%	6.9%	5.8%					TBC	National	Chief People Officer
	% Agency spend of Pay Bill	3.2%	0.2%	0.2%	0.2%					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	21	21	29		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	Jul-25	Aug-25	Sep-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 (May 24 to Apr 25)	Assurance and variance not applicable			May-21	National	Chief Nurse and Medical Director
	12 months Hospital Standardised Mortality Ratio (HSMR)	100	102	102		102 (Aug 24 to Jul 25)	Assurance and variance not applicable			May-21	National	Chief Nurse and Medical Director
	Crude Mortality Rate		1.0%	1.0%	1.0%	1.0%				May-21	No Target	Chief Nurse and Medical Director
	DNA Rate - IMD Deciles 1 and 2	5%	9.5%	9.5%	8.7%	9.1%				Feb-24	Local	Director of Health Equality and Inclusion
	DNA Rate - IMD Deciles 3 - 10	5%	6.3%	5.7%	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	Jul-25	Aug-25	Sep-25	YTD	Assurance	Variation	Trend	Data Quality Assessment	Local or National Target?	Exec Lead
Responsive (Emergency Care)	Emergency Department 4 hour waits LLR	78%	79.3%	78.5%	77.0%	77.1%				Mar-23	National	Chief Operating Officer
	Emergency Department 4 hour waits UHL	61%	64.7%	63.1%	62.2%	60.8%				Mar-23	National	Chief Operating Officer
	Mean Time to Initial Assessment	15	7.3	7.8	7.8	9.3				Nov-24	National	Chief Operating Officer
	% 12 hour trolley waits in Emergency Department (DTA)	10.3%	2.7%	4.2%	2.6%	2.9%				Mar-23	National	Chief Operating Officer
	% of 12 hour waits in the Emergency Department	10.3%	8.4%	11.6%	9.2%	9.5%				Mar-23	National	Chief Operating Officer
	Average Clinical Handover time for ambulance handovers (Minutes)	30	33	56	34	41				Data sourced externally	Local	Chief Operating Officer
	Non Elective Average Length of Stay	7.2	7.1	7.6	7.1	7.2				Aug-25	Local	Chief Operating Officer
	% of Patients Discharged on Discharge Ready Date	88.3%	87.5%	88.2%	87.8%	88.2%				Aug-25	Local	Chief Operating Officer
	Average Delay (Post Discharge Ready Date)	3.8	3.5	4.2	4.4	4.0				Aug-25	Local	Chief Operating Officer
	Trust Bed Occupancy	92.0%	89.5%	85.2%	87.4%					Dec-23	National	Chief Operating Officer
	Long Stay Patients (21+ days) as a % of G&A Bed Occupancy	10%	18.3%	18.1%	17.9%					Apr-23	Local	Chief Operating Officer

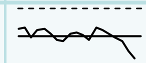
Please note the in month RAG ratings are based on trajectories for some of the indicators (see slide 14).

Performance Overview (Responsive Elective Care)

Domain	Key Performance Indicator	Target	Jul-25	Aug-25	Sep-25	YTD	Assurance	Variation	Trend	Data Quality Assessment	Local or National Target?	Exec Lead
Responsive (Elective Care)	Referral to Treatment Incompletes	105,500	109,635	110,728	109,233					Jun-23	Local	Chief Operating Officer
	Referral to Treatment (RTT) 18 wk performance	62.3%	53.4%	51.9%	51.6%					TBC	Local	Chief Operating Officer
	Referral to Treatment (RTT) – First Attendance - % waiting less than 18 weeks	68.1%	63.3%	62.6%	62.5%		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%	2.9%	3.1%	3.3%					TBC	Local	Chief Operating Officer
	6 Week Diagnostic Test Waiting Times	5%	26.5%	24.6%	23.1%					Jul-23	National	Chief Operating Officer
	Theatre Utilisation	85.0%	81.3%	80.7%	81.1%	82.0%				Dec-23	National	Chief Operating Officer
	Patient Initiated Follow Up	5.5%	4.4%	4.9%	5.0%	5.3%				Oct-23	Local	Chief Operating Officer
	% Outpatient Did Not Attend rate	4.9%	6.9%	6.4%	6.3%	6.4%				Apr-23	Local	Chief Operating Officer
	% Outpatient Non Face to Face	25%	26.9%	26.7%	25.9%	27.8%				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	Jul-25	Aug-25	Sep-25	YTD	Assurance	Variation	Trend	Data Quality Assessment	Local or National Target?	Exec Lead
Responsive (Cancer)	28 Day Faster Diagnosis Standard	80%	69.5%	64.9%		73.2%				May-24	National	Chief Operating Officer
	Cancer 31 Day Combined	96%	75.9%	68.4%		73.7%				May-24	National	Chief Operating Officer
	62 Day Backlog Combined	152	511	590	540					Dec-24	Local	Chief Operating Officer
	Cancer 62 Day Combined	70%	54.5%	43.9%		55.9%				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	Jul-25	Aug-25	Sep-25	YTD	Assurance	Variation	Trend	Data Quality Assessment	Exec Lead
Finance	Trust level control level performance	-£9.4m	-£1.4m	-£3.9m	£0.6m	-£13.4m				Jun-22	Chief Financial Officer
	Capital expenditure against plan	£30m	£4.5m	£4.5m	£6.3m	£20m				Jun-22	Chief Financial Officer
	Cost Improvement (Includes Productivity)	£27.1m	£6.4m	£4.9m	£4.8m	£25.5m				Dec-23	Chief Financial Officer
	Cashflow	No Target	-£41.9m	£11.3m	-£27.3m	£17.6m				Jun-22	Chief Financial Officer
	Aged Debt	No Target	£15.7m	£13.1m	£12.9m					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%	96%					Feb-24	Chief Financial Officer

Performance Overview (Activity)

Domain	Activity Type	Plan 25/26	Plan in Month (M6)	Activity In Month (M6)	Variance In Month (M6)	Plan YTD	Actual YTD	Variance YTD	YTD Variance to 19/20
Activity	New Outpatients (inc. NFTF)	270,077	23,446	28,319	4,873	134,796	133,876	-920	-1,124
	Follow Up Outpatients (inc. NFTF)	601,725	50,904	48,166	-2,738	300,905	272,700	-28,205	-25,185
	Outpatient Procedures	220,367	18,956	18,415	-541	111,331	102,007	-9,324	25,853
	Daycase	137,582	11,640	11,707	67	70,465	57,625	-12,840	3,144
	Inpatient	22,053	1,894	1,771	-122	11,045	11,117	73	1,140
	Emergency	114,624	9,333	10,213	879	55,745	58,316	2,570	9,321
	Non Elective	22,843	1,877	1,887	10	11,455	11,745	290	787
	Emergency Department (inc. Eye Casualty)	282,655	23,428	23,756	328	139,074	141,262	2,188	10,912
	Diagnostic Imaging (inc. Direct Access)	398,464	35,014	33,713	-1,301	192,386	194,636	2,250	111,965
	Other	11,473,688	985,167	1,064,053	78,887	5,646,324	6,114,228	467,903	1,677,738
	TOTAL	13,544,078	1,161,657	1,242,000	80,343	6,673,527	7,097,511	423,985	1,814,551

**Source Early Cut and Forecasting File*

The DM01 plan for imaging activity for M6 was 1,699 below plan in month (27,905 vs 26,206) and was 12,289 below plan YTD (166,070 vs 153,781).

Performance Overview (Workforce Performance Overview)

Key Performance Indicator	Target (National KPI cap)	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25
% Bank spend of Pay Bill	8%	6.48%	5.80%	5.39%	6.54%	6.90%	5.78%
% Agency spend of Pay Bill	3.20%	0.51%	0.39%	0.44%	0.20%	0.21%	0.17%

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%

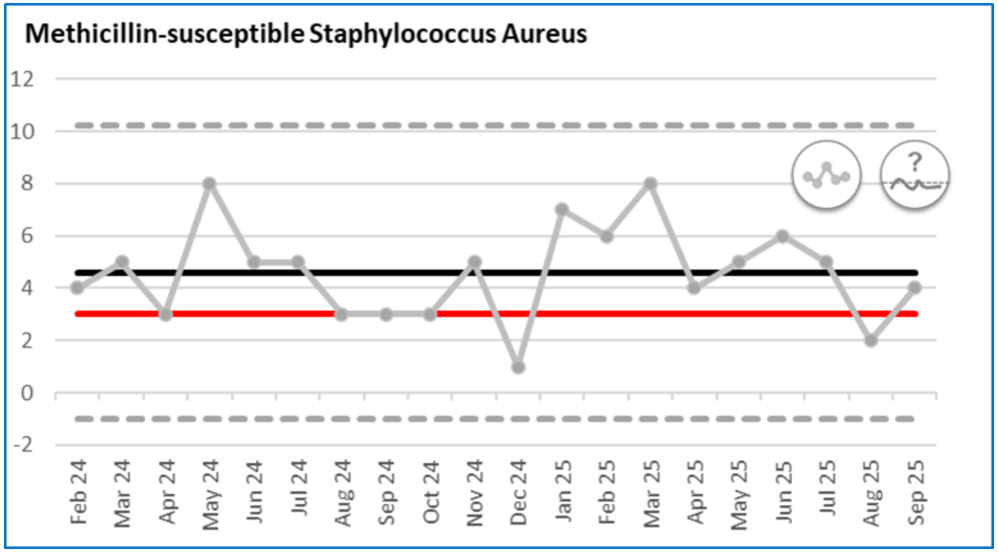
Performance Overview

Exception Reports

Finance

Appendix - Data Quality Assessment

Safe – Methicillin-susceptible Staphylococcus Aureus



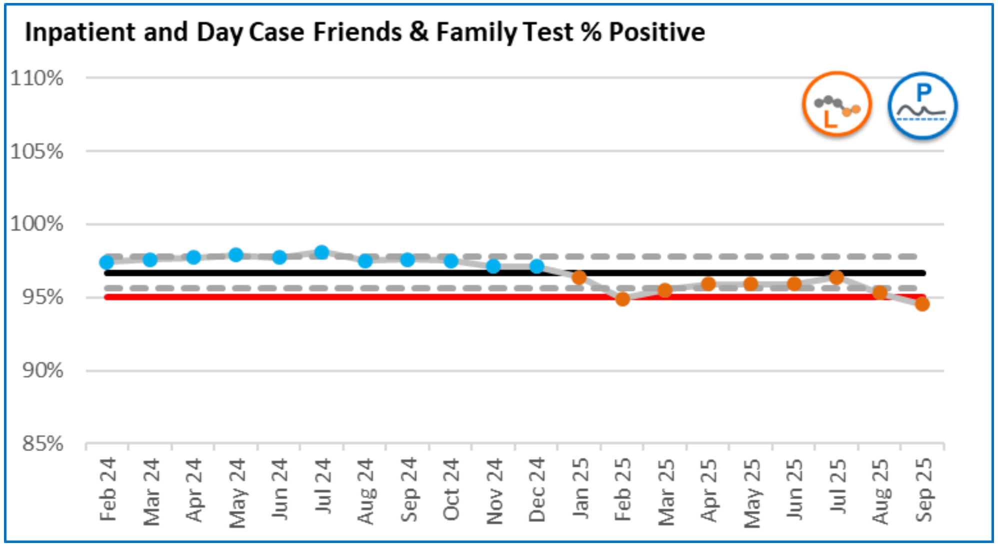
Current Performance		
Sept 25	YTD	Target
4	26	40

National Position & Overview

	Sept	Total	
MSSA NHSE Threshold 25/26	3	40	
* Actual Infections (HOHA) 25/26	1	14	
* Actual Infections (COHA) 25/26	3	6	
*** Actual Infections Total (HOHA & COHA)** 25/26	4	20	
UHL 100,000 Bed Days (HOHA) 23/24	2.1	**5.5**	***YTD UKHSA Report**
National Average	8.76		
National Highest	44.65		
National Lowest	0		

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

Caring – Inpatient and Day Case Friends & Family Test % positive



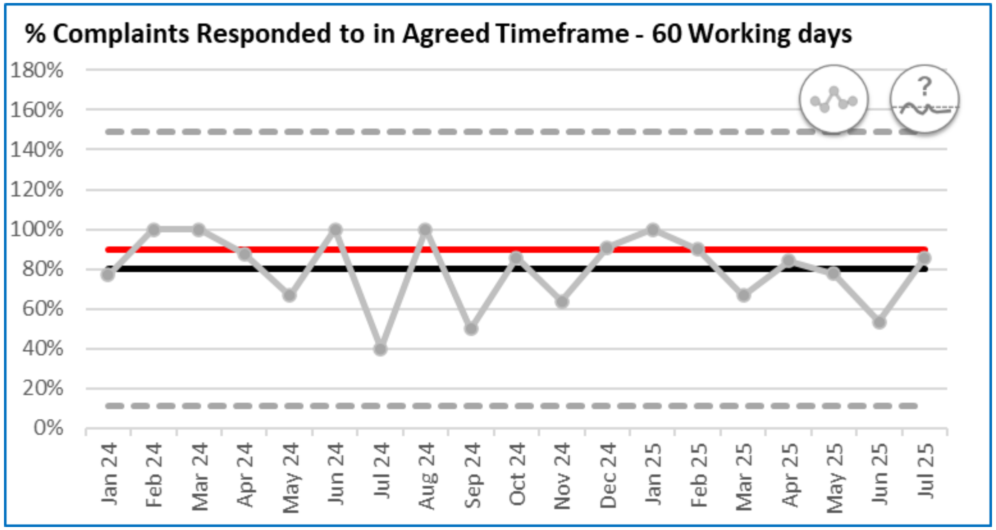
Current Performance		
Sep 25	YTD	Target
94.5%	95.6%	95%

National Position & Overview

The most recent national FFT result available is August 2025 with an overall NHS Trusts average (excluding independent sector providers) was 94.7% positive. The Trust inpatient peer group result for August was 94.9% positive.

