University Hospitals of Northamptonshire NHS Group

University Hospitals of Leicester NHS Trust

Meeting title:	Boards of Directors of Kettering General Hospital NHS Foundation Trust (KGH), Northampton General Hospital NHS Trust (NGH) (University Hospitals of Northamptonshire NHS Group - UHN) and the University Hospitals of Leicester NHS Trust (UHL) Meeting together					
Date of the meeting:	8 May 2026					
Title:	**UHL Integrated Performance Report and Executive Summary**					
Report presented by:	Richard Mitchell Group CEO, Sarah Taylor UHL Deputy COO Emergency Care					
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	
Which Group Priorities does this link to:	Transform patient care	X	Strengthen our culture	X	Deliver our financial plan	X
Where this report has been discussed previously:	Board Committees April 2026					

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
N/A (assurance report)

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

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.

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST AND UNIVERSITY HOSPITALS OF NORTHAMPTONSHIRE GROUP

BOARD OF DIRECTORS
8 MAY 2026

Main report detail

Key headlines in performance are summarised below:

Summary of UHL Performance: MARCH 2026

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** 	March 2026 saw an increase of 1,029 Emergency Department attendances to plan with a year-to-date overperformance of 5,319 attendances. Paediatric ED saw a decrease of 559 attendances compared to March 2025 year to date though they are under by 863 thereby overall increase in the adult department. Eye Casualty in March 2026 has seen a year-to-date overperformance of 1278 attendances. 4-hour performance in March achieved the trajectory of 59.62% with a performance of 66.42% (UHL only). This achieved the March sprint of a greater than 4% improvement. LRI monthly ambulance handovers improvement has continued with the implementation of Release to Respond seeing a significant reduction in lost hours pre handover. We had 0 extended delays on ambulances (over 8 hrs). In March 2026, LRI monthly ambulance handovers over 60 minutes decreased to 3.9% (219 out of 5,567 handovers) compared to February 2026 when LRI was 10.0% (503 out of 5,013 handovers). The 12-hour performance (total time in dept) was 7.28% achieving trajectory of 8.80%. Emergency admissions were over plan by 481 admissions, year to date is 4429 admissions over plan. Actions for improvement and Achievements in March • Continuing to embed Release to Respond and 24hr in the Emergency Department SOP – resulting in significant improvement in Ambulance handovers. • Increased the number Same Day Emergency Care services – over performance against trajectory. • Implemented direct access pathways for our GP and Ambulance colleagues • Ongoing Implement the Trust's Winter plan including super surge actions • Increase the call volume through clinical bed bureau - achieved.

	• Ward improvement programme across Specialist medical wards due to completed in February – next steps are to develop a roll out plan and Length of Stay reduction programme. • Discharge improvement programme to improve flow through our hospitals.
Elective Care **Referrals and Outpatient performance** **Elective activity** **Pathway Improvements**	Performance across Elective Care remains significantly challenged, particularly in relations to waiting list size, RTT (Referral to Treatment) standards and long waits (65 week and 52 week RTT waits). Nationally there was an extension to the submission of the March 2026 RTT performance data. This was to support Trusts to ensure that all activity up until the end of March had an outcome and that the waiting list had been validated. The final submitted figures for UHL for March are a total waiting list of c. 113,973 and RTT performance of 59.09%. Data validation activity over the past 28 days has primarily focused on over 18-week pathways and selected cohorts and specialities, helping to build insight that will inform the direction of future training and improvement activity. The current expected March position for 65 week waits is 49 patients. April looks similarly challenged with the impact of Industrial Action and Easter impacting progress. Forecast for the end of April is 50-60 patients waiting 65 weeks or more. Orthopaedics remains the speciality most at risk and alone contributing to 40% of the breached patients. The current expected final March position for 52-week waits is c.2,500 patients (similar to last month) which would represent 2.17% of the total waiting list size (assuming a total waiting list size of c115,000) and is significantly above plan. The plan for 25/26 and 26/27 is to deliver less than 1% of the total waiting list over 52-weeks. Actions being taken to improve performance include: • Super clinics (Orthopaedics and general surgery) • Additional paediatric max fac clinics • Increased insourced adult max fac clinics • Use of Independent Sector (particularly for orthopaedics) • Focused validation.
Cancer **Referrals** **2 week wait** **Faster Diagnosis Standard** **62-day referral to treatment**	Referrals year to date have seen an increase of 3.9% compared to the previous year. The conversion rate year to date is 5.9% and is in line with the national average. February performance improved markedly compared to January across two of the three standards. February FDS delivered 74.5%, a 6.8% improvement on January. Breast remained the main driver of variance in February due to the ongoing capacity gap, with the emerging risk in ENT beginning to become apparent in the month's results. Both these tumour sites remain a risk for the Trust and are reliant on additional capacity, insourcing and recruitment. Whilst some improvement in Breast had been noted in the last few months, it is fragile and significant improvement is not expected until June as vacancies are filled.

	31-day performance was the second standard to see an improvement, of 9.1% to 87.2%. This standard has shown steady, sustained improvement since August 2025, supported by the wait times improving in radiotherapy and drug performance becoming more stable. 62-day performance in February saw a slight deterioration of 0.9% to 53.0%. For 62-day performance there are several key challenges across multiple tumour sites. Constraints include increased demand, additional diagnostic tests per patient and decision-making turnaround times (radiology, pathology and MDT sequencing), alongside waits to see an oncologist and surgical theatre capacity. The fragility of staffing levels, most prominent in breast radiology, pathology and ENT has increased the challenge alongside a reduced uptake of waiting list initiatives this year to mitigate these risks. Increased clinical engagement to ensure pathways are streamlined, and a continued drive to reduce backlogs to below 150 patients will be key to improving 62-day performance into 26/27.
Quality	The overall quality position continues to improve, with strengthened assurance across infection prevention and control (IPC), harm reduction and patient experience. IPC surveillance, governance and ward-level accountability arrangements are well embedded, enabling timely identification of issues and focused improvement action. This has supported a stabilising and improving position, providing increased confidence in IPC oversight. Performance relating to hospital-acquired pressure ulcers (HAPUs) has improved, reflecting sustained focus on prevention, timely risk assessment and improved documentation. Learning from harm reviews is being consistently applied, supporting a reduction in avoidable harm and more reliable care for patients at risk. Patient experience is also improving, with better timeliness in complaints responses and clearer executive oversight of delays. Learning from complaints is increasingly informing quality improvement alongside Duty of Candour and PSIRF processes, strengthening the connection between experience, safety and organisational learning. Continued focus remains in place to sustain progress during ongoing operational pressures.
Finance	The YTD position for the Trust is a deficit of £46.4m (subject to audit) against a plan of £0m. The main drivers are loss of DSF funding £25.9mA and non delivery of CIP £19.4mA. Excluding DSF, this position equates to a deficit of £85.3m, which is in line with the position notified to NHSE. Emergency/Non Elective inpatient activity continues to over-perform; at M12 the additional activity over the year equated to £28m of income that won't be received due to the block arrangement however the cost of delivery will be in the Trust's non-pay. The Trust committed net capital expenditure of £92.7m to Month 12 resulting in an underspend of £0.5m against its revised CDEL target. The cash position at the end of Month 12 was £34.7m, which is a decrease of £5.3m from M11.
Workforce	The overall Whole Time Equivalent (WTE) workforce in M12 was 18,421 WTE which is 1161 WTEs above plan (a 6.73% variance to plan) largely

driven by high bank usage and increase in Agency usage above the planned position.

Agency staff usage increased from the previous month's usage by 9 WTEs and was above plan by 9 WTE which equates to a 29.92% variance against plan. This was the first time in year for an above plan position for Agency usage. Spend remained 0.58% which is below the NHS KPI for agency spend of 3.20%. This increase was mostly within CSI (for AHPs Physiotherapy as well as within LRI Ultrasound and Chemistry reporting areas). For MSK, agency use was mostly within Medical staff within the ENT team. ESM also recorded agency use across AHPs, Qualified Nurses and Medical staff with high agency usage within N56 Ward 3 at LGH.

Bank staffing has increased compared to previous month by 79 WTE with usage at 1038 WTE which is 798 WTE above plan, equating to 332.52% over the planned position. Bank usage is mostly high in CHUGGS particularly for support to nursing staff with high usage in W64 Ward 21 at LRI and W73 Ward 35 at GGH. ESM also recorded high bank usage mostly for Qualified nursing staff with Preston Lodge recording high usage. RRCV had high bank usage mostly for Qualified Nursing staff especially within cost centre C23 Ward 20, and for Medical staff mostly within C67 Cardiology department. Overall Bank spend is recorded at 6.72% (of the total paybill) which is below the national KPI spend cap of 8%.

Contracted Substantive staff was recorded at 17,345 WTE which is 2.08% (354 WTE) above the planned position of 16,991 WTE. This year end position represents a reduction in contracted staff by 278 WTEs compared to M1 (April 2025) position which was 17,623.

Workforce turnover has remained at 7.6% in March against the 10% target.

All nursing roles now comply with the general nursing agency price cap. A key area is focus is the reduction of bank rates aligned to local benchmarking and consultation with trade unions, bank workers and key stakeholders. From 1 March following consultation, we are paying the rate for the shift, and from 1 April the rates will include WTD (working time directive annual leave), with some exceptions for lower grades to ensure their pay does not reduce below the national minimum wage.

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 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.

For 2026/27, NHSE have kept national agency price caps at the same level as 2025/26.