Root Cause	Actions	Impact/Timescale
• Introduction of automated SMS feedback in Jan-25 lowered average % positive score to a new baseline but does not account for the recent declining trend • In September 2025 CHUGGS and RRCV had the most non-positive feedback, both having had a concordant increase in patient throughput/feedback since Apr-25 :- amplifying their effect on Trust score • Admission areas LRI GAU, LRI GI Surgical SDEC/ESAC and GH CDU collectively are the bottom 3 wards for their overall contribution in reducing the positive score	Complete Co-pilot analysis of Sep-25 non-positive FFT comments in admission areas to identify top areas of concern Complete Co-pilot analysis of Sep-25 ALL FFT comments for ALL WARDS to compare/contrast and identify top areas of concern CMGs to consider theming analysis results in their area to target improvements Patient Experience to support CMGs in using Co-pilot to analyse feedback	Themes from admission areas are: 1 Waiting times 2 Communication 3 Pain management 4 Hospital Environment 5 Discharge process 6 Staff attitude Themes from ALL WARDS are: 1 Waiting times 2 Communication 3 Discharge Process 4 Hospital Environment 5 Pain Management 6 Staff attitude

Caring – % Complaints Responded to in Agreed Timeframes

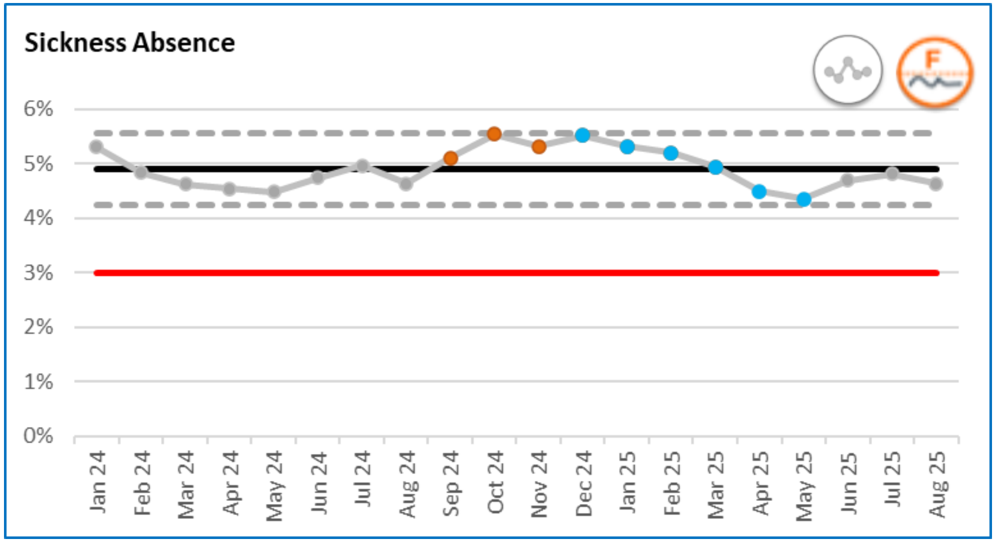


25 Working Days			60 Working Days		
Aug 25	YTD	Target	Jul 25	YTD	Target
78.6%	62.7%	90%	85.7%	75.3%	90%

National Position & Overview

Root Cause	Actions	Impact/Timescale
• Improvement in 60 working day response timeframe	• Close monitoring of deadlines continues • More meetings are being arranged within the timescales, with the use of additional administrative support	• Ongoing

Well Led – Sickness Absence



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

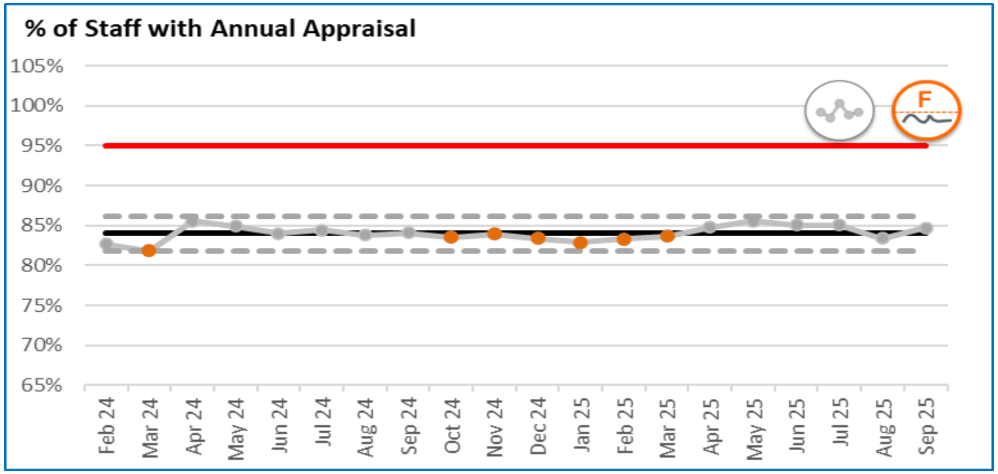
National Position & Overview

Peer data not available.

We have seen a 0.24% reduction in sickness absence between July (4.81%) and August (4.64%).

Root Cause	Actions	Impact/Timescale
• Clinical CMG's have seen a reduction of 0.16% and Corporate Directorates a reduction of 0.32%. • Over the last 12 months, the highest levels of absence are in E&F (6.01%), W&C (5.57%), RRCV (5.14%). • The areas achieving the 3% target are within the Corporate Directorates • The top 3 reasons for sickness absence are anxiety/stress/depression (27.94%), Other known reasons (19.65%) and cough/cold/flu (10.16%)	• Improving accurate reporting reasons for sickness absence is essential for CMGs to ensure appropriate local and Trust wide interventions – reducing the 'unknown' absence reasons. • Wellbeing information is shared through corporate and local induction, HWB Ambassadors, monthly restaurant stands and weekly and monthly newsletters • Sickness absence data is reviewed with CMG's through PRM, Board and Specialty Meetings and local 'Making if all happen / Health and Wellbeing' reviews. • RRCV have undertaken a deep dive to inform their local actions and health and wellbeing support, including drop-in sessions for managers. • E&F have prioritized training for managers, implemented 'making it all happen' meetings for hot spot areas and recently moved to Optima for improved reporting and recording of sickness absence. • W&C are focusing on long term sickness absence and medical absences and have rolled out line manager training and scheduled drop- in sessions. • For longstanding and complex cases, case conferences with OH occur. • As we head into winter and recognizing the increased levels of respiratory illness including COVID-19, face masks have been re-introduced in COVID-19 symptomatic areas and where colleagues have a runny nose, sore throat, cough or sneezing and is well enough to work. • The flu vaccination programme is underway to protect our patients, colleagues and families. • The ER and Health and Wellbeing UHL Connect site covers all aspects of support, training, information, TALK toolkit for wellbeing conversations, template documents etc.	• The NHS Long Term Workforce Plan highlights improved retention of our workforce as one of its key pillars, which includes supporting them to stay well. • Through the 2024 Staff Survey results, we have continued to improve in the in the People Promise Theme "We are safe and healthy". • We are seeing an improvement in recording reasons for sickness absence over the last 3 months, where in 24/25 M8 we had 10.06% of absences recorded as 'unknown' reason, and in 25/26 M5 we have seen a further reduction to 2.54%.

Well Led – % of Staff with Annual Appraisal



Current Performance		
Sep 25	YTD	Target
84.7%	-	95%

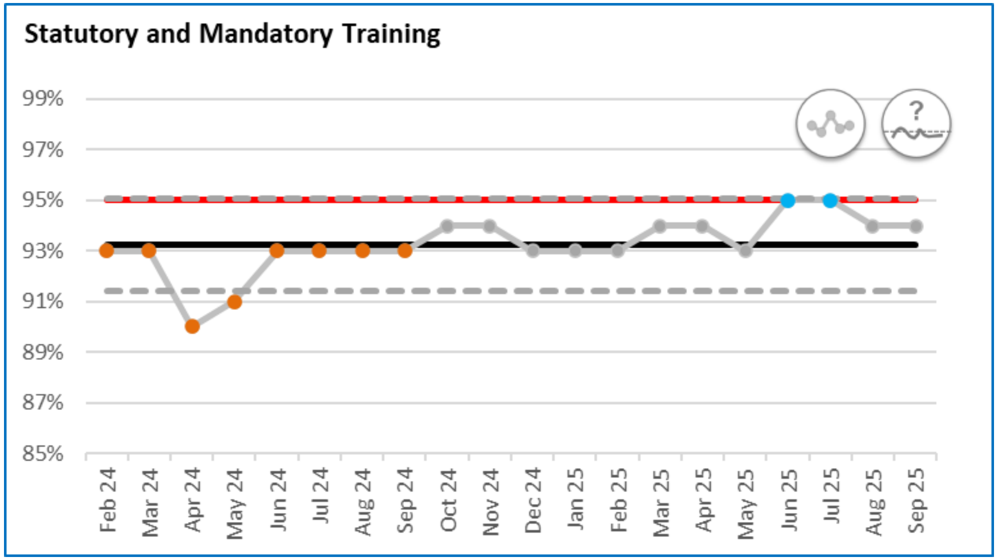
National Position & Overview

Peer data not available.

The September figure shows an increased position on the previous month of 1.3. We are 10.3% 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 increased, an improvement on last month's position. • The Trust's compliance in month has been due to increases in all clinical and corporate areas, bar CSI and Corp & Legal, HR and IT respectively.	• 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 September 2024 Appraisal performance was at 84.1% which was an increase in compliance on the previous month of August 2024; this year we also see a slightly improved position compared to the September 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



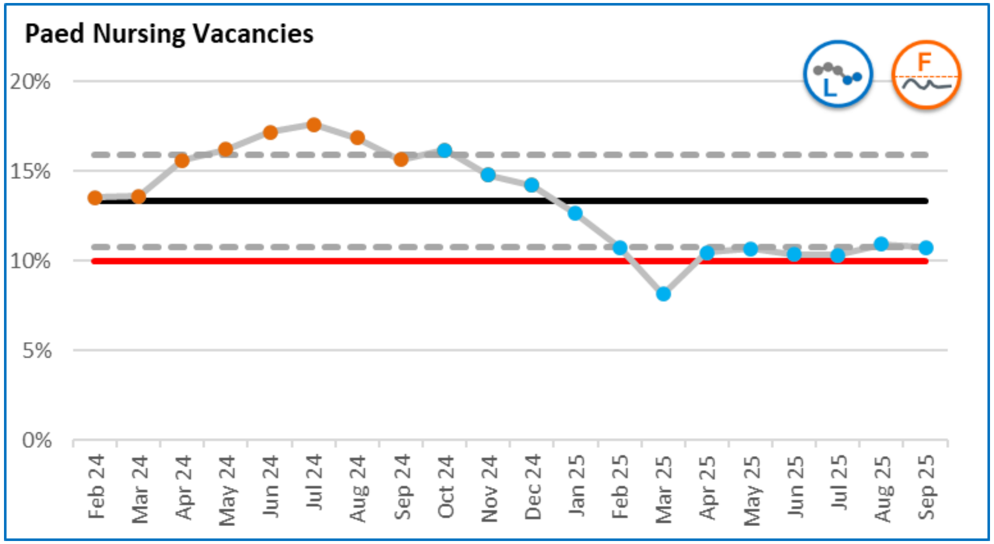
Current Performance		
Sep 25	YTD	Target
94%	-	95%