	Statutory and Mandatory training remains stable at 94% against the target of 95% Appraisal performance has remained at 83.1% against the 95% target. The focus remains on both improving performance and the quality of appraisals and acknowledge this has been challenging with operational demands over winter. Sickness absence is reported a month in arrears, and we have seen a 0.19% reduction in January. Over the last 12 months, the CMGs with the highest levels of absence are E&F (6.28%), W&C (5.58%) and ITAPS (4.90%). One of the key priorities in the NHS 10-year plan is to shift from sickness to prevention. A UHL working group has been established to take this forward for our workforce, along with plans to achieve the national 4.1% target. Workforce performance is reviewed through CMG Performance Review meetings, CMG Boards, Senior Leadership Teams, and Specialty Reviews. An amber rating remains in place.
Tranformation & Productivity **Key Overview** **e.g Urgent and Emergency Care, Elective, digital, Estates etc**	**Theatres** In March, overall theatre utilisation was 81.4%, representing a slight reduction from February (81.9%), with year-to-date performance at 81.5%. Trust performance continues to be rated Green (Quartile 3) on Model Hospital System. For the week ending 22nd March 2026, utilisation was 83.5%, exceeding both the peer median of 80.7% and the national median of 80.9%. Late starts have increased from 19.0% last month to 23.4%, driven primarily by LRI (38%) and UHLiC (39%). Work is underway to embed consistent 08:20 theatre walk-rounds to enable early identification and escalation of operational issues, alongside strengthened use of the ORMIS free-text field to accurately capture causes of delay and ensure clinically approved Golden Patients Cancellations remained high at 9.7%, predominantly driven by DNAs (61 cases), procedure-complexity-related overruns (56 cases), and lack of adult bed availability (39 cases). Weekly performance meetings will recommence on 22 April to drive specialty-level accountability, address root causes, and deliver a sustained reduction in on-the-day cancellations. BADS performance was reported at 80.5% in December 2026, improving from 77% in August; however, UHL remains in the lowest quartile. Underperformance is largely driven by data quality issues. Management and GIRFT support were requested at the APOM meeting on 16 April to accelerate improvement. Internal theatre data shows early improvement, but issues persist with INTMANIG coding, limiting correct management selection at listing. Trust-wide defaulting to day case remains the key improvement opportunity across all procedures with >50% target. EMPCC Super Week is scheduled for w/c 18 May. Planning is underway to increase planned surgery delivery, optimise theatre and workforce utilisation,

	reduce avoidable cancellations, and improve starts and patient flow. This is a focused improvement week - not business as usual, enabled through clinically approved Golden Patients, use of standby patients, daily huddles, rapid escalation of challenges, and visible senior leadership. **Outpatients** • Patient Initiated Follow-Up (PIFU) performance increased to 5.6% in March from 5.2% in February, bringing the year-to-date average to 5.3%. This remains above the national target of 5% but below the local target of 5.5%. Work is now underway to reset targets in line with national benchmarks and to continue working with clinical teams to identify additional pathways where PIFU can be safely and appropriately implemented. • The DNA rate decreased slightly from 6.1% to 6.0% in March, with a year-to-date position of 6.2%. DNAs remain a key area of focus due to their impact on patient access, clinic efficiency, and waiting times. A range of interventions is underway to improve performance, including strengthening patient communications, enhancing reminder processes, and targeting support for groups facing greater barriers to attendance. Sustained focus and ongoing monitoring will be required to bring DNA rates back within target. • **Appointment Reminders:** A revised Accurx reminder schedule—sending reminders at 14, 7, and 3 or 1 days prior to appointments—is technically ready but currently on hold due to dependencies with the Ambient Scribe rollout. Once resolved, implementation will be prioritised, as the enhanced reminder schedule is expected to support improved attendance and reduce DNAs. Increased character limits will also enable more tailored messaging to patients. • The rollout of Scribe will introduce a live feed from Nervecentre to Accurx, which should further strengthen the flow of communication with patients. **UEC** • 6,009 monthly SDEC attendance delivered in March (14% above monthly target) • Surpassed 25/26 target of increasing SDEC activity by 11%. Delivered increase of 19%. (an additional 6263 attendance above target) • 2,688 calls received to Clinical Bed Bureau in March which is 17 % above target compared to average calls per month previous year. • Met 25/26 target of increasing the average calls received in CBB per month by increasing calls received by 4.37% • 24hour red line patients at 1% in March, improved from 1.3% in February • Average Ambulance Time 24 minutes, a 6-minute improvement from February, and a 26-minute improvement from the same period last year. • GP to Fracture Clinic Pathway Pilot began. • Demand and Capacity piece underway to agree targets for 26/27.

Supporting documentation

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

The key changed 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

March 2026

Oversight Framework

Key Performance Indicator	Target	Jan-26	Feb-26	Mar-26	YTD	Assurance	Variation	Trend	Data Quality Assessment	Local or National Target?	Exec Lead
Clostridium Difficile per 100,000 Bed Days	167 Cases	13.6	19.3	21.3	15.0				Mar-24	Local	Chief Nurse and Medical Director
Methicillin Resistant Staphylococcus Aureus	0	0	1	1	8				Mar-24	Local	Chief Nurse and Medical Director
E-Coli per 100,000 Bed Days		13.6	17.2		16.1				TBC	No Target	Chief Nurse and Medical Director
Hospital Acquired Pressure Ulcers - All categories per 1000 bed days	1.7	2.0	2.1	1.3	1.7				Jun-21	Local	Chief Nurse and Medical Director
Sickness Absence	3%	5.2%	4.9%		5.0%				Mar-25	Local	Chief People Officer
30 Day Readmission Rate		11.2%	10.9%		10.6%				TBC	No Target	TBC
Published Summary Hospital-level Mortality Indicator (SHMI)	100				99 (Jul 24 to Jun 25)	Assurance and variance not applicable			May-21	National	Chief Nurse and Medical Director
Emergency Department 4 hour waits UHL *	61%	61.8%	63.0%	66.4%	62.8%				Mar-23	National	Chief Operating Officer
% of 12 hour waits in the Emergency Department	10.3%	11.5%	9.2%	7.3%	9.2%				Mar-23	National	Chief Operating Officer
Referral to Treatment (RTT) 18 wk performance *	62.3%	51.7%	55.7%						TBC	Local	Chief Operating Officer
Referral to Treatment (RTT) 52+ weeks as a % OF Total Incompletes *	0.9%	2.6%	2.1%						TBC	Local	Chief Operating Officer
6 Week Diagnostic Test Waiting Times *	5%	21.8%	14.3%	12.3%					Jul-23	National	Chief Operating Officer
28 Day Faster Diagnosis Standard *	80%	67.7%	74.5%		71.3%				May-24	National	Chief Operating Officer
Cancer 62 Day Combined *	70%	53.9%	53.0%		54.6%				May-24	Local	Chief Operating Officer
Trust level control level performance	£0m	-£6.7m	-£1.9m	-£5.4m	-£46.4m				Jun-22		Chief Financial Officer
Capital expenditure against plan	£93.2m	£7.8m	£8.3m	£39.6m	£92.7m				Jun-22		Chief Financial Officer

*Please note the indicators marked with * are RAG rated based on monthly plan trajectories (see slide 15 of the Integrated Performance Report for more details).*

University Hospitals Leicester

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

March 2026

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Appendix - Data Quality Assessment

Performance Overview (Safe)

Domain	Key Performance Indicator	Target	Jan-26	Feb-26	Mar-26	YTD	Assurance	Variation	Trend	Data Quality Assessment	Local or National Target?	Exec Lead
Safe	Never events	0	0	0	0	4				Nov-22	National	Chief Nurse and Medical Director
	Clostridium Difficile per 100,000 Bed Days	167 Cases	13.6	19.3	21.3	15.0				Mar-24	Local	Chief Nurse and Medical Director
	Methicillin Resistant Staphylococcus Aureus	0	0	1	1	8				Mar-24	Local	Chief Nurse and Medical Director
	Methicillin-susceptible Staphylococcus Aureus	40	3	7	1	49				Mar-24	Local	Chief Nurse and Medical Director
	All falls reported per 1000 bed days	4.0	3.4	3.7		3.2				Aug-22	Local	Chief Nurse and Medical Director
	Rate of Moderate harm and above Falls per 1,000 bed days	0.19	0.07	0.17		0.09				Aug-22	Local	Chief Nurse and Medical Director
	Hospital Acquired Pressure Ulcers - All categories per 1000 bed days	1.7	2.0	2.1	1.3	1.7				Jun-21	Local	Chief Nurse and Medical Director
	% of all adults Venous Thromboembolism Risk Assessment on Admission	95%	98.0%	97.2%	97.3%	97.3%				Oct-21	National	Chief Nurse and Medical Director
	Number of Patient Safety Incident Investigations (PSIIs) commissioned		1	1	0	14	Awating more data for assurance and variance			Nov-24	No Target	Chief Nurse and Medical Director
	Number of reported Patient Safety Incidents		2567	2348	2442	29230				Nov-24	No Target	Chief Nurse and Medical Director
	Rate of reported Patient Safety Incidents (per 1000 inpatient, outpatient and ED attendances)		18.3	17.8	16.7	18.4				Nov-24	No Target	Chief Nurse and Medical Director

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Performance Overview (Caring)

Domain	Key Performance Indicator	Target	Jan-26	Feb-26	Mar-26	YTD	Assurance	Variation	Trend	Data Quality Assessment	Local or National Target?	Exec Lead
Caring	Single Sex Breaches		43	36	15	214				Jul-22	No Target	Chief Nurse and Medical Director
	Inpatient and Day Case Friends & Family Test % Positive	95%	95%	95%	96%	96%				Jul-22	Local	Chief Nurse and Medical Director
	A&E Friends & Family Test % Positive	81%	86%	88%	88%	85%				Jul-22	Local	Chief Nurse and Medical Director
	% Complaints Responded to in Agreed Timeframe - 25 Working days	90%	70%	92%		56%				Jul-23	Local	Chief Nurse and Medical Director
	% Complaints Responded to in Agreed Timeframe - 60 Working days	90%	100%			79%				Jul-23	Local	Chief Nurse and Medical Director