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 3096 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 – Paed Nursing Vacancies



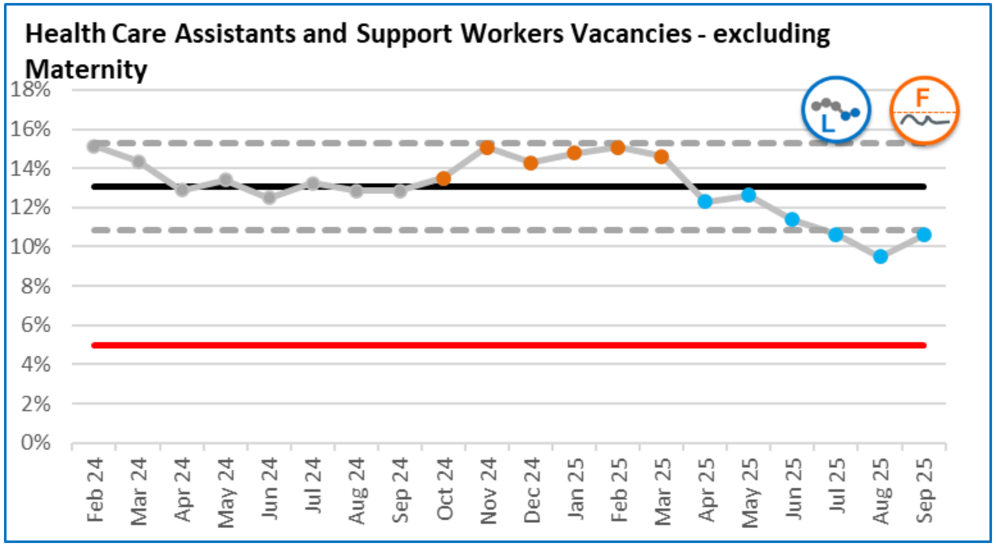
Current Performance		
Sep25	YTD	Target
10.7%	-	10%

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	• The 2025 CH NQN recruitment campaign targeted candidates nationwide • Once in post, all inpatient B5 posts will be filled, with the exception of reserved B5 funding in anticipation of MAPs recruitment • All Internationally Educated Nurses (IENs) have completed their OSCE programs and are awaiting PINs	• The following data set has been provided by the Children's Hospital Matron for Safe Staffing, Recruitment and Retention for Oct-25 (AfC Bands 4-7 for direct clinical areas) • Vacancies: 51.75 wte **(15%)** • Non-NQN pipeline: 3.13 wte • NQN pipeline: 29.60 wte • NA pipeline: 1.92 wte • Known Leavers: 1.92 wte • Projected vacancy Jan-26: 19.02 wte **(6%)** • Further 3.80 wte in pipeline for Feb/ March

Well Led – HCA and Support Workers Vacancies – excluding Maternity



Current Performance		
Sep 25	YTD	Target
10.6%	-	5%

National Position & Overview

- Model Hospital is reporting the "Support to Nurses" role vacancy at 10.6% (Jul-25).
- This suggests that UHL is line with the national average.
- The UHL position in month is showing a slight upward trend.

Root Cause	Actions	Impact/Timescale
• Work stream completed for bank to substantive workforce • Retention has been maintained for HCSW • Small number of HCSW transitioned to TNA programme	• Recent HCA recruitment drive for Aug-25; 44 applicants successful at interview are currently undergoing HR checks. • Converting some Healthcare Assistant (HCA) posts into Registered Nurse (RN) posts across the organisation to increase the percentage of RNs on duty. These changes have been 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.	• Once all HCSW have commenced in post the trajectory should be downward • NMAER meetings are ongoing with annual report completion in Q3.

Well Led – Non Clinical Agency- No. of Staff

Awaiting more data for SPC chart

Current Performance		
Sep 25	YTD	Target
3	24	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 There is an exit plan in place for 1 of the agency workers as the projects completes in December.. 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

Current Performance		
Sep 25	YTD	Target
29	150	0

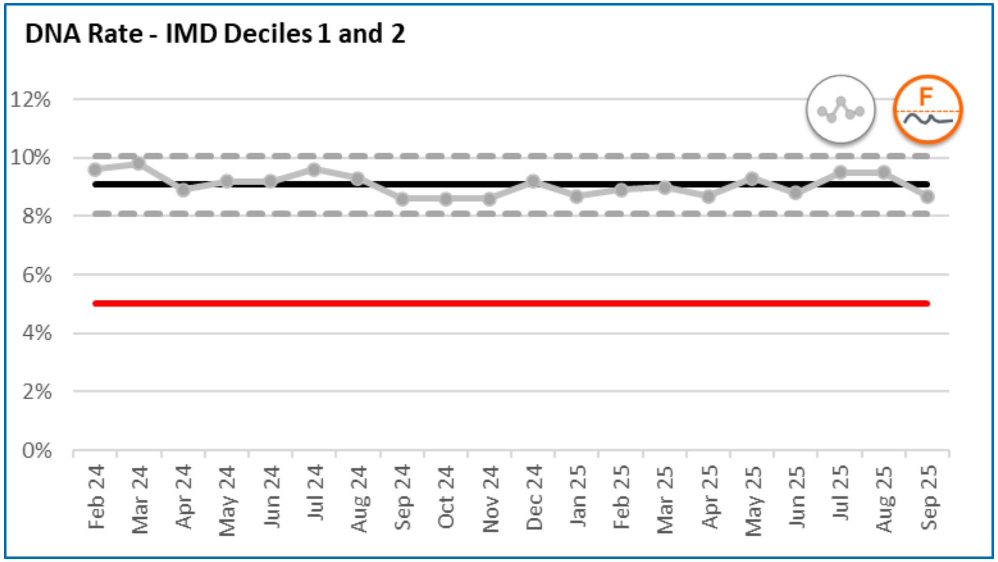
Awaiting more data for SPC chart

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 •AHP specialist roles such as Sonography, Radiogrpahy and Cardiac Physiotherapists are over price cap due to the specialist skill sets and specialist nature of the roles.	Attendance at Regional NHSE steering groups with milestone plans introduced to reach price cap compliance across all staff groups.	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 (3)who remain over the price cap but these are acknowledged to be in specialist fragile services. A milestone plan has been submitted to reach price cap by April 26 • We are over price cap only in specialist roles in Sonography, Radiograpy and Cardio respiratory for AHP/ST&T. Attendance at regional group by Chief AHP. Milestone plan in place, however across the region we have the lowest rates.

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



DNA Rate – IMD Deciles 1-2			DNA Rate – IMD Deciles 3-10		
Sep 25	YTD	Target	Sep 25	YTD	Target
8.7%	9.1%	5%	5.7%	5.7%	5%

National Position & Overview

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

Root Cause

- A total of **6,168 patients DNA'd** their appointment in September 2025.
- **1,405** Responses were received - **26**% of delivered texts.
- The response rate from the most deprived decile (IMD1) was 21% compared with 32% in the least deprived (IMD10)
- **"I didn't know I had an appointment"** remains the most common reason for DNA in September (37% of responses) - across all IMD quartiles. **Forgetting** the date or time and **trying to cancel or requesting to cancel/rebook** via text are the next highest reasons (32% combined) for non-attendance across all IMD quartiles, but forgetting is higher in IMD quartile 1 (14%) than the lesser deprived quartiles (7%). After these reasons, non-attendance for **medical/mobility reasons** is the next highest reason for DNA (11%).

Actions

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

Impact/Timescale

IMDs 1 & 2 have an average DNA rate of **8.7%** for Sept 25. Disaggregated by contact these rates are:

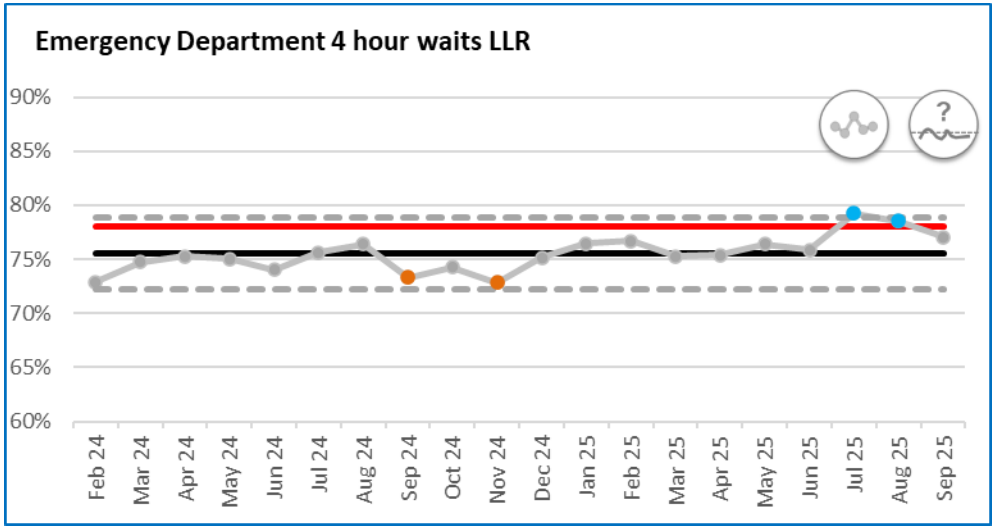
IMD1
- Patients contacted DNA rate **5.76%**
- Patients not contacted DNA rate **9.43%**

IMD2:
- Patients contacted DNA rate **5.95%**
- Patients not contacted DNA rate **14.78%**

Inclusion Healthcare:
- DNA rate for those contacted **37.5%**
- DNA rate for those not contacted **25%**

Paediatric Outpatients
- WNB rate contacted **3.05%**
- WNB rate not contacted **12.59%**

Responsive (Emergency Care) – Emergency Department 4 Hour Waits



UHL Performance			LLR Performance		
Sep 25	YTD	Target	Sep 25	YTD	Target
62.2%	60.8%	61%	77.0%	77.1%	78%

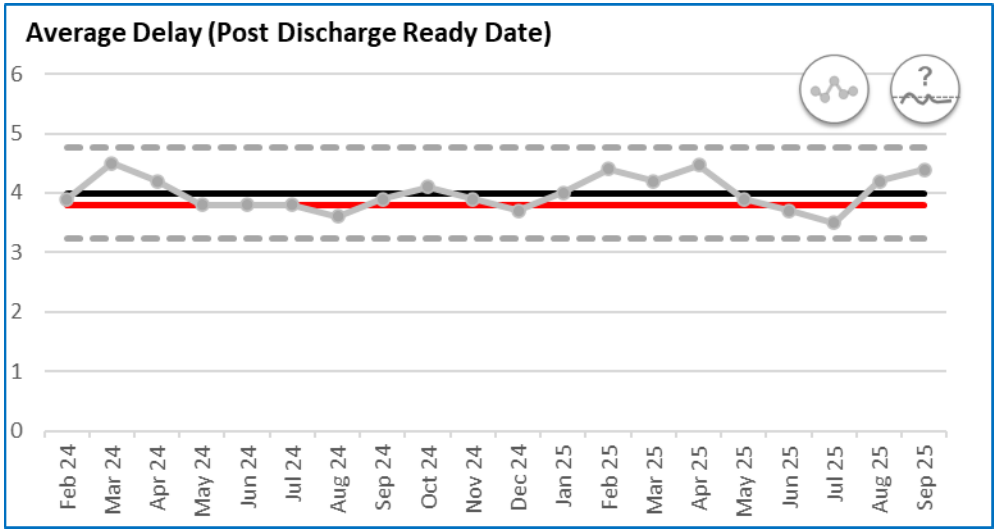
National Position & Overview

In September, UHL ranked 47 out of 123 Acute Trusts based on its acute footprint. The National average was 75.0%. 33 out of the 123 Acute Trusts achieved the target. UHL ranked 6 out of the 18 UHL Peer Trusts. The best value within our peer group was 84.0% and the worst value was 65.7%.

UHL performance was above trajectory for September (59.2%).

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

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



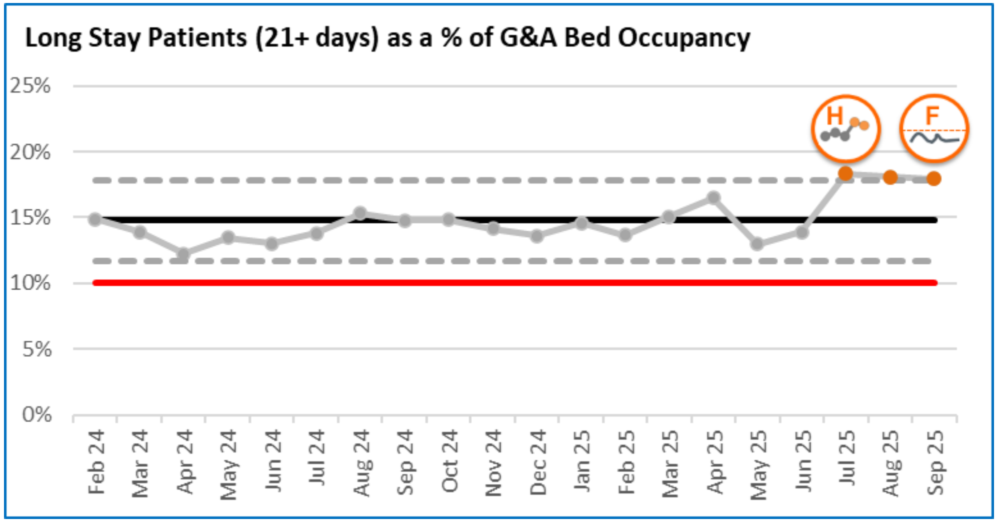
Current Performance		
Sep 25	YTD	Target
4.4	4.0	3.8

National Position & Overview

In August, UHL ranked 34 out of 125 Acute Trusts that submitted acceptable data. The National average was 5.9. 25 out of the 125 Acute Trusts achieved the target. UHL ranked 4 out of the 18 UHL Peer Trusts. The best value within our peer group was 2.7 and the worst value was 8.9.

Root Cause	Actions	Impact/Timescale
Poor outflow from the inpatient wards through • **Process delays** internally relating to ward processes, diagnostics, discharge delays (TTO's etc.) and externally (Emed ambulance, equipment) **276 complex patients stayed an additional night in hospital in September (253 August)** • LLR system discharge hub interface and capacity delays to provide timely plans for discharge. **Increased numbers of medically optimised complex patients awaiting a P1-P3 outcome. (157 patients at the end of Sept, 143 August, 130 July,)**	• Continue to embed weekly long wait for outcome escalation meetings with Adult Social Care and CMG's – identify themes for action. • Review reasons for delays/ identify themes for transformation • Continue to promote early referral of patients (currently 34%) • Work with SM on discharge Improvement Pilot • Review LEAF QI projects relating to discharge for shared learning of what works well.	• Aim to reduce number of MOFD (Discharge Ready) patients waiting for discharge in UHL beds. • Reduce time to discharge from MOFD identification • Improving Patient Discharge Project plan in place and reviewed within the discharge improvement meeting with CMG's

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



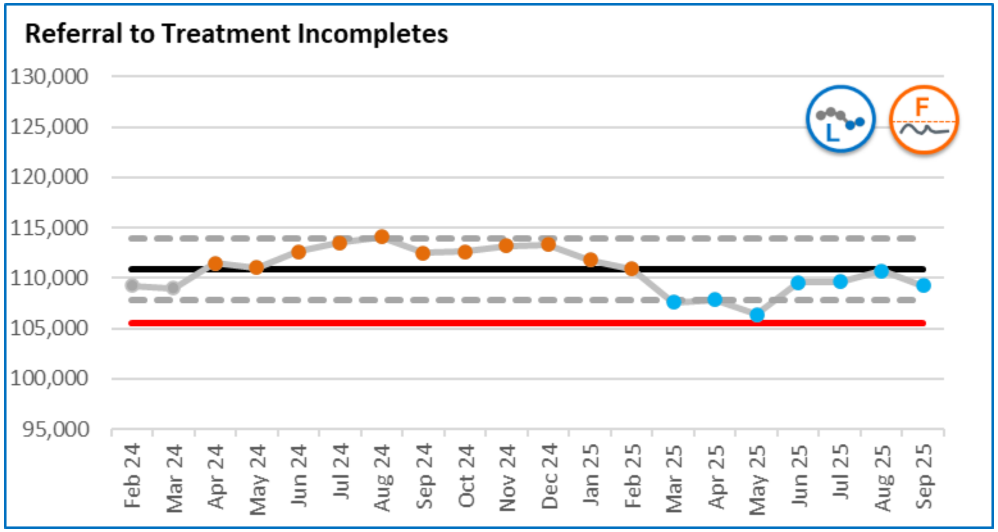
Current Performance		
Sep 25	YTD	Target
17.9%	-	10%

National Position & Overview

- 53 (382) Patients (14%) 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 (12 patients).
- 80 Patients (21%) are medically optimised complex patients awaiting discharge with no reason to stay in an Acute Trust.

Root Cause	Actions	Impact/Timescale
• Data quality issues arising from changes to PAS (data pulling pre-admit codes, delays to discharge coding/ inaccurate coding) • At the end of September there were circa 55 patients over 21 days length of stay awaiting a discharge outcome from LLR.	Continue to work with the 'Discharge PAS squad' to understand and rectify data inaccuracies with continued spot checks for data accuracy. Continue to work with health and social care system partners during October 2025 to: • Maximise the use of P1/ P2 capacity in LLR. • Continue to 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. (38% September). • Process for moving to a weekly CMG in depth review of > 21 day patients agreed. • Finalise design phase of Specialist Medicine Discharge Intervention 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 (Elective Care) – RTT Incompletes



Current Performance		
Sep 25	**Sep Plan**	**Target**
109,233	107,643	105,500

National Position & Overview

At the end of August, UHL ranked 15 out of 18 trusts in its peer group with a total waiting list size of 110707 patients. The best value within our peer group was 66395, the worst value was 187912 and the median value was 87310. (Source: NHSE published monthly report)

Root Cause

- 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

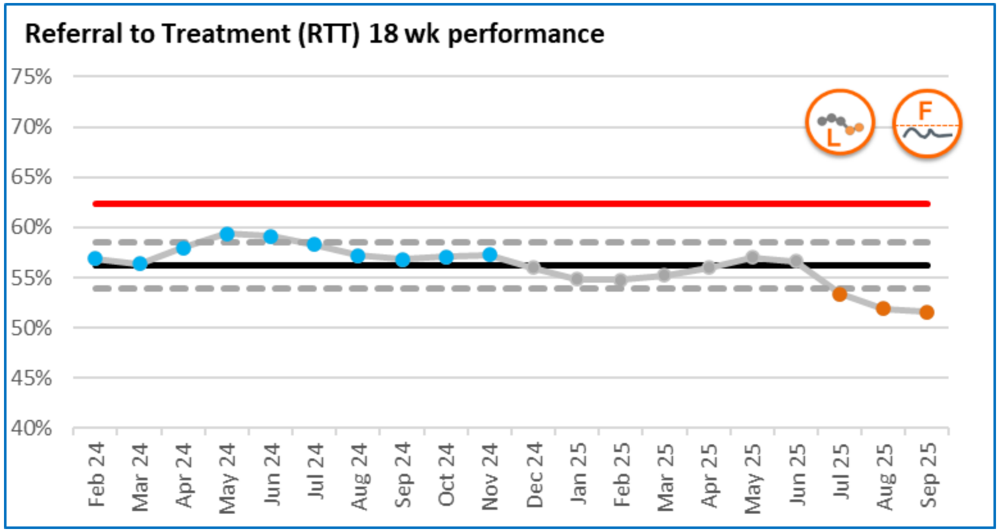
Actions

- 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.

Impact/Timescale

- Q2 validation sprint did not bring in funding, because of previous year (baseline) high level of validation. 6 week sprint for Q3 starts in November.
- 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 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		
Sep 25	Sep Plan	Target	Sep 25	Sep Plan	Target
51.6%	58.1%	62.3%	62.5%	63.4%	68.1%

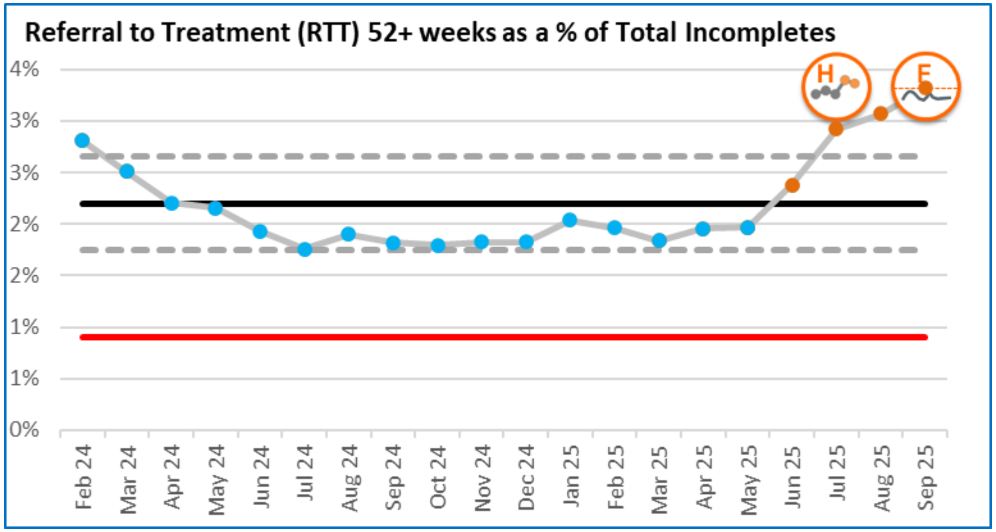
National Position & Overview

At the end of August, UHL ranked 17 out of 18 trusts in its peer group with RTT 18 Week Performance at 51.9%. The best value within our peer group was 72.8%, the worst value was 51.9% and the median value was 57.3%. (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		
Sep 25	Sep Plan	Target
3.3%	1.3%	0.9%

National Position & Overview

At the end of August UHL ranked 11 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 5.0% and the median value was 2.9%. (Source: NHSE published monthly report)

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.

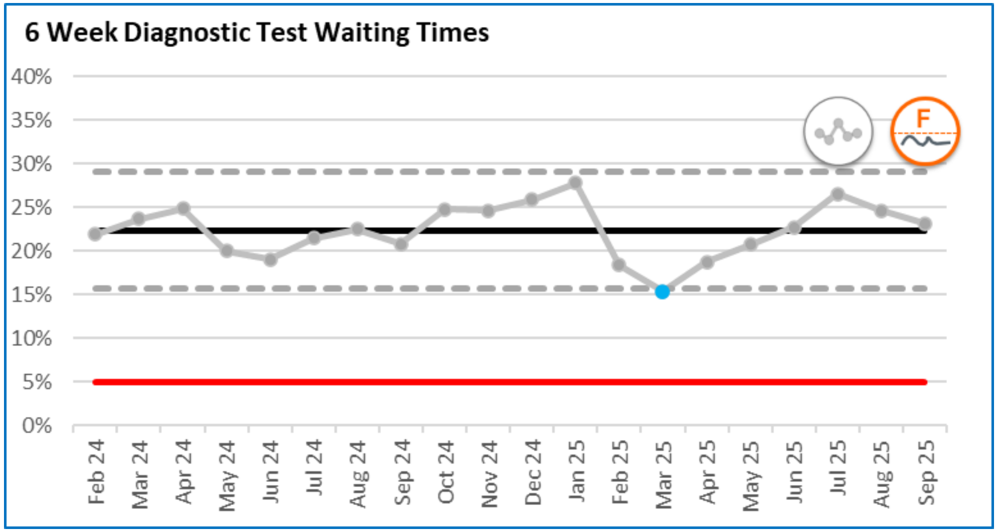
Actions

- 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 in July & 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		
Sep 25	YTD	Target
23.1%	-	5.0%

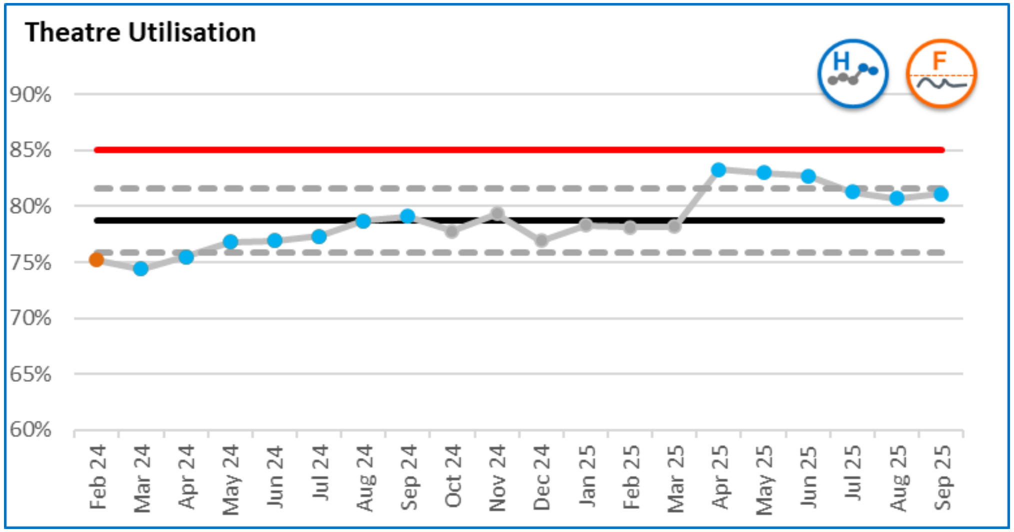
National Position & Overview

Published National data at the end of August 25 shows 1.65m patients on the diagnostic waiting list with 24% waiting over 6 weeks. For Sept 25, UHL with 27,537 patients would comparatively rank as the 6th highest waiting list. The 6-week trajectory for September was set to deliver 10.6%, the actual was 23.1%, 12.5% behind plan, driven by NOUS and Endoscopy. There were 6,370 patients waiting >6 weeks an improvement of 293 from August 25.