Performance Overview (Well Led)

Domain	Key Performance Indicator	Target	Jan-26	Feb-26	Mar-26	YTD	Assurance	Variation	Trend	Data Quality Assessment	Local or National Target?	Exec Lead
Well Led	Turnover Rate	10%	7.2%	7.6%	7.6%		P	H		Aug-22	Local	Chief People Officer
	Sickness Absence	3%	5.2%	4.9%		5.0%	F			Mar-25	Local	Chief People Officer
	% of Staff with Annual Appraisal	95%	83.6%	83.1%	83.1%		F			Mar-25	Local	Chief People Officer
	Statutory and Mandatory Training	95%	94%	94%	94%		F	H		Dec-22	Local	Chief People Officer
	Adult Nursing Vacancies	7%	4.7%	5.3%	5.0%		?			Dec-23	Local	Chief People Officer
	Paed Nursing Vacancies	10%	3.7%	7.1%	4.3%		?	L		Dec-23	Local	Chief People Officer
	Midwives Vacancies	7%	0.0%	-4.4%	-4.4%		?	L		Dec-23	Local	Chief People Officer
	Health Care Assistants and Support Workers Vacancies - excluding Maternity	5%	18.3%	9.0%	8.4%		F	L		Dec-23	Local	Chief People Officer
	Health Care Assistants and Support Workers Vacancies - Maternity	5%	4.1%	9.4%	6.4%		P	H		Dec-23	Local	Chief People Officer
	% Bank spend of Pay Bill	8%	6.6%	6.4%	6.7%		P	H		TBC	National	Chief People Officer
	% Agency spend of Pay Bill	3.2%	0.4%	0.4%	0.6%		P	L		TBC	National	Chief People Officer
	Agency Off Framework activity- No. of shifts	0	0	0	0		Awaiting more data for assurance and variation			May-25	National	Chief People Officer
	Non Clinical Agency- No. of Staff	0	2	2	2		Awaiting more data for assurance and variation			May-25	National	Chief People Officer
	Agency Staff above Price cap	0	18	20	24		Awaiting more data for assurance and variation			May-25	National	Chief People Officer
	Agency shifts above £100/hr but not signed off by Chief Exec	0	0	0	0		Awaiting more data for assurance and variation			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		Awaiting more data for assurance and variation			May-25	National	Chief People Officer
	Bank shifts above £100/hr but not signed off by Chief Exec	0	0	0	0		Awaiting more data for assurance and variation			TBC	National	Chief People Officer

Performance Overview (Effective)

Domain	Key Performance Indicator	Target	Jan-26	Feb-26	Mar-26	YTD	Assurance	Variation	Trend	Data Quality Assessment	Local or National Target?	Exec Lead
Effective	Published Summary Hospital-level Mortality Indicator (SHMI)	100				99 (Jul 24 to Jun 25)	Assurance and variance not applicable			May-21	National	Chief Nurse and Medical Director
	12 months Hospital Standardised Mortality Ratio (HSMR)	100				102 (Sep 24 to Aug 25)	Assurance and variance not applicable			May-21	National	Chief Nurse and Medical Director
	Crude Mortality Rate		1.1%	0.8%	0.8%	0.9%				May-21	No Target	Chief Nurse and Medical Director
	DNA Rate - IMD Deciles 1 and 2	5%	9.0%	8.9%	8.8%	8.9%				Feb-24	Local	Director of Health Equality and Inclusion
	DNA Rate - IMD Deciles 3 - 10	5%	5.5%	5.4%	5.3%	5.6%				Feb-24	Local	Director of Health Equality and Inclusion

Performance Overview (Responsive Emergency Care)

Domain	Key Performance Indicator	Target	Jan-26	Feb-26	Mar-26	YTD	Assurance	Variation	Trend	Data Quality Assessment	Local or National Target?	Exec Lead
Responsive (Emergency Care)	Emergency Department 4 hour waits LLR	78%	76.4%	77.0%	79.5%	77.0%	?			Mar-23	National	Chief Operating Officer
	Emergency Department 4 hour waits UHL	61%	61.8%	63.0%	66.4%	62.8%	?	H		Mar-23	National	Chief Operating Officer
	Mean Time to Initial Assessment	15	7.3	6.9	6.2	7.8	P	L		Nov-24	National	Chief Operating Officer
	% 12 hour trolley waits in Emergency Department (DTA)	10.3%	4.5%	3.5%	2.5%	3.2%	P			Mar-23	National	Chief Operating Officer
	% of 12 hour waits in the Emergency Department	10.3%	11.5%	9.2%	7.3%	9.2%	?			Mar-23	National	Chief Operating Officer
	Average Clinical Handover time for ambulance handovers (Minutes)	30	39	30	24	39	?			Data sourced externally	Local	Chief Operating Officer
	Non Elective Average Length of Stay	7.2	7.2	7.7	7.4	7.3	?			Aug-25	Local	Chief Operating Officer
	% of Patients Discharged on Discharge Ready Date	88.3%	88.4%	87.9%	88.6%	88.4%	?			Aug-25	Local	Chief Operating Officer
	Average Delay (Post Discharge Ready Date)	3.8	4.6	4.2	4.6	4.2	?	H		Aug-25	Local	Chief Operating Officer
	Trust Bed Occupancy	92.0%	93.4%	91.5%	88.5%		?			Dec-23	National	Chief Operating Officer
	Long Stay Patients (21+ days) as a % of G&A Bed Occupancy	10%	19.4%	18.9%	18.3%		F	H		Apr-23	Local	Chief Operating Officer

Please note the in month RAG ratings are based on trajectories for some of the indicators (see slide 15).

University Hospitals Leicester

Performance Overview (Responsive Elective Care)

Domain	Key Performance Indicator	Target	Jan-26	Feb-26	Mar-26	YTD	Assurance	Variation	Trend	Data Quality Assessment	Local or National Target?	Exec Lead
Responsive (Elective Care)	Referral to Treatment Incompletes	105,500	105,825	117,449						Jun-23	Local	Chief Operating Officer
	Referral to Treatment (RTT) 18 wk performance	62.3%	51.7%	55.7%						TBC	Local	Chief Operating Officer
	Referral to Treatment (RTT) – First Attendance - % waiting less than 18 weeks	68.1%	60.9%	61.6%			Awating more data for assurance and variance			TBC	Local	Chief Operating Officer
	Referral to Treatment (RTT) 52+ weeks as a % OF Total Incompletes	0.9%	2.6%	2.1%						TBC	Local	Chief Operating Officer
	6 Week Diagnostic Test Waiting Times	5%	21.8%	14.3%	12.3%					Jul-23	National	Chief Operating Officer
	Theatre Utilisation	85.0%	80.0%	81.9%	81.4%	81.5%				Dec-23	National	Chief Operating Officer
	Patient Initiated Follow Up	5.5%	5.4%	5.1%	5.6%	5.3%				Oct-23	Local	Chief Operating Officer
	% Outpatient Did Not Attend rate	4.9%	6.1%	6.0%	6.0%	6.2%				Apr-23	Local	Chief Operating Officer
	% Outpatient Non Face to Face	25%	27.8%	27.1%	25.4%	27.7%				Apr-23	National	Chief Operating Officer

Please note the in month RAG ratings are based on trajectories for some of the indicators (see slide 15).

Performance Overview (Responsive Cancer)

Domain	Key Performance Indicator	Target	Jan-26	Feb-26	Mar-26	YTD	Assurance	Variation	Trend	Data Quality Assessment	Local or National Target?	Exec Lead
Responsive (Cancer)	28 Day Faster Diagnosis Standard	80%	67.7%	74.5%		71.3%				May-24	National	Chief Operating Officer
	Cancer 31 Day Combined	96%	78.1%	87.2%		77.5%				May-24	National	Chief Operating Officer
	62 Day Backlog Combined	152	434	414	271					Dec-24	Local	Chief Operating Officer
	Cancer 62 Day Combined	70%	53.9%	53.0%		54.6%				May-24	Local	Chief Operating Officer

Please note the in month RAG ratings are based on trajectories for some of the indicators (see slide 15).

Performance Overview (Finance)

Domain	Key Performance Indicator	Target YTD	Jan-26	Feb-26	Mar-26	YTD	Assurance	Variation	Trend	Data Quality Assessment	Exec Lead
Finance	Trust level control level performance	£0m	-£6.7m	-£1.9m	-£5.4m	- £46.4m				Jun-22	Chief Financial Officer
	Capital expenditure against plan	£93.2m	£7.8m	£8.3m	£39.6m	£92.7m				Jun-22	Chief Financial Officer
	Cost Improvement (Includes Productivity)	£91.9m	£7.2m	£7.4	£9.9m	£72.5m				Dec-23	Chief Financial Officer
	Cashflow	No Target	£5m	£27.8m	-£5.3m	£34.7m				Jun-22	Chief Financial Officer
	Aged Debt	No Target	£13.8m	£14.1m	£15.3m					Feb-24	Chief Financial Officer
	Invoices paid within 30 days (value)	95%	96%	94%	93%					Feb-24	Chief Financial Officer
	Invoices paid within 30 days (volume)	95%	91%	88%	86%					Feb-24	Chief Financial Officer

Performance Overview (Activity)

Domain	Activity Type	Plan 25/26	Plan in Month (M12)	Activity In Month (M12)	Variance In Month (M12)	Plan YTD	Actual YTD	Variance YTD	YTD Variance to 19/20
Activity	New Outpatients (inc. NFTF)	270,077	23,235	24,079	844	270,077	275,328	5,251	9,790
	Follow Up Outpatients (inc. NFTF)	601,725	51,166	42,821	-8,345	601,725	533,605	-68,120	-68,926
	Outpatient Procedures	220,367	18,550	22,652	4,101	220,367	216,524	-3,843	62,909
	Daycase	137,582	11,148	10,459	-689	137,582	117,735	-19,847	11,623
	Inpatient	22,053	1,899	2,348	448	22,053	24,655	2,602	5,191
	Emergency	114,624	10,009	10,488	479	114,624	119,030	4,406	21,160
	Non Elective	22,843	1,938	2,079	141	22,843	24,304	1,461	2,169
	Emergency Department (inc. Eye Casualty)	282,655	24,255	25,388	1,132	282,655	289,092	6,437	35,576
	Diagnostic Imaging (inc. Direct Access)	398,465	33,799	36,748	2,949	398,465	395,288	-3,177	231,638
	Other	11,473,688	942,842	1,046,029	103,187	11,473,688	12,011,484	537,796	3,441,398
	TOTAL	13,544,079	1,118,842	1,223,090	104,248	13,544,079	14,007,046	462,967	3,752,528

**Source Early Cut and Forecasting File*

The DM01 plan for imaging activity for M12 was 646 above plan in month (27,810 vs 28,456) and was 19,711 below plan YTD (333,575 vs 313,864).