Root Cause	Actions	Impact/Timescale

Diagnostics pressure areas are in the main:
• NOUS
• Endoscopy
• Audiology
• MRI for complex long waiters
 	
Root cause
• Clinical workforce gaps
• Admin recruitment
• Reporting and coding errors
• Overall NOUS growth
• Pressure from emergency, cancer and elective long wait pathways
	• QLIK & PAS WLMDS training
	• Increased productivity of resources
	• Increase capacity
	    • New endoscopy unit – Nov 25
	    • Hinckley Community Diagnostics Centre – opened June 25
	    • NOUS and Audiology – 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 – Dec 25.
	• Sleep to increase capacity and review workforce sustainability
		• Training following PAS upgrade – Nov 25
		• Validation – ongoing for all DM01
		• Productivity metrics Sept - improvements in DNA for CT. Endoscopy booking and in-session utilisation is on target. Outpatients modalities added from Q2 and showing Cystoscopy and Urodynamics utilisation above 90%
		• MRI recovery on track vans x2 on site supporting recovery - Q4
		• NOUS recovery commenced - expected by end of Q3
		• Echo and Sleep are now on trajectory
		• Review of 5year MRI & CT D&C – Complete Sept 25, recommendation to proceed with costs TLT – Dec 25
		• Audiology recovery – Q4
		• Endoscopy recovery - Q4

Responsive (Elective Care) – Theatre Utilisation



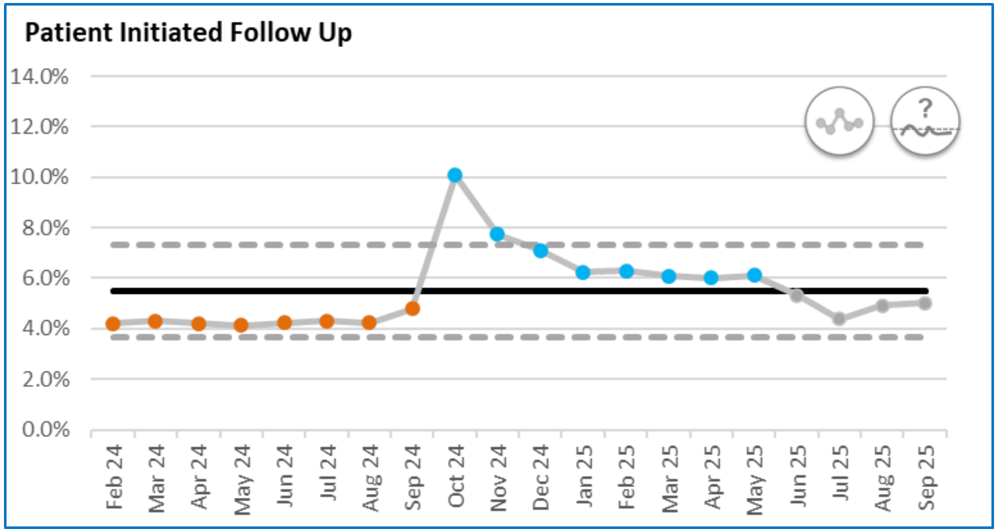
Current Performance		
Sep 25	YTD	Target
81.1%	82.0%	85%

National Position & Overview

For the week ending 07/09/2025, the MHS system value for theatre utilisation was 82.5%, outperforming both peer systems (80.9%) and the national average (81.2%). The system is currently rated Green, Quartile 3.

Root Cause	Actions	Impact/Timescale
• LRI: Performance at 75.1%. Key issues include a high rate of late starts (34%) and a significant number of OTDC (11%). • EMPCC: Performance at 75.9%. Challenges stem from procedure durations being shorter than planned, leading to underrunning lists (average 98 minutes), increased late starts (26%) and OTDC (7.4%). • LGH: Performance at 83.9%, slightly below target with measured levels of late starts (16%). • UHLiC performance: 78.5%, below target due to 34% late starts and OTDC increase (5% → 8%) in one service, causing average site underruns of 48 mins.	• Implement automated theatre reminders to improve patient readiness and reduce patient-related cancellations, which accounted for 37.5% of all cancellations in Sept. • Reinforce the policy of no TCI before approved fitness for non-urgent patients to reduce delays and cancellations on the day (All) • Specialty performance meetings for EMPCC to engage teams in targeted improvement plans (EMPCC). • Specialities to review actual procedure durations and adjust scheduling to reflect average case times, improving list scheduling & utilisation (EMPCC) • Implement and monitor an automated process to send the first patient on each theatre list to reduce late starts (LRI) • Complex LA Clinic Trial to address OTDC rates in Urology (LGH) • Analyze UHLiC OTDC rise from 5% to 8% in one service.	• Exploring the feasibility of automated theatre reminders, to reduce patient cancellations (DNAs and patients unwell). Q3 25/26 • Minimisation of avoidable clinical cancellations - Ensures patients are fit and have completed all necessary investigations prior to listing, improving efficiency and reducing cancellations. (Ongoing) • EMPCC meetings will promote the use of real-time data to guide actions, ensuring that improvement plans are responsive and targeted (Oct 25 – In-Progress) • Actual Case Duration - Enhances scheduling, reducing the risk of under- and overruns (Oct 25 – In-Progress) • Since implementation, LRI late starts have reduced from 42% (average delay of 28 minutes) to 34% (average delay of 22 minutes), indicating a positive trend. (ongoing)

Responsive (Elective Care) – PIFU



Current Performance		
Sep 25	YTD	Target
5.0%	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 (August 2025): UHL achieved a ranking of 20 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

The deployment of the new PAS system has introduced inconsistencies in the recording of PIFU pathways under specific conditions, which has directly impacted the ability to apply PIFU in those scenarios

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.

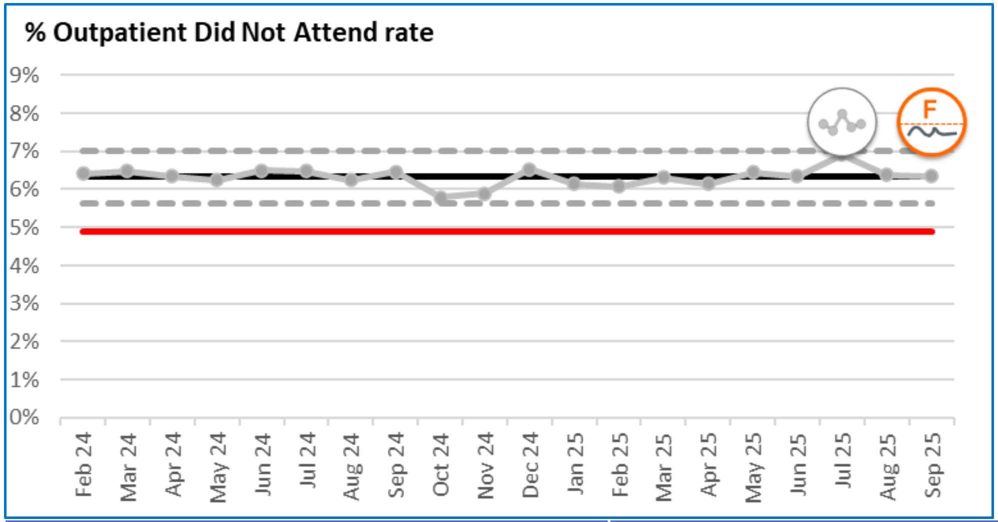
Actions

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

Impact/Timescale

Changes in PAS – PAS updates are scheduled to restore support for previous scenarios by December 2025
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 throughout 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

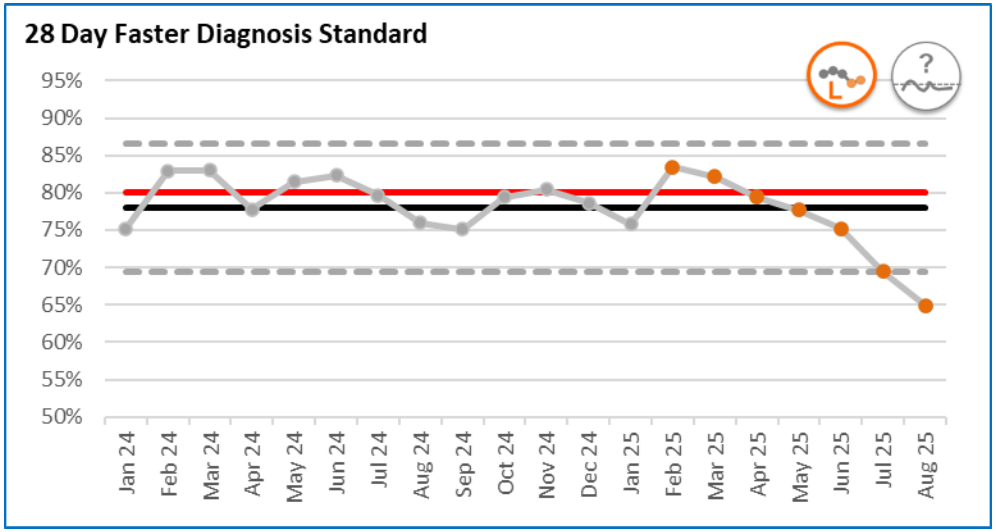


Current Performance		
Sep 25	YTD	Target
6.3%	6.4%	4.9%

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			
Aug 25	**YTD**	**Aug Plan**	**Target**
64.9%	**73.2%**	**77%**	**80%**

National Position & Overview

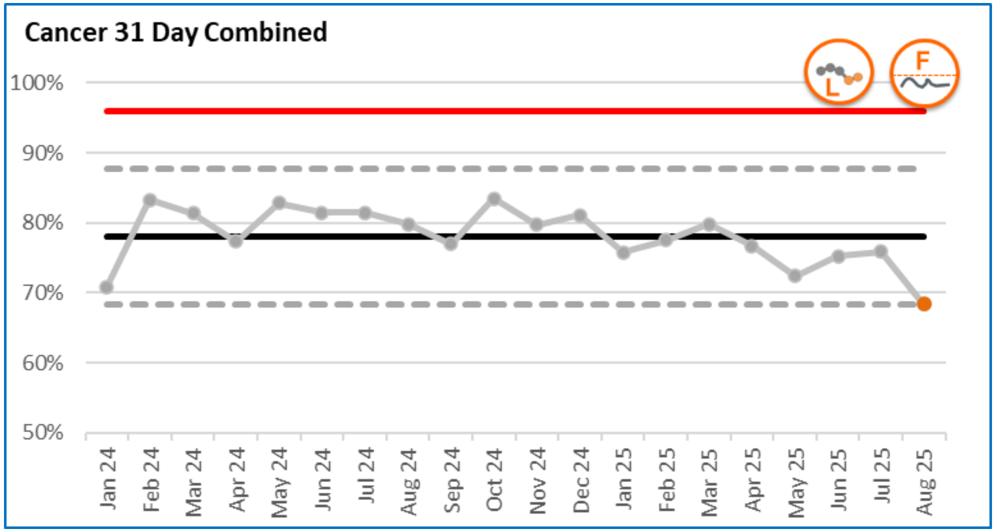
In August, UHL ranked 122 out of 140 Acute Trusts. The National average was 74.6%. 63 out of the 140 Acute Trusts achieved the target. UHL ranked 17 out of the 18 UHL Peer Trusts. The best value within our peer group was 84.8%, the worst value was 52.1% and the median value was 74.2%.

Performance deteriorated due to unexpected loss of locum capacity/WLIs in Q2 in Skin, Breast & H&N. Without this loss FDS would have delivered above 77%.

Root Cause	Actions	Impact/Timescale

• Unexpected loss of capacity in
  • Breast (decline in WLI)
  • Skin (loss of locum short notice mid-July)
  • 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 second time since Sep 23.
Without this loss of capacity performance would have been above 77%.
	Breast
	• ERF & Insourcing – agreed until year end.
	• Sustainable plan in development for 26.27
	H&N
	• Locum in place (Aug)
	• Review of referral criteria completed and change to STT pathway proposed – Nov 25
	• Sustainable plan in development for 26.27 (use of alt workforce).
	Skin
	• Locum in place (Aug)
	• Increase first appointment capacity – complete Oct 25
	• Change to SCC/AI pathways – complete Oct 25
		Breast
		• Wait times still currently 5 weeks
		• Impact from insourcing/ERF expected from Nov 25, remains a risk until additional capacity can be sourced.
		• Sustainable plan required for 26.27.
		H&N
		• Time to first appointment now 13 days, FDS improvements seen in Sept.
		Skin
		• Waits now 11 days average.
		• Increase in capacity following AI changes, change to booking process and super clinics ran to support, improvements noted in Sept. Expect recovery of FDS by end of October.

Responsive Cancer – Cancer 31 Day Combined



Current Performance			
Aug 25	YTD	Aug Plan	Target
68.4%	73.7%	79.5%	96%

National Position & Overview

In August, UHL ranked 138 out of 139 Acute Trusts. The National average was 91.6%. 69 out of the 139 Acute Trusts achieved the target. UHL ranked 18 out of the 18 UHL Peer Trusts. The best value within our peer group was 98.6%, the worst value was 68.4% and the median value was 90.2%.

Root Cause

- 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 31 days

Actions

- 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

Impact/Timescale

Radiotherapy

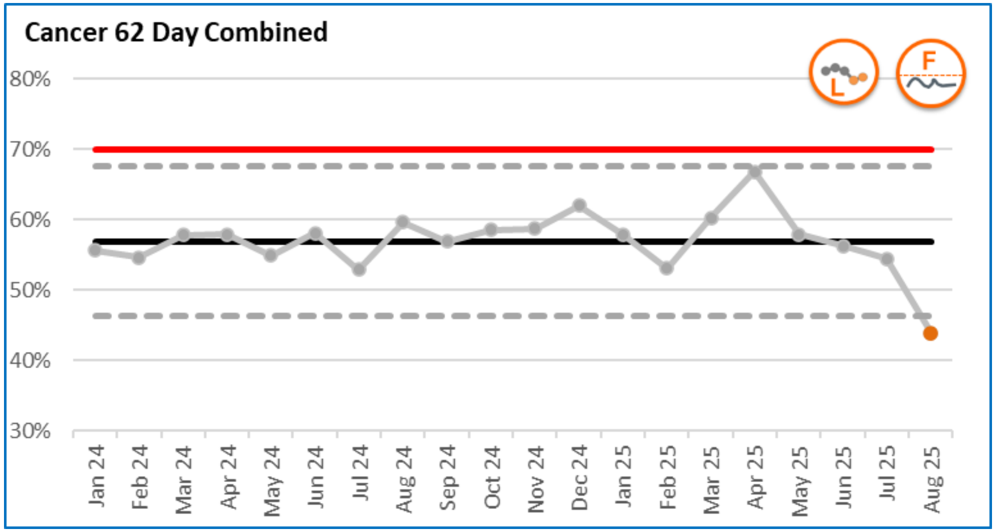
- 5th linac –recovery on track to deliver in Q4. Breast ahead of plan to deliver 31days in Q3. Prostate backlog reducing – delivery expected by end of Q4. Mutual aid continuing until Q4. D&C EM review & EM GIRFT - a/w recommendations.
- Workflow rescheduling time to maximise patient throughput in place.

Surgical dating – improvements in Breast sustained, further work others by Q4.

Oncology

- OPD review– PAS reports issues delayed - with NTTdata to resolve.
- Digital opportunities - first form in place, review prior to second form roll out – Q3.

Responsive Cancer – Cancer 62 Day Combined



Current Performance			
Aug 25	**YTD**	**Aug Plan**	**Target**
43.9%	**55.9%**	**63.1%**	**70%**

National Position & Overview

In August, UHL ranked 142 out of 148 Acute Trusts. The National average was 69.1%. 82 out of the 148 Acute Trusts achieved the target. UHL ranked 18 out of the 18 UHL Peer Trusts. The best value within our peer group was 80.4%, the worst value was 43.9% and the median value was 64.5%.

Unexpected loss of capacity in Skin, affected performance in August, deteriorating to bottom quartile in England. Without this performance would have remained above 50%.

Root Cause

- 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

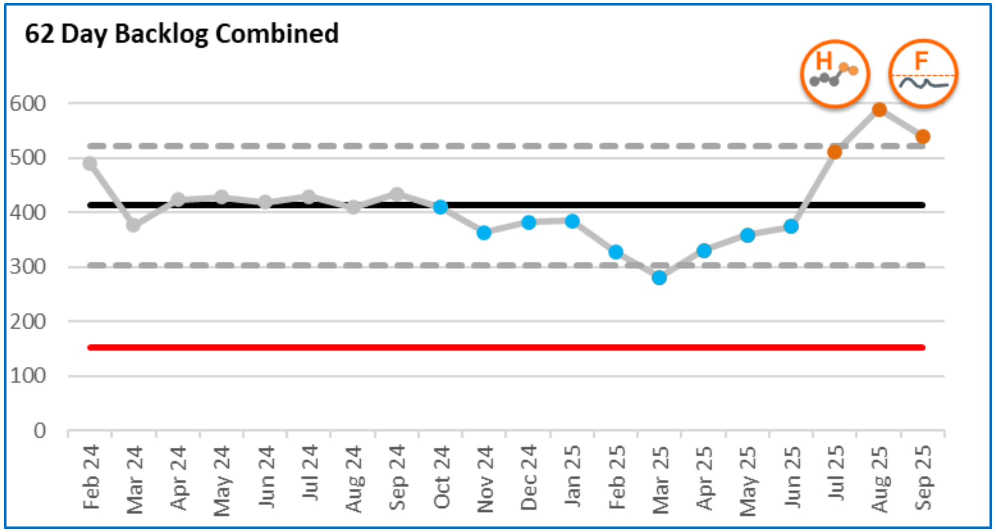
Actions

- Clinical prioritisation of patients and increased emphasis at PTL meetings to bring confirmed cancers within target - weekly
- Escalation process – review required
- Recovery & Performance (RAP) in place & 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 comms to reduce sequential diagnostic ordering and agree next steps ahead of MDTs
- EMCA & NHSE additional funding supporting increased activity/mutual aid

Impact/Timescale

- 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 Nov 25.
- Breast improvement project underway - expected to impact Q3.
- Extending PTLs to capture ‘likely’ cancers notifications to support earlier prioritisation – Oct 25
- Escalation process to tighten timescales – in place and impact being assessed.

Responsive Cancer – Cancer 62 Day Backlog



Current Performance		
Sep 25	YTD	Target
540	-	152 (by Mar26)

National Position & Overview

National data is not available.
Midlands trend – increases in backlog seen in 6/11 systems over 4 week period while LLR saw the biggest reginal reduction.
> 62 day 344 behind plan.
> 104 day 101 behind plan.
PAS implementation impacted on PTL size, backlog and speed of tracking/service actions, now returning to pre go-live levels

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 – services exploring options to support (Skin, H&N, Breast and Gynaecology) – ongoing, expect improvements from Oct 25 • Requested clinical validation to support – ongoing • Expansion of PSFU opportunities scoped – agreed to commence Skin by Q4. • Use of audits to streamline and increase out of decision MDT steps • Overall backlog continues to reduce into October.

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Executive Summary

- The month 6 YTD position for the Trust is a deficit of £13.4m which is £4m adverse to plan. The main drivers are reduced patient care income excluding EDD £5mA (mainly elective care) impact of PAS implantation £2.1mA, under-recovered other operating income excluding donated assets of £2.9mA, offset by pay/non-pay underspend of £6.7mF (excluding EDD) and industrial action in M4 of £1.3mA and other £0.6mF.

- The Trust reported a year-to-date deficit of £52.3m at the end of September excluding deficit support. Further substantial improvement to the run-rate is required to match the increasing monthly CIP targets over the remaining months of the financial year.

- The Trust committed net capital expenditure of £20m in Month 6 after deducting charitable donations/capital grants, resulting in an underspend of £10m against CDEL target of £30m for M6.

- The cash position at the end of Month 6 was £17.6m, which is a decrease of £27m from M5. The Trust made a PDC Dividend payment in month of £10m, payments to creditors were higher by £11m and PCI income reduced by £6m.

Summary Financial Position – YTD M6

I&E

	I&E YTD		
	Plan	Actual	Variance to Plan
	£'000	£'000	£'000
NHS Patient-Rel Income	812,771	803,619	(9,151)
Other Operating Income	90,461	87,406	(3,055)
Total Income	**903,231**	**891,025**	**(12,206)**
Pay	(566,995)	(564,037)	2,959
Non Pay	(299,050)	(294,152)	4,898
Total Costs	**(866,045)**	**(858,188)**	**7,857**
EBITDA	**37,186**	**32,836**	**(4,349)**
Non Operating Costs	(44,323)	(44,152)	172
Retained Surplus/(Deficit)	**(7,137)**	**(11,315)**	**(4,178)**
Donated Assets	(2,268)	(2,117)	151
Control Total Surplus/(Deficit)	**(9,405)**	**(13,432)**	**(4,027)**

Comments – YTD Variance to Plan

Total Income: £12.2mA:

- Under recovery of PCI income of £9.2m which includes an assumption of £2.1mA impact of PAS implementation, £5mA reduced patient care income mainly elective, passthrough excluded drugs and devices lower than plan £1.3mA (this includes a reduction of £0.6m relating to hybrid loops), £0.5mA industrial action impact and other £0.3mA.
- Other income includes reduced donated income £0.2mA offset by donated asset adjustment, CSI £1.2mA (mainly relating to pathology, pharmacy, imaging), reduced private/overseas patients £0.3mA, reduced E&F income £1.1mA mainly relating to car parking/catering and other £0.3mA.

Pay: £3mF:

- Medical and dental £4.6mA 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 vacancy controls across CMGs.
- Other clinical driven by vacancy control across most CMGs.
- Non-clinical mainly driven by £0.3mA R&I pay award pressure and CIP non delivery in CSI.

Bank (£34.7m) and Agency (£1.8m) spend YTD amounts to £36.5m which is 6.5% of total pay.

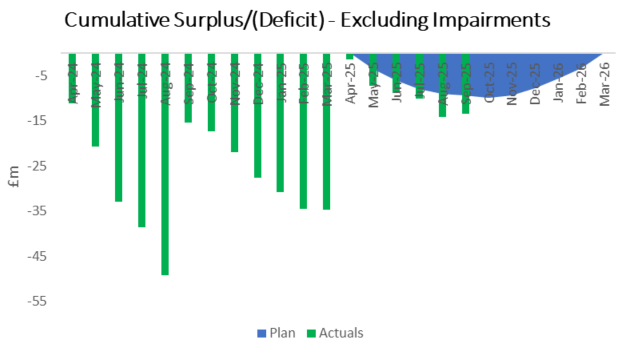
Non-Pay: £4.9mF:

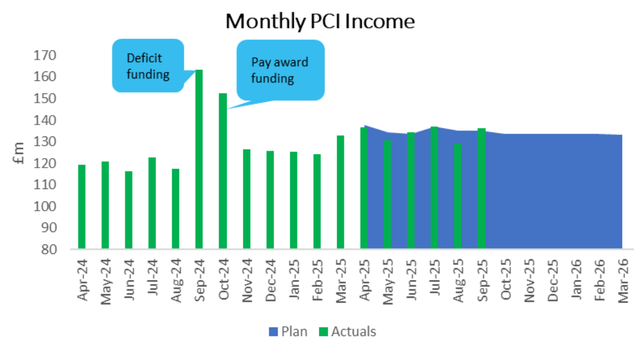
- Clinical Negligence £2.1mF relating to the maternity incentive scheme rebate.
- Drugs £2.4mA - mainly due to CHUGGS block baseline drugs in Haematology/Oncology, ITAPS mainly baseline drugs in sleep/theatres, RRCV relating to renal and respiratory and undelivered CIP.
- Other is driven mainly by CHUGGS reduced Gastroenterology insourcing usage and closure of Vanguard unit, slippage in the opening of the CDC unit/lower level of activity and E&F mainly from the review of prior year food provision.