Performance Overview (Productivity Dashboard)

	Productivity Dashboard v4.0 - UHL Trustwide	2025/2026 Actuals													Assurance			
	Metric (Refer to metadata for definitions, derivations, data source and SPC variation/assurance detail)	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	YTD	Variation	Assurance	25/26 Target	19/20 Baseline
£	Finance: CpWAU	4,027	3,945	4,076	3,989	4,010	3,935	4,021	3,923	3,753				3,964			-	4,250
Ops & Clinical Productivity	Ops: Avg LoS for Elective Inpatients (nights)	3.26	3.06	3.05	3.53	3.41	3.05	3.17	3.22	3.36	3.12	3.20	3.22	3.22			-	3.37
	Ops: Avg LoS for emergency admissions	3.74	3.62	3.47	3.41	3.63	3.36	3.51	3.29	3.46	3.46	3.56	3.45	3.50			-	3.85
	Ops: Bed occupancy	86.9%	85.4%	86.5%	89.3%	85.1%	87.4%	92.8%	87.4%	88.9%	93.4%	91.5%	88.4%	88.6%			-	~
	Ops: Do not meet Criteria to Reside (avg pts per day)	469	431	444	436	480	481	476	471	477	511	506	476	471			-	~
Theatres	Theatres: Capped Utilisation	83.3%	83.0%	82.7%	80.9%	80.7%	81.2%	80.7%	81.2%	80.9%	80.2%	82.0%	81.4%	81.5%			85.0%	68.1%
	Theatres: ACPL	1.97	2.00	1.97	1.97	1.99	1.99	1.98	1.92	1.96	1.90	1.96	1.98	1.97			-	2.06
	% Theatre Sessions Utilised																	
	Theatres: OTDC	8.9%	7.9%	8.0%	8.4%	8.2%	8.3%	8.4%	8.5%	8.7%	9.4%	8.9%	9.8%	8.6%			5.0%	8.5%
	Diagnostics (Endoscopy): APPL	8.00	8.10	7.10	7.40	7.50	8.80	8.50	7.80	7.30	7.70	7.90	8.30	7.87			10.50	~
Outpatients	Outpatients: Clinic Utilisation	91.8%	92.2%	92.0%	91.9%	97.0%	96.5%	96.6%	98.5%	96.7%	97.9%	97.7%	98.2%	95.6%			95.0%	90.9%
	Outpatients: DNA Rate	6.3%	6.7%	6.5%	7.0%	6.4%	6.3%	5.9%	6.1%	6.1%	6.1%	6.0%	6.0%	6.3%			5.0%	6.6%
	Outpatients: % PIFU	6.1%	6.2%	5.4%	4.5%	4.9%	4.8%	5.2%	5.5%	5.5%	5.5%	5.1%	5.7%	5.4%			5.5%	~
	Outpatient: % OPA Follow Up without procedure	54.7%	55.3%	56.3%	54.1%	53.2%	52.9%	52.1%	51.2%	51.2%	51.5%	49.9%	49.5%	52.7%			53.4%	~
	A&G: Specialist Advice Utilisation Rate	11.6	13.0	13.6	15.1	13.5	12.7	12.7	11.8	10.6	8.8			12.3			12.6	~
Diagnostics	Diagnostics: MRI Machine Productivity (Adjusted)	76.1%	76.4%	70.4%	70.1%	72.9%	70.4%	71.4%	68.9%	78.5%	72.2%	69.8%	72.7%	72.5%			-	~
	Diagnostics: MRI scans per hour	1.40	1.40	1.30	1.29	1.30	1.30	1.30	1.30	1.30	1.40	1.30	1.30	1.32			1.80	~
	Diagnostics: MRI DNA rate	3.4%	3.8%	3.4%	3.8%	4.1%	4.2%	3.9%	3.7%	4.1%	2.9%	3.4%	3.6%	3.7%			3.0%	~
	Diagnostics (Endoscopy): In session booked utilisation	94.1%	94.3%	89.1%	90.5%	90.4%	92.5%	95.6%	93.4%	86.4%	83.4%	83.3%	90.2%	90.3%			95.0%	~
	Diagnostics (Endoscopy): In session actual utilisation	86.9%	87.7%	81.6%	83.5%	80.3%	85.2%	86.0%	85.3%	79.1%	76.6%	76.3%	82.6%	82.6%			85.0%	~
	Diagnostics: CT Machine Productivity (Adjusted)	79.8%	86.8%	78.4%	77.5%	74.3%	78.2%	82.0%	72.2%	72.0%	79.1%	90.4%	80.8%	79.3%			-	~
	Diagnostics: CT scans per hour	2.19	2.39	2.20	2.13	2.00	2.10	2.30	2.00	2.10	2.30	2.50	2.40	2.22			3.30	~
	Diagnostics: CT DNA rate	3.2%	3.0%	3.5%	3.0%	2.8%	2.7%	2.9%	2.6%	3.2%	1.8%	2.8%	2.9%	2.9%			3.0%	~

Performance Overview (Productivity Dashboard Commentary)

Section	Commentary
Finance	December 25 latest available update. In year CPWAU may be impacted on by move to Nerve Centre PAS and subsequent DQ issues.
Ops & Clinical Productivity	Emergency LoS reduced again in March - year to date lower than 19/20 Baseline. Further plans for continuing improvement in place. Bed occupancy remains high but reducing as Winter pressures decrease. Criteria to Reside also continues to improve in March.
Theatres	See escalation report: Responsive (Elective Care)- Theatre Utilisation for further detail. Theatre utilisation and average case per list remains stable above 80% for capped theatre utilisation. All specialities are being asked to focus on initiatives to reduce on the day cancellation rates across the Trust for the first quarter of the year. This indicator remains high- above the Trust target of 5% and is the single biggest factor in preventing further improvements in overall theatre utilisation.
Outpatients	Outpatient performance remains strong with a significant improvement seen in March for patients added to a PIFU which is positive. More work needs to occur on reducing DNA/DNB rates for clinics, with little progress made across the year, see escalation report: Responsive (Elective Care)-Outpatient DNA rate.
Diagnostics	Endoscopy APPL remains well below target, however shows improvement in March. MRI productivity (adjusted) remains below target in March, with no sustained recovery from the mid year decline. MRI scans per hour remain static and significantly below the expected standard. Endoscopy actual utilisation remains below target but records an improvement in March. Booked utilisation shows improvement as well. CT productivity has deteriorated compared to February and remains below target overall. CT scans per hour remain well below the required level. DNA rates remain low, confirming that capacity and flow, not attendance, are the main constraints.

Performance Overview (Workforce Performance Overview)

Activity Type	WTE	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26
Performance against the workforce plan (Contracted Substantive)	Planned in Month	17,650	17,646	17,653	17,663	17,641	17,528	17,483	17,438	17,393	17,215	17,170
	Actuals in Month	17,623	17,590	17,547	17,486	17,562	17,507	17,487	17,464	17,427	17,389	17,373
	Variance (Actual vs Plan)	-27	-56	-107	-178	-78	-20	5	27	34	174	203
	% Variance (Actual vs Plan)	-0.15%	-0.32%	-0.61%	-1.01%	-0.44%	-0.12%	0.03%	0.15%	0.20%	1.01%	1.19%

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

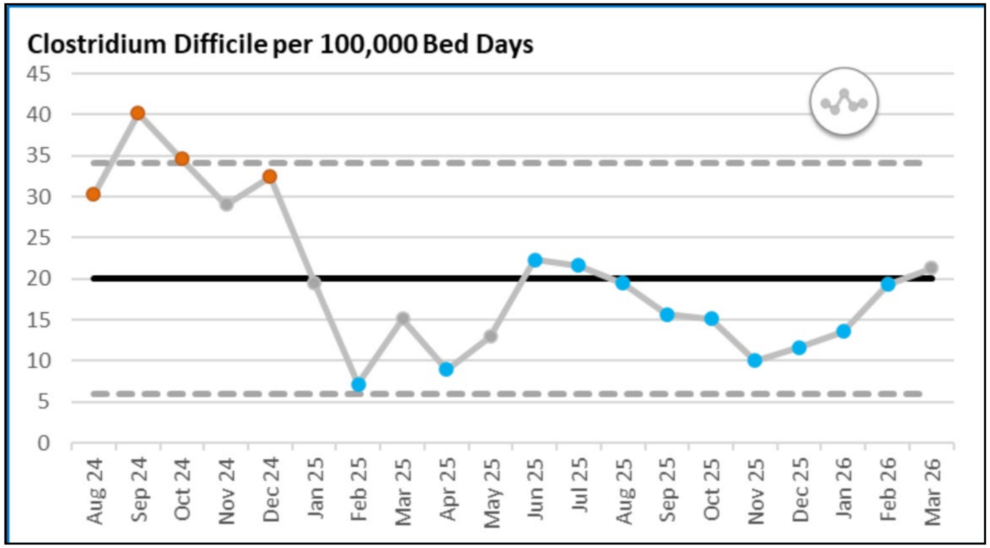
Exception Reports

Finance

Appendix - Data Quality Assessment

University Hospitals Leicester

Safe – Clostridium Difficile per 100,000 Bed Days



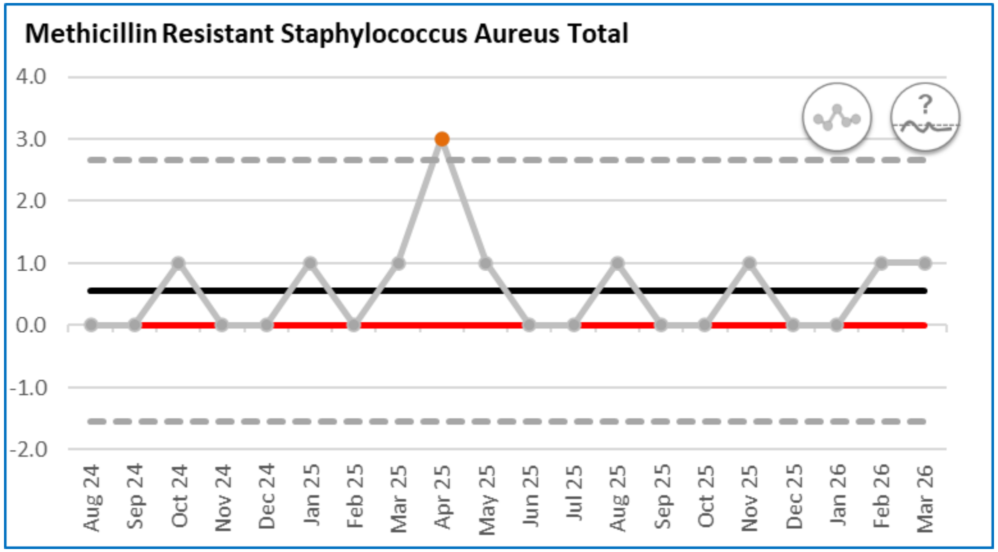
Number of Cases			Number of Cases per 100,000 bed days		
Mar 25	YTD	Target	Mar 25	YTD	Target
18	147	167	21.33	15	

National Position & Overview

	March 25	Total	
CDIFF NHSE Threshold 25/26	14	167	
* Actual Infections (HOHA) 25/26	11	92	
* Actual Infections (COHA) 25/26	7	55	
*** Actual Infections Total (HOHA & COHA)** 25/26	18	147	
UHL 100,000 Bed Days (HOHA) 25/26	21.33	**15**	***YTD UKHSA Report**
National Average	16.88		
National Highest	76.61		
National Lowest	0		

Root Cause	Actions	Impact/Timescale
• No changes to current themes identified in previous month across UHL; Themes include: • Delay in identification of cases ifive tool under utilised • Delay in isolation into a single room on suspicion of infection. • Delay in antimicrobial treatment • Poor compliance with stool chart documentation • Laxatives not reviewed for altered bowel output prior to specimen sent.	• A CDI report and reduction plan was submitted to TIPAC Q3 and was discussed at TIPOG on the 5th February. • CMGs are working towards actions identified in the UHL CDI Reduction Plan • These are identified on the Action Trackers for each CMG and monitored via TIPOG • IP PSIRF reviews (Patient Safety Incident Response Framework) are completed for CDI cases, and where required an MDT table top review	• Any immediate actions to be taken will be raised in TIPOG and the wards accordingly and this was further discussed with CMGS at TIPOG 16.04.2026 • CDI thematic review to be submitted for Q4 to TIPAC

Safe – Methicillin Resistant Staphylococcus Aureus

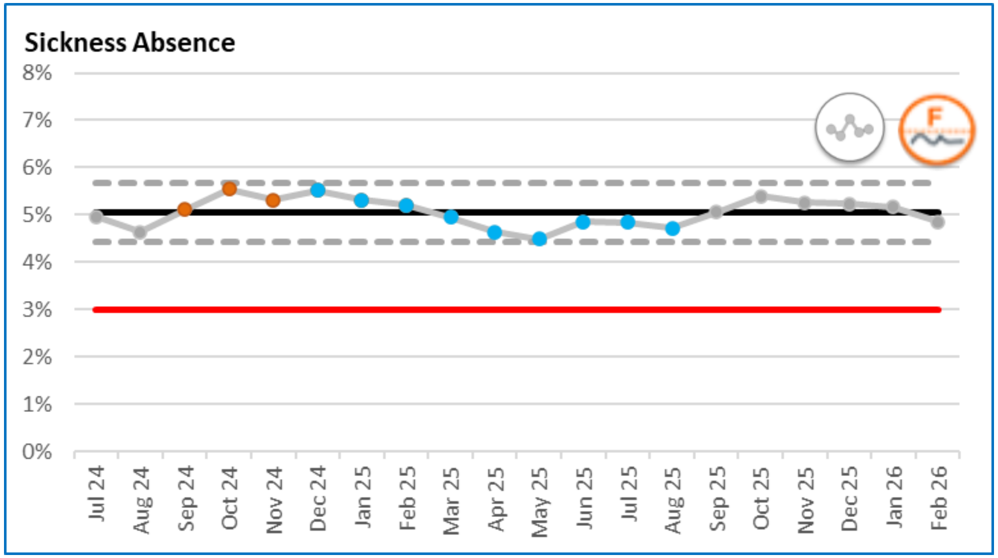


Current Performance		
Mar 25	YTD	Target
1	8	0

National Position & Overview			
	Mar 26	Total	
MSSA NHSE Threshold 25/26	0	0	
* Actual Infections (HOHA) 25/26	1	8	
* Actual Infections (COHA) 25/26	0	0	
*** Actual Infections Total (HOHA & COHA)** 25/26	1	8	
UHL 100,000 Bed Days (HOHA) 25/26	1.94	1.33	***YTD UKHSA Report**
National Average	0.67		
National Highest	11.27		
National Lowest	0		

Root Cause	Actions	Impact/Timescale
• Initial review of Trust wide MRSA policy audit and adherence to practice indicated improvement in compliance with the MRSA policy is required. • This was the findings upon review of this case. • Please note this data refers to HOHA cases only, which are in the sphere of UHL review	• Revised IP PSIRF (Patient Safety Incident Response Framework) for HCAI, including MRSA bloodstream infections, has been developed and has been used for this case. • All CMG have completed an MRSA reduction plan and these will be reviewed and managed through TIPOG. Actions will be discussed and the importance of policy compliance reiterated • The first Vascular Access Report from the Transformation Team is now in draft form and is being reviewed.	• MRSA reduction plan was specifically reviewed on the16.04.2026 TIPOG with CMGs • A thematic review of the year 25/26 MRSA incidence will be presented during Q1 to the Quality and Safety Committee

Well Led – Sickness Absence



Current Performance		
Feb 26	YTD	Target
4.9%	5.0%	3%

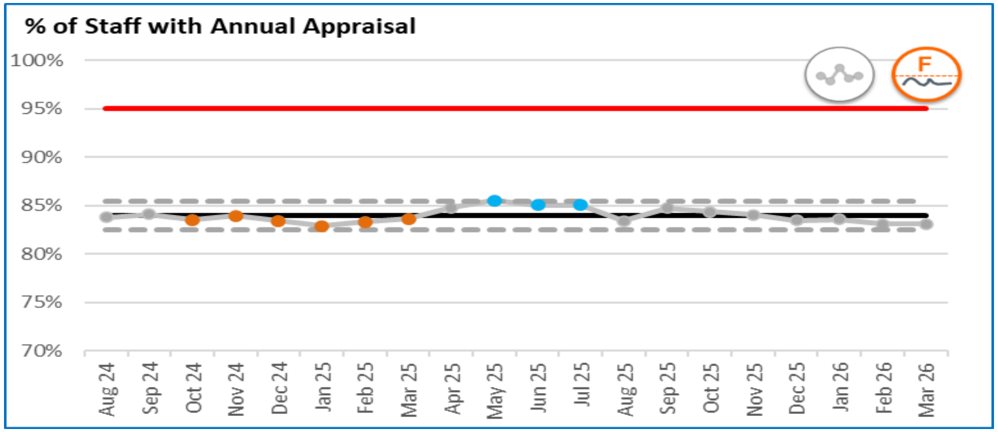
National Position & Overview

Peer data not available.

The February sickness absences rates shows a reduction of 0.19% to the previous month.

Root Cause	Actions	Impact/Timescale
• Clinical CMG's have seen a 021% reduction and Corporate Directorates a 0.10 increase in February December. • Over the last 12 months, the highest levels of absence are in E&F (6.28%), W&C (5.58%) and ITAPS (4.90%). • The areas achieving the 3% target are within the Corporate Directorates • The top 3 reasons for sickness absence are anxiety/stress/depression (23.27%), Other known reasons (15.84%) and cough/cold/flu (10.85%)	• One of the key priorities in the NHS 10-year plan is to shift from sickness to prevention. A UHL working group has been established to take this forward for our workforce, along with plans to achieve the national 4.1% target. • Nursing and Midwifery have also set up a staff group specific working group to review sickness absence / improve attendance. • 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. • CMGs are taking local targeted actions to support the wellbeing of colleagues and management of sickness absence. • For longstanding and complex cases, case conferences with OH occur. • The ER and Health and Wellbeing UHL Connect site covers all aspects of support, training, information, TALK toolkit for wellbeing conversations, template documents etc.	• The NHS Long Term Workforce Plan highlights improved retention of our workforce as one of its key pillars, which includes supporting them to stay well. • Through the 2025 Staff Survey results, we have seen a decline in our score by 0.08 but remain above our comparators by 0.16 in the People Promise Theme "We are safe and healthy". • We have sustained the improvement in recording reasons for sickness absence over the last year where in 24/25 M8 we had 10.06% of absences recorded as 'unknown' reason, and in 25/26 M11we are at 1.97%.

Well Led – % of Staff with Annual Appraisal



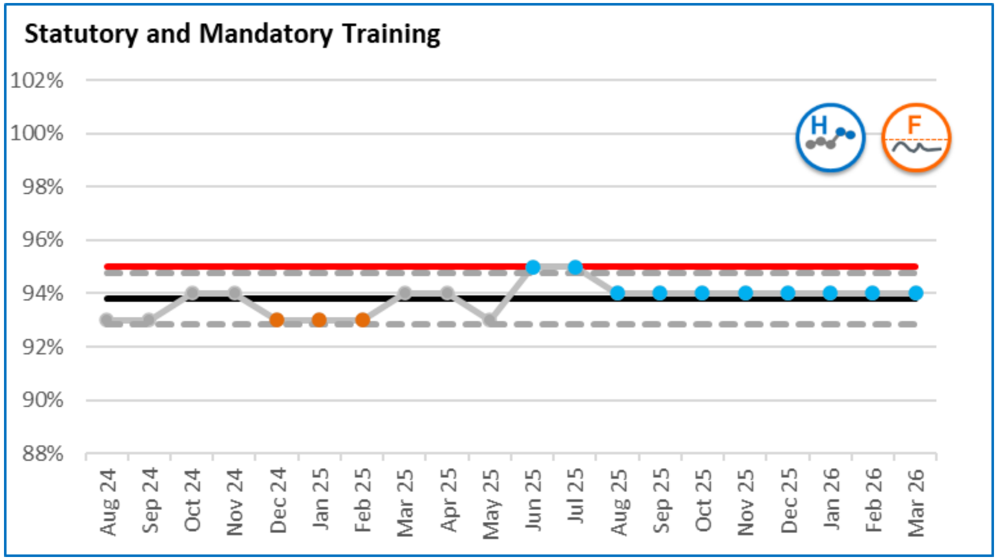
Current Performance		
Mar 26	YTD	Target
83.1%	-	95%

National Position & Overview

Peer data not available.
The March figure shows a static position the previous month. We are still 11.9% away from the Trust target of 95%.

Root Cause	Actions	Impact/Timescale
• A number of colleagues have had appraisals within the last 12 months, outside the reporting/ incremental date and therefore show as non-compliant. • Appraisal reporting/ inputting is still a contributing factor in some areas and continued plans are underway to support capturing this across services. This is regularly highlighted as impacting the data. • In month, the appraisal average for UHL has been static. • The Trust's overall compliance in month has been due to marginal increases in mainly clinical areas and decreases more noticeably in corporate services.	• It is 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 in these areas. • The roll out of Managers Self-Serve should see improvements in appraisal performance, particularly through reporting (see 'root cause') • The automation agenda also sees the review of the appraisal system to create administrative efficiencies, improve reporting and to allow a better focus on talent conversations. Implementation is envisaged to be May 2026 Trustwide • Line managers are asked to review appraisal performance and identify any additional targeted support required	• In March 2025 Appraisal performance was at 83.6%, an increase in compliance on the previous month of February 2025, and surpassing this month's compliance. • Appraisals are reviewed through regular line management, service and Board oversight meetings. • CMG/ Directorate leadership are to focus on quality appraisal discussions as essential to the employee experience and achieving our key objectives within areas this year. Engagement work has taken place to review how we carry out appraisals. • The 2025 Staff Survey results show that career progression and talent management will be areas of focus under the Diversity and Equality agenda, all linked to appraisal conversations.

Well Led – Statutory and Mandatory Training



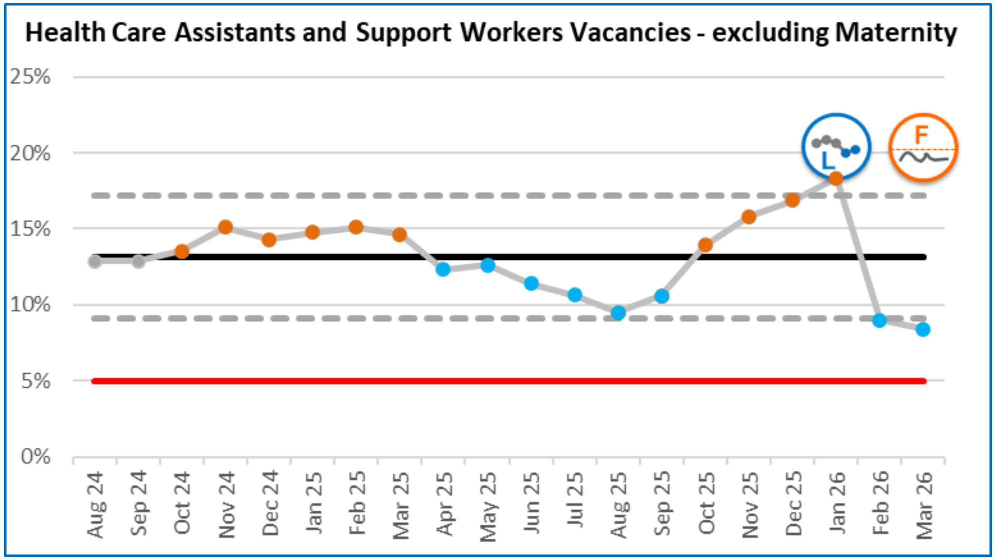
Current Performance		
Mar 26	YTD	Target
94%	-	95%

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, visitor and staff safety.	Performance against trajectories is being monitored via Trustwide Performance Reviews. Access to compliance data and emailed reports to 3086 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. The Workforce, Training and Education Steering Group (WTESG) and the Mandatory Learning Oversight Group (MLOG) 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 – HCA and Support Workers Vacancies – excluding Maternity



Current Performance		
Mar 26	YTD	Target
8.4%	-	5%

National Position & Overview

Root Cause	Actions	Impact/Timescale

• Several areas are currently reviewing the proportion of unregistered staff within their workforce and reassessing the optimal skill mix. Consequently, recruitment activity has progressed more slowly while these evaluations are underway but this has had a positive impact on reducing HCA vacancies	• Nursing and Midwifery Annual Establishment Review (NMAER) approved by Trust Board on Thursday 12th February 2026. This will be enacted in M1	Recruitment drive progress:
		• Band 2-3 pathway:
		  • Dec-25 = 12wte (9 within pre-employment checks, 3 applicants with start dates).
		  • Mar-26 = advert closed 04/03/2026; 16 colleagues appointed.
		
		• Band 3 HCA:
		  • Interviews to taken place on 20/03/2026., with between 70-80 colleagues appointed.

Well Led – Non Clinical Agency- No. of Staff

Current Performance		
Mar 26	YTD	Target
2	39	0

Awaiting more data for SPC chart

National Position & Overview

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

Root Cause	Actions	Impact/Timescale
• There are 2 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 These workers are funded from the capital and not revenue. These roles are supported by the Director of Estates & Facilities . 1 agency worker left on 20th March which leaves 1 remaining agency worker. The service has been advised not to procure any further agency workers.

Well Led – Agency Staff above Price cap

Awaiting more data for SPC chart

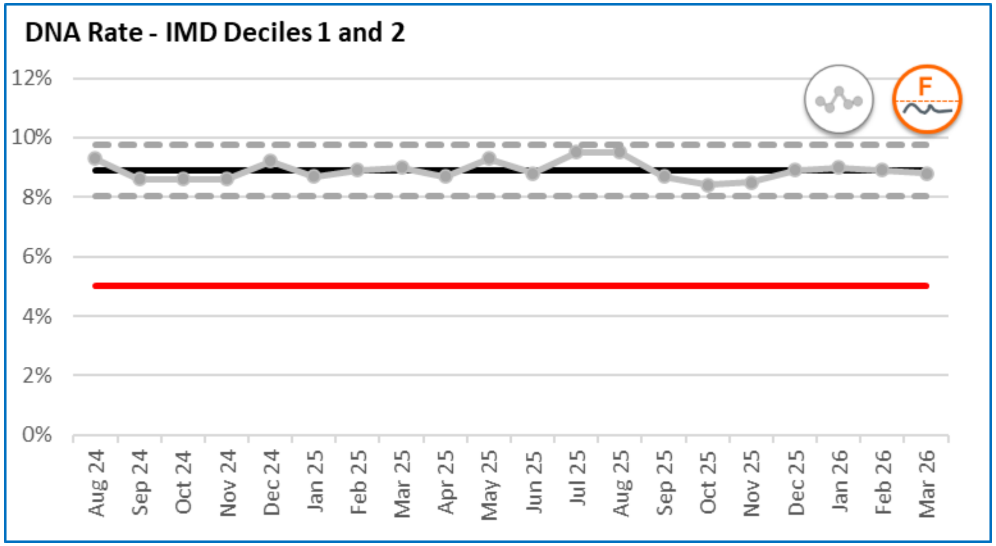
Current Performance		
Mar 26	YTD	Target
24	287	0

National Position & Overview

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

Root Cause	Actions	Impact/Timescale
• Historically, all medical posts are over the agency price caps – this is a national issue • AHP specialist roles such as Sonography, Radiography 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. There has been an increase of 4 additional workers since last month over price cap within the medical staff group due to the service requirements which have received the relevant approval levels. These are in MSS Orthopaedics	Agency price caps have been confirmed to remain the same from April 26 by NHSE. The price cap breaches continue to be reported to NHSE on a monthly basis. Attendance at regional NHSE steering groups continues. Exit plans aligned to recruitment plans are being progressed.

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



DNA Rate – IMD Deciles 1-2			DNA Rate – IMD Deciles 3-10		
Mar 26	YTD	Target	Mar 26	YTD	Target
8.8%	8.9%	5%	5.3%	5.6%	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

- The DNA Florey is no longer being sent to patients, as of Jan 2026, therefore there is no in month root cause data.
- However consistent themes that have emerged over the course of the DNA florey have been:

1. Patients or carers tried to contact UHL to cancel but could not get through.
2. Patients had a mobility issue that meant they were unable to access the sites.
3. Patients had a medical or health reason for not attending on the day.

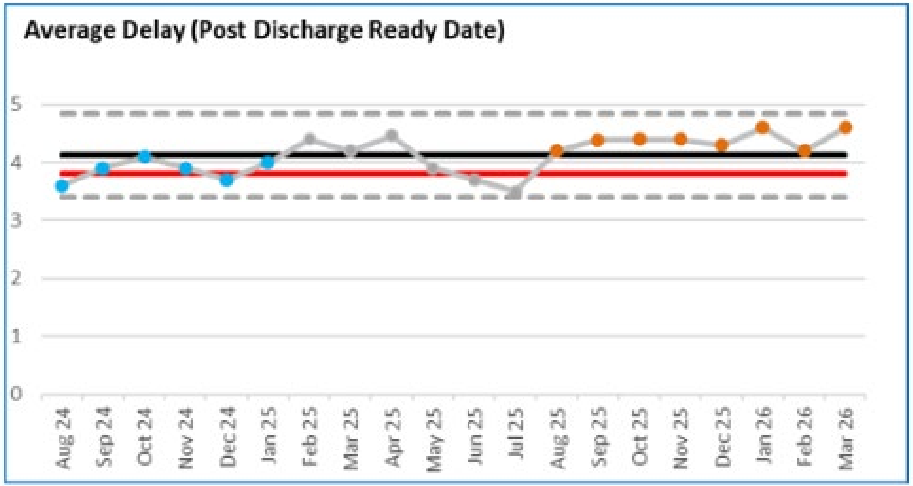
Actions

- 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.
- Community engagement to explore barriers.
- Trialing of AI to support cancellations/re-booking.
- Work starting in Community services.

Impact/Timescale

- IMDs 1 & 2 have an average DNA rate of **10%** for Mar 26. Disaggregated by contact these rates are:
- **IMD1**
- Patients contacted DNA rate 4.96%
- Patients not contacted DNA rate 13.27%
- **IMD2:**
- Patients contacted DNA rate 3.9%
- Patients not contacted DNA rate 18.03%
- **Inclusion Healthcare:**
- DNA rate for those contacted 0%
- DNA rate for those not contacted 12.5%
- **Paediatric Outpatients**
- WNB rate contacted 4.2%
- WNB rate not contacted 23.33%

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



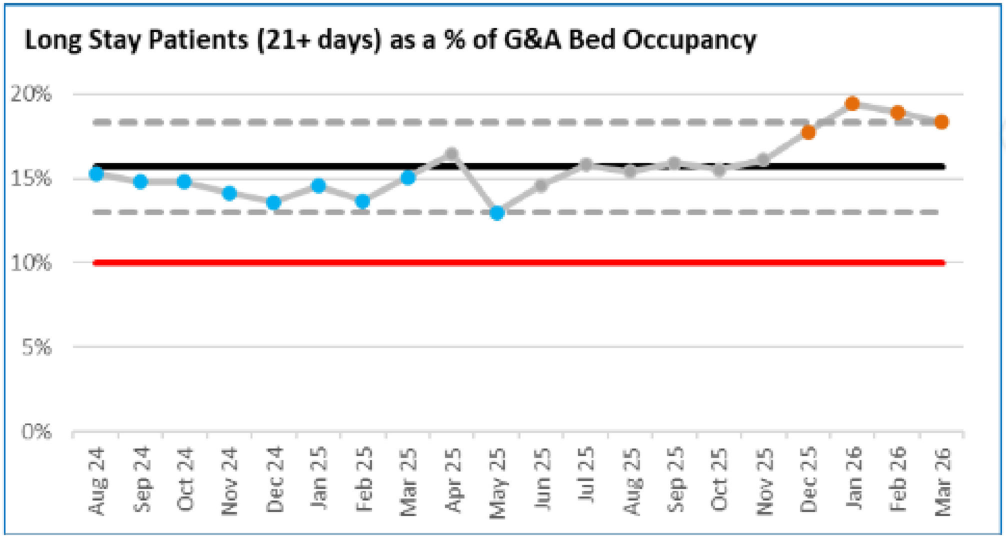
Current Performance		
Mar 26	YTD	Target
4.6	4.2	3.8

National Position & Overview

In January, UHL ranked 33 out of 117 Acute Trusts that submitted acceptable data. The National average was 5.9. 20 out of the 117 Acute Trusts achieved the target. UHL ranked 6 out of the 18 UHL Peer Trusts. The best value within our peer group was 2.1 and the worst value was 9.8.

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) **286 complex patients stayed an additional night in hospital in March 63 patients more than February (223 February)** • **LLR system discharge hub interface and capacity delays** continue to impact the ability to provide timely P1-3 discharge plans . **99 Patients waiting at the end of March.** • **Deterioration in LOS from MOFD to discharge for P1 (0.46 days from Feb) P3 (2.42 days from Feb).**	•**Continue weekly escalation meetings** with Adult Social Care and CMGs to address long waits, ensuring themes for action are identified and tracked. •**Assess the underlying causes for discharge delays** and highlight recurring themes to inform transformation initiatives. •**Increase early patient referrals** currently at 38% March (39% February) through targeted engagement and process improvements. •**Share learning from LEAF and wider discharge QI projects** to inform approach to practice. •Undertake Pathway 0-3 events during April.	• 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



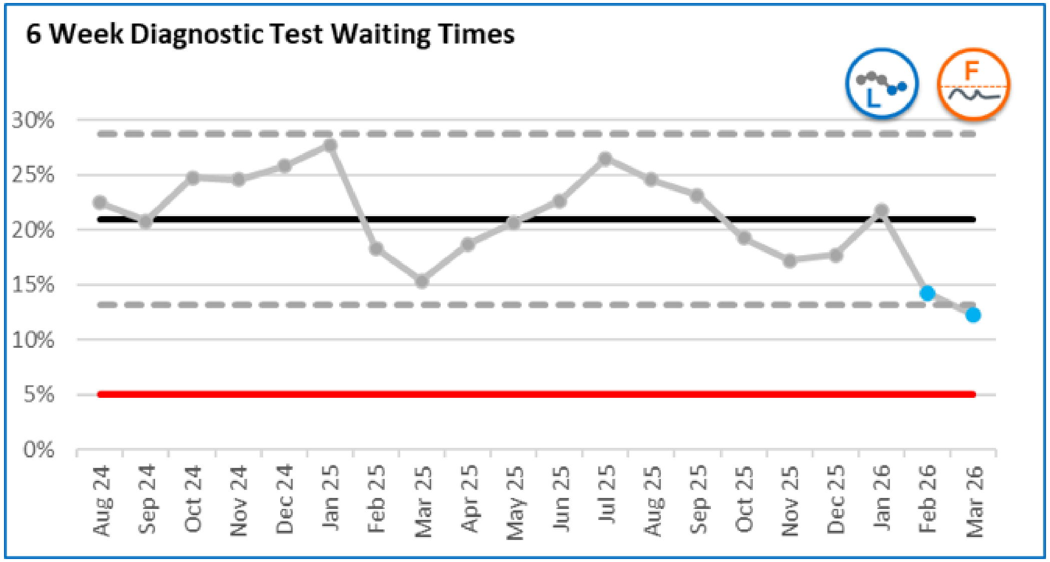
Current Performance		
Mar 26	YTD	Target
18.3%	-	10%

National Position & Overview

- 64 (340) Patients (19%) are receiving appropriate care/ treatment on a neuro rehabilitation or brain injury pathway or on an Intensive Care Unit, Infectious Diseases Unit or in UHL at Preston Lodge (26 patients).
- 75 Patients (22%) are medically optimised complex patients awaiting discharge with no reason to stay in an Acute Trust.
- Approx. 80 (24%) patients data quality issue (not UHL inpatient)

Root Cause	Actions	Impact/Timescale
• **Data quality issues (Approx. 80) continue** to arise following PAS changes. These include the system pulling pre-admission codes, delays in discharge coding, and missing outcomes. • **LLR system discharge hub interface and capacity delays** As of the end of March there were around 75 patients with length of stay over 21 days awaiting a confirmed discharge outcome from LLR.	• A weekly Power BI DQ dashboard highlights patients needing outcomes, with issues monitored through the PAS Data Quality Improvement Plan • Collaborate with Nervecentre to resolve the system fault that is preventing discharge coding from being completed after three months **Throughout April 2026:** **Work with health and social care system partners to:** • Maximise the use of P1/ P2 capacity in LLR. • Discuss >1 week for discharge outcome cases weekly. **Work with CMG's to:** • Promote the early referral of patients to the discharge hub prior to being MOFD. (**38% March** 39% February, 32% January). • Maintain Weekly CMG reviews of > 21 day patients and top 100 day patients • Review impact of Stroke ward PDSA on LoS having an additional 2 therapists.	• Aim to reduce number of MOFD patients waiting for discharge in UHL beds. • Reduce time to discharge from MOFD identification. • Increase use of Virtual wards and criteria led discharge where possible • Staff feel better equipped to manage and coordinate the safe discharge and transfer of Patients

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



Current Performance		
March 26	March Plan	Target
12.3%	5%	5.0%

National Position & Overview

Published National data at the end of Feb'26 shows 1.86m patients on the diagnostic waiting list with 20.2% waiting over 6 weeks. For Mar'26, UHL with 23,635 patients would comparatively rank as the 15th highest waiting list. The 6-week trajectory for March was set to deliver 5%, the actual was 12.3%, 7.3% behind plan, driven by Endoscopy, Sleep, Audiology and Echo. There were 2,902 patients waiting >6 weeks, an improvement of 485 patients from Feb '26.

Root Cause	Actions	Impact/Timescale

Diagnostics pressure areas are in the main:
• Endoscopy
• Sleep
• Audiology
• Echocardiography
 	
Root cause
• Clinical & administration workforce gaps
• Reporting and coding errors
• Pressure from emergency, cancer and elective long wait pathways
	• QLIK & PAS WLMDS Data Quality training
	• Improve productivity
	• Increase capacity
	  ◦ New endoscopy unit – opened Nov 25
	  ◦ Hinckley Community Diagnostics Centre – opened June 25
	  ◦ Additional lists (Echo, Audiology)
	• Review demand data with ICB
	• Expand direct access diagnostics
	• 5year MRI/CT D&C plan – complete, £ assessment underway as part of CDC expansion business case.
	• Scope possible CDC expansion opportunities
		• Validation & DQ – ongoing, work in progress with Digital/NC support.
		• Productivity - Improvements seen in CT DNA, MRI productivity and Endoscopy. Sleep paediatric, Cystoscopy and Urodynamics utilisation remain above 90%.
		• Endoscopy – behind plan due to A&C workforce. Weekly escalations in place and additional staff being recruited. Recovery actions to be shared with Committee members this month.
		• Sleep quality improvement project commenced with RTT prioritised, recovery expected later in Q1.
		• Audiology – ERF supporting additional activity, workforce review in progress.
		• CDC & direct access opportunities scoped, await outcome of expansion business case.

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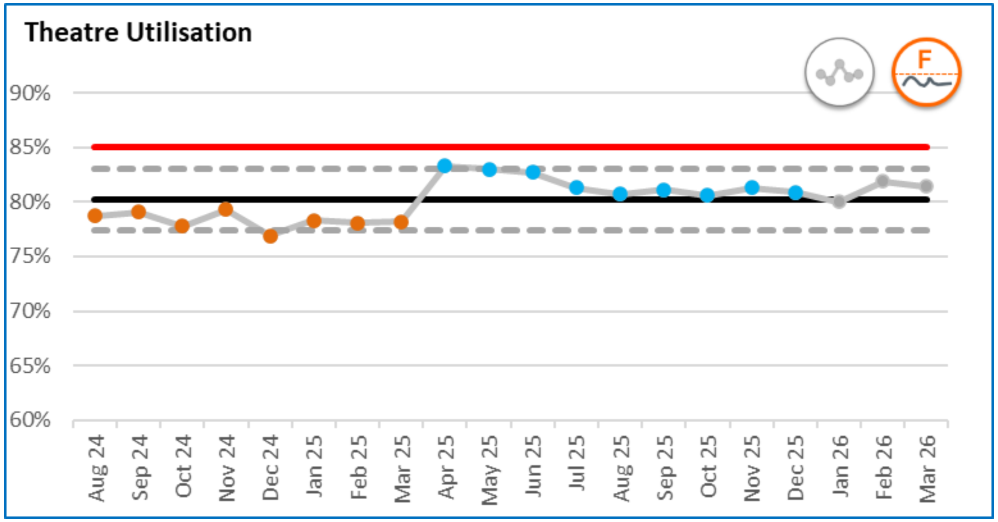
Responsive (Elective Care) – Theatre Utilisation



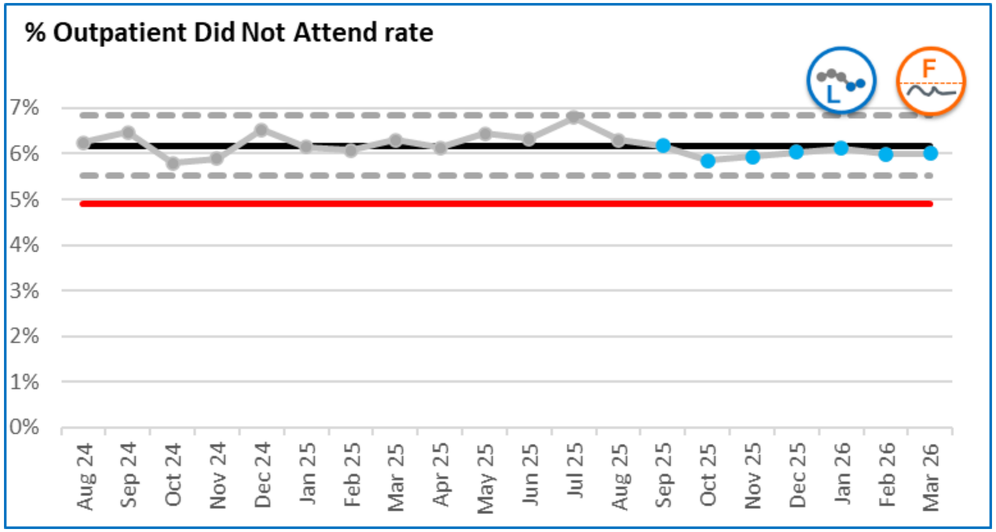
Current Performance		
Mar 26	YTD	Target
81.4%	81.5%	85%

National Position & Overview

In March, overall theatre utilisation was 81.4%, representing a slight reduction from February (81.9%), with year-to-date performance at 81.5%.Trust performance continues to be rated Green (Quartile 3) on Model Hospital System. For the week ending 22nd March 2026, utilisation was 83.5%, exceeding both the peer median of 80.7% and the national median of 80.9%

Root Cause	Actions	Impact/Timescale
• LGH: Utilisation 84.9%, continued improvement. • UHLiC: Utilisation 82.3%, improvement; late starts increased by 9% (from 30% to 39%). Work ongoing to improve scheduling using consultant-level procedural times to reduce underruns (>45 mins) and increase ACPL. • EMPCC: Utilisation 77.2%, static. Only 2 of 8 specialties above 85%. High cancellations at 8.2% (44 patients) occurring across all the pathway. • LRI: Utilisation 75.5%, declining. Emergency and bed pressures drove 62 cancellations (26%). OTDCs (11.7%) and late starts (38.2%) are increasing, with significant specialty variation (83.1%–32.9%). Paediatric services remain among the lowest-performing lists, with paediatric and adult utilisation at 69.9% and 77.5% respectively.	• Weekly performance meetings (from April) to drive a reduction in on-the-day cancellations (OTDC), with clear specialty-level ownership and routine weekly performance tracking. • UHLiC: Implementation of targeted actions to reduce late starts, including mandatory use of the golden patient model across all operating lists. • EMPCC suitability: 50-patient enhanced pre-assessment and anaesthetic review pilot to address suitability-related cancellations (currently delayed). • EMPCC "Super Week" (May): Enhanced patient preparation, embedding best practice and ensuring patients are confirmed fit prior to TCI. • LRI – late starts: Strengthened monitoring and escalation of recurrent delays, alongside process review to improve start-time performance (May – supported by recruitment of a new Service Manager). • LRI: Focused specialty-level performance reviews, prioritising Paediatric services.	• Weekly performance meetings (staring 22nd April): Expected to drive service level actions and drive OTDC supporting utilisation >85% . • UHLiC -To reduce late starts and first-case delays by ensuring a fully prepared and confirmed first patient for each list, allowing theatre set up and prompt start. • EMPCC Suitability Trial (due to start 23rd April – delayed due to POA staffing gaps): Expected to reduce clinical / suitability-related cancellations. • EMPCC Super Week (May): Will test and refine operational processes, identify what works well and inform future best-practice models to improve productivity (planning in progress) • LRI Late Starts: Expected to stabilise and reduce • Paediatric - Expected to reduce specialty-level variation, improve utilisation, and support recovery in overall site (LRI) performance

Responsive (Elective Care) – Outpatient DNA Rate

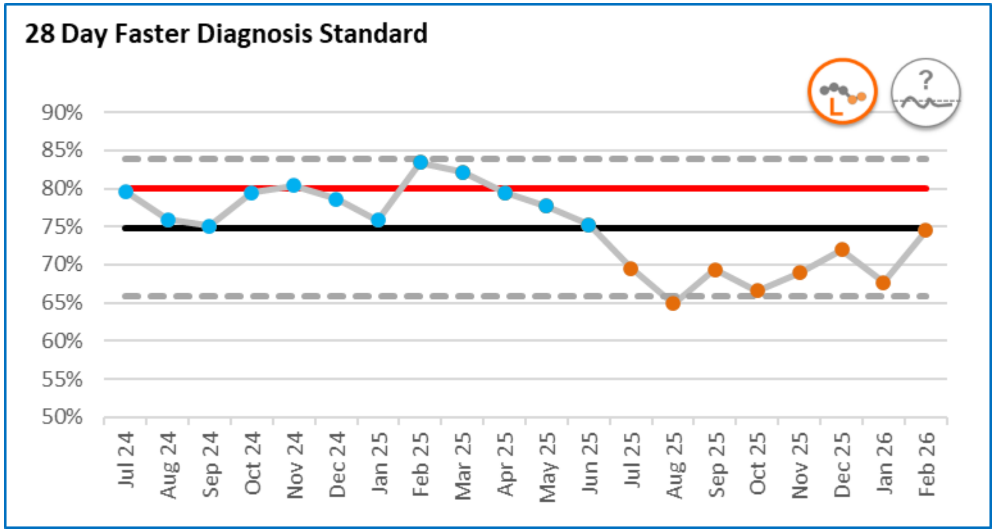


Current Performance		
Mar 26	YTD	Target
6.0%	6.2%	4.9%

National Position & Overview

Root Cause	Actions	Impact/Timescale
1. The launch of Nervecentre PAS has meant continuous issues with the data feed going to Accurx so patients aren't always receiving automated reminders 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 6. The NHS App currently