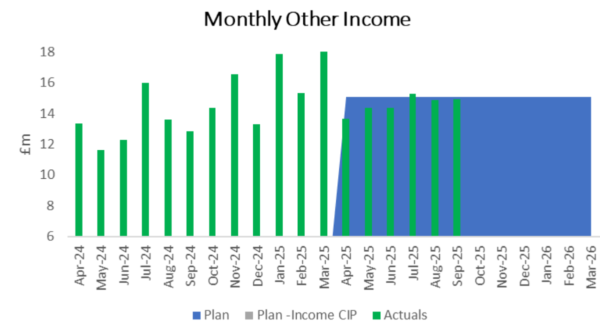
Non-Operating Costs £0.2mF mainly from increased interest receivable £0.6mF offset by disposals £0.4mA.

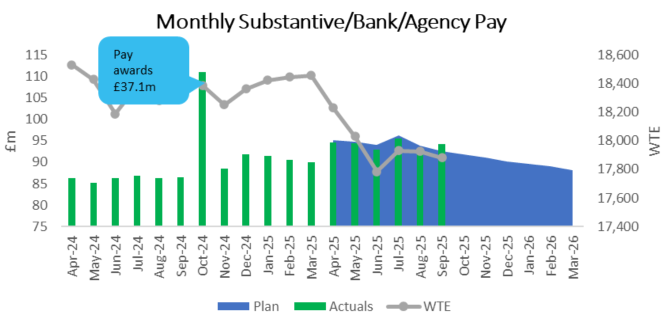
Donated assets variance is driven by lower donations than planned (this is offset in other income).

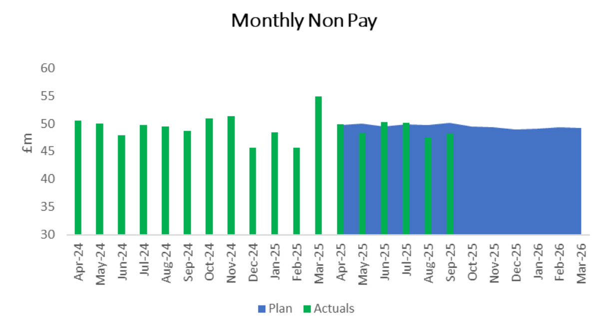
Month 6 I&E Dashboards

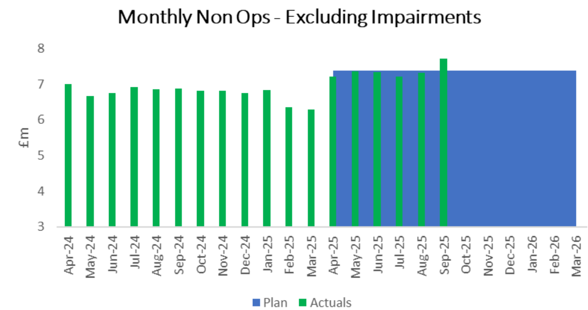


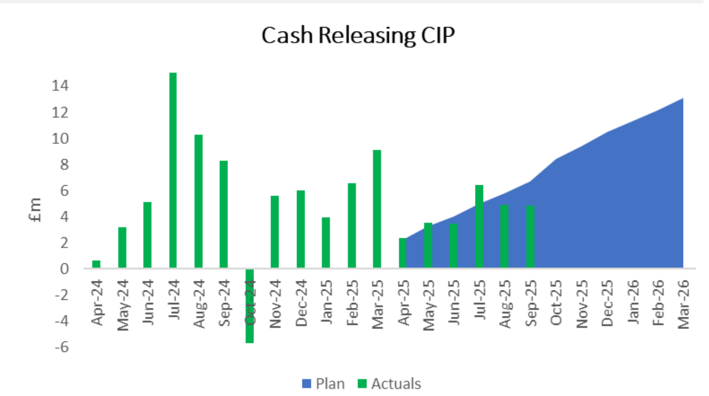


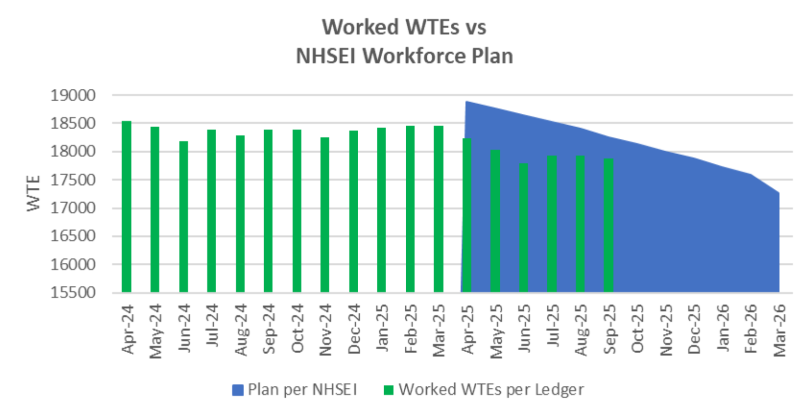












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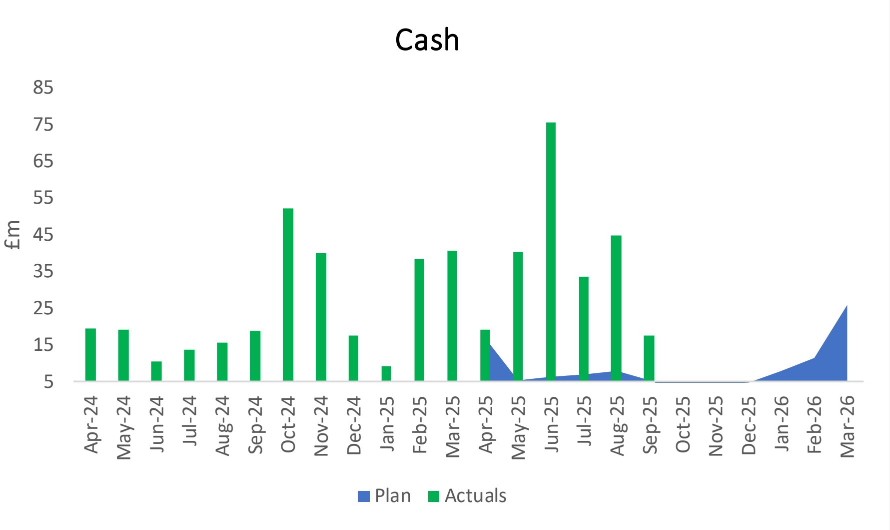
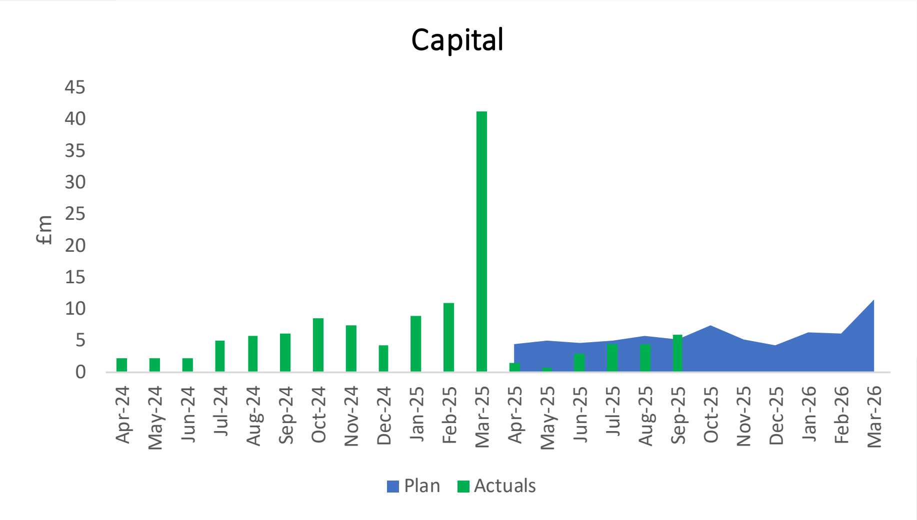
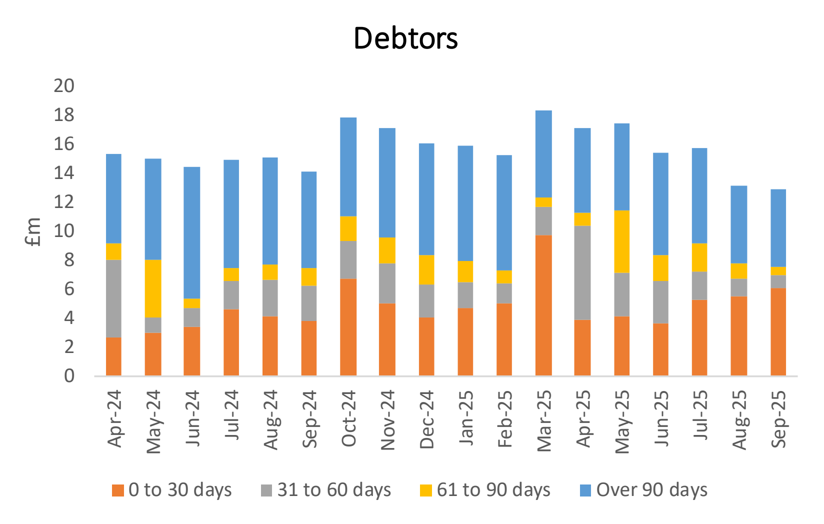
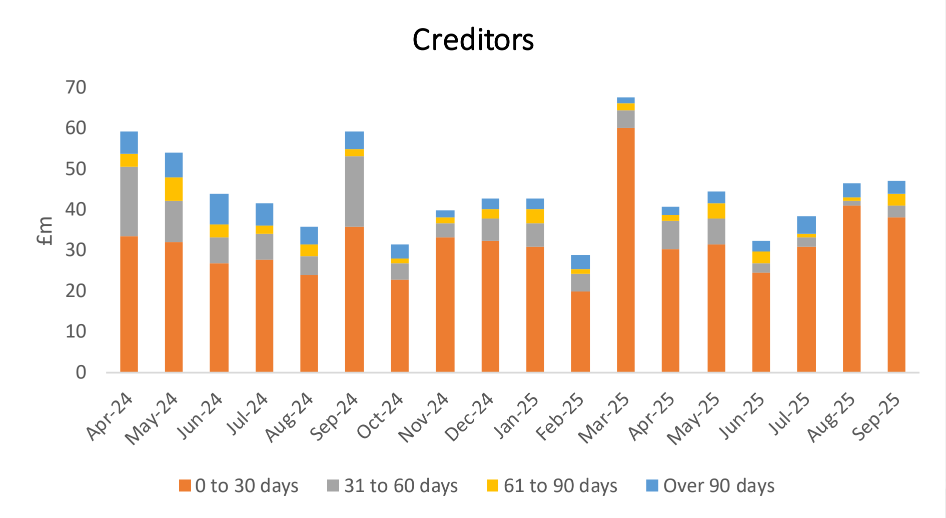
Month 6 Balance Sheet Dashboards









Statement of Financial Position

£m	31-Mar-25	31-Aug-25	30-Sep-25	In Month Movement	YTD Movement
Non Current Assets					
Intangible assets	31.1	31.5	32.2	0.7	1.2
Property, plant and equipment	776.0	765.7	766.4	0.7	(9.6)
Other non-current assets	4.4	4.5	4.5	0.0	0.1
Total non-current assets	**811.5**	**801.7**	**803.2**	**1.4**	**(8.3)**
Current Assets					
Inventories	28.6	28.3	28.6	0.3	0.0
Trade and other receivables	41.2	59.9	64.8	5.0	23.7
Cash and cash equivalents	40.7	44.9	17.6	(27.3)	(23.1)
Total Current Assets	**110.4**	**133.1**	**111.1**	**(22.0)**	**0.6**
Current Liabilities					
Trade and other payables	(147.8)	(136.3)	(129.4)	6.9	18.4
Leases < 1 Year	(9.0)	(7.7)	(8.8)	(1.0)	0.2
Accruals	(19.8)	(27.8)	(23.9)	3.9	(4.1)
Deferred income	(4.7)	(28.2)	(25.7)	2.4	(21.1)
Dividend payable	0.0	(9.4)	0.0	9.4	0.0
Provisions < 1 year	(9.3)	(9.0)	(9.1)	(0.1)	0.2
Total Current Liabilities	**(190.6)**	**(218.4)**	**(196.9)**	**21.4**	**(6.4)**
Net Current Assets / (Liabilities)	**(80.1)**	**(85.3)**	**(85.9)**	**(0.6)**	**(5.8)**
Non Current Liabilities					
Leases > 1 Year	(43.3)	(40.9)	(40.5)	0.3	2.8
Provisions for liabilities & charges	(3.6)	(3.6)	(3.6)	0.0	0.0
Total Non Current liabilities	**(46.9)**	**(44.5)**	**(44.1)**	**0.3**	**2.8**
Total Assets/(Liabilities)	**684.5**	**672.0**	**673.2**	**1.2**	**(11.3)**
Capital and Reserves					
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	476.5	475.3	(1.2)	11.3
Total Capital & Reserves	**(684.5)**	**(672.0)**	**(673.2)**	**(1.2)**	**11.3**

The Statement of Financial Position (SOFP) at the end of Month 6 is presented in the table opposite. The key month on month movements are explained as follows:

- **Non-Current Assets -** Non-current assets increased by £1.4m as capital additions of £6.7m were offset by M6 depreciation and amortisation of £5.3m.
- **Trade and other receivables –** Trade and other receivables have increased by £5m in month, of which £3.5m relates to an increase in PCI income as a result of activity performance.
- **Cash Balances –** Cash balances reduced by £27.3m to £17.6m.
- **Trade and other payables and accruals** – Trade and other payables reduced by £6.9m, which was reflective of the settlement of the higher Tax, NI and pension creditors due to the pay award accrued at M5 and paid in M6.
- **Accruals** - Reduced by £3.9m of trade accruals, which was mainly due to a release of consumables accrual.
- **PDC Dividend** – Reduced by £9.4m as the first bi-annual payment was paid in month 6.
- **Deferred Income** – The reduction of £2.4m was due to the release of PCI income, in relation to the increase in activity performance.
- **Income and Expenditure Reserve –** The improvement in the I&E reserve of £1.2m is consistent with the in year reported income and expenditure position.

Liquidity (1/2)

Cash

The Trust cash balance at the end of September £17.6m, representing an in-month reduction of £27.3m. Main factors impacting this reduction are:

- Higher 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.
- Payment of PDC Dividends in month of £10m
- Reduction in PCI income received £6m

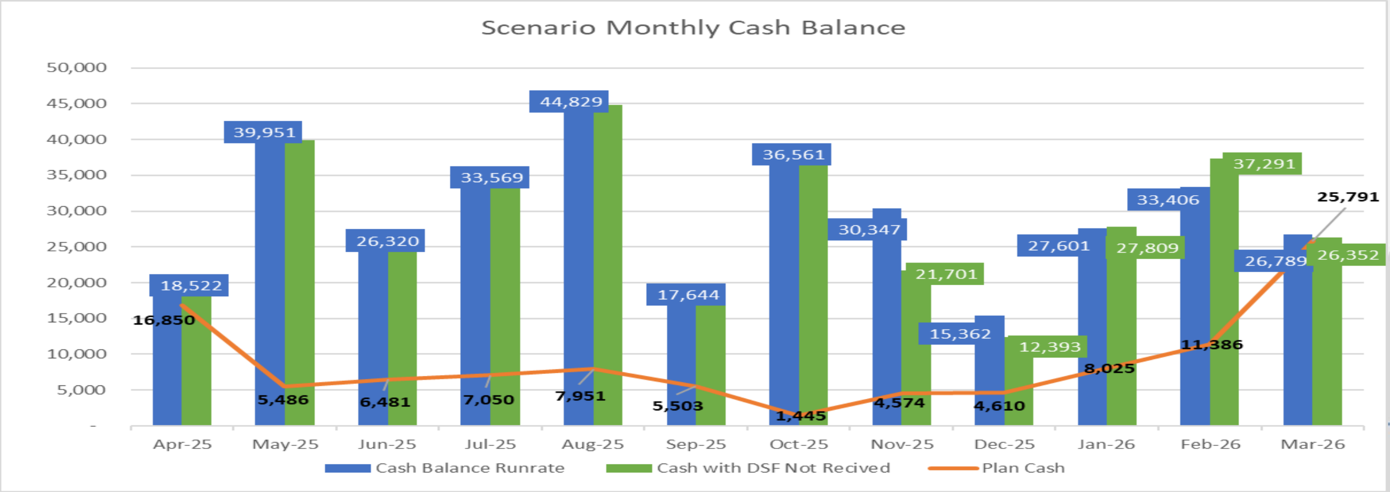
We are currently modelling two forecast cashflow scenarios:

Run rate (Blue bar and line on graphs below)

The run rate is based on latest forecast for income and run rate cash spend. With this scenario we are projecting a year end cash balance of £25.7m, consistent with delivery of the original year end cash plan. This balance at year end is necessary to make the anticipated payment runs in April 26 which will be inflated by larger capital payments due to the acceleration of capital programme commitments towards the 25/26 year end. In order to achieve this balance, we will need to reduce creditor payments by £5m in total in 25/26, In order to maintain a minimum £2m daily cash balance, we will also need to manage the timing of weekly creditor payments across weeks. For example, in October (starting on 9 October), we are forecasting we will need to defer payments runs by £11m, before being able to make those payments later in the month, when we have received funding mid month.

Deficit Support Funding Reduction (Green bar and line on graph)

This scenario assumes that the planned deficit support funding for Q3 and Q4 will not be received due to the Trust financial performance.[effective M8 onwards] We are projecting an end of year cash balance of £25.4m, to deliver minimum cash balance in Quarter 1 26/27. To achieve this the payments runs would need to be reduced by a further £25.5m in addition to the £5m reduction based on run rate (total £30.5m). As in the scenario above, the timing weekly payments will also need to be deferred to ensure minimum daily cash balances are maintained.



Liquidity (2/2)

Receivables

Out of a total debt of £12.9m (£13.1m M5) receivables over 90 days was **£5.3m** (£5.3m in M5) comprised of non-NHS £4.7m and NHS £0.6m.

Overseas Visitors over 90 day was £2.6m, of which; £1m has been referred to our credit reference agency; £1m will be put forward for write off; £0.4m is on repayment plans; and £0.3m is going through the credit control process.

Private Patients over 90 days was £245k. Sundry Companies over 90 days was £1m; £269k of VAT corrections which will be marked for write off for M6, £160k is in query and £606k going through Credit control process.

Salary Overpayments over 90 days was at £422k, of which £209k is with credit reference agency with judgements and enforcements expected. £85k will be put forward for write off and £76k have informal agreements for payment. and £52k is in dispute.

Payables

BPPC performance remained high at 98% Value and 96% volume. Total payables increased by £0.3m to £46.9m. Over 60 days increased by £1.5m, 56% of which relates to the 10 suppliers. Accounts Payable are working with the respective departments to resolve in Month 7. The key blockers for invoices being cleared in this ageing category relate to purchase order invoices; those requiring goods receipt); invoices rejected as no PO quoted; and new PO required. A P2P working group has been reestablished to develop and implement an action plan to unblock these issues, inorder to improve the automatic 3 way matching percentage (currently 67% on purchase orders) to drive efficiencies and cost reduction in Accounts Payable. This includes the roll out of a new training programme for all requisitioners to educate new starters and re-educate existing members of staff which has commenced. All requisitioners will need to attend a training session inorder to retain system access to be able to order and receipt goods and services.

	Month 6						Month 5					
	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	10,112	4,373	637	372	4,730	47%	9,471	3,709	539	530	4,694	50%
NHS receivables	2,777	1,678	305	195	599	22%	3,635	1,786	674	594	582	16%
Total receivables	**12,889**	**6,051**	**942**	**567**	**5,329**	**41%**	**13,106**	**5,495**	**1,212**	**1,123**	**5,276**	**40%**
Non-NHS payables	42,589	34,862	2,828	2,589	2,310	5%	42,807	38,042	1,186	653	2,926	7%
NHS payables	4,368	3,236	65	167	900	21%	3,820	2,965	52	32	771	20%
Total payables	**46,957**	**38,098**	**2,893**	**2,756**	**3,210**	**7%**	**46,627**	**41,007**	**1,238**	**685**	**3,697**	**8%**

Capital Programme

The Trust committed YTD gross expenditure of £23.5m in M6 against a plan of £34.9m (£16.5m at M5), which netted down to £20.0m, after deducting charitable donations/capital grants and disposals of £3.5m in month. The overall programme is therefore behind the year-to-date plan by £10.0m across all areas at month 6 (£10.8m at M5). The majority of programmes will 'catch up' over the coming months and deliver to plan. Mitigation plans to bring forward schemes from 26/27 are in place to offset forecast underspends mainly in relation to UTC, IFRS16 and Aseptic.

The current net forecast is a £60.2m against a plan of £73.3m resulting in a projected underspend is £11.1m. The slippage is largely driven by slippage on the UTC (£7.9m), IFRS16 plan (£2.4m) and Aseptic schemes (£0.9m). In order for the Trust to deliver to the plan for this financial year, underspends for these three areas requires mitigation for which there are plans in place are set out in the table below.

Mitigation plans	£m	
Forecast Underspend		
Aseptic	0.9	
UTC	7.9	
IFRS16	2.3	**11.1**
Bring Forward Plans		
MES	(5.8)	
IT Infrastructure	(1.2)	
EPR – medical records	(1.1)	
Back log Estates	(1.0)	**(9.0)**
Additional Schemes to be		
Redeployment Schemes to be set		
LRI Maternity	(0.7)	
Other	(1.4)	**(2.1)**
Total Forecast Underspend		**0.0**

		Year to Date		
£million	**Annual Plan**	**YTD Plan**	**M6 Actuals YTD**	**Variance to M5 YTD Plan**
Estates Major Schemes				
LGH Endoscopy	4.2	4.2	4.1	(0.1)
Preston Lodge (UEC)	3.6	2.5	3.1	0.6
CHP	1.4	0.0	0.0	
Mortuary	1.8	0.0	72.0	72.0
Aseptic Lab	1.0	1.0	0.0	(1.0)
UTC	10.2	1.6	0.2	(1.3)
Leicester Diabetes Centre	5.3	4.6	2.9	(1.7)
NHP	1.1	1.0	0.8	(0.2)
Total Estates Major Schemes	**28.5**	**14.7**	**83.1**	**68.3**
Other Estates Schemes	10.6	4.1	3.3	(0.8)
IM&T Programme	5.5	4.6	1.7	(3.0)
EPR	5.6	3.5	4.3	0.8
Medical Equipment	7.7	1.6	0.1	(1.4)
MES including enabling works	11.1	2.4	1.8	(0.7)
Other Capital Expenditure	3.4	(1.1)	(1.3)	(0.2)
Contingency	(0.5)	0.0	0.0	0.0
VAT Credit	(1.4)	0.0	(1.2)	(1.2)
Total Capital Programme	**70.5**	**30.0**	**91.8**	**61.8**
Funded by:				
Internally Generated	41.9	21.1	14.6	(6.5)
PDC Funded	24.3	5.2	4.0	(1.2)
Donated/Granted	4.6	4.9	3.2	(1.7)
IFRS 16	7.2	3.6	1.7	(1.9)
Total Funding	**77.9**	**34.9**	**23.5**	**(11.4)**
Donated Income/Grant Rec'd	(4.6)	(4.9)	(3.2)	1.7
Disposals - NBV	0.0	0.0	(0.0)	(0.0)
Disposals - NBV IFRS16	0.0	0.0	(0.3)	(0.3)
NET CDEL	**73.3**	**30.0**	**20.0**	**(10.0)**

The development of the 26/27 capital plan has commenced and is being led by the new Strategic Capital Group (SPG) to ensure that constrained capital resources is prioritised for key strategic and operational requirements. An initial high level draft plan for 26/27 has been prepared and will be presented to CMIC and SPG in October. Currently only c£2m is potentially uncommitted (assuming a comparable the same System allocation as 25/26), assuming de-minimus allocations are made to core infrastructure areas and allocations are made for MES, EPR, Aseptic and EPR schemes consistent with the approved business cases or planned replacement programme. A contingency of £1m is also currently included.

- 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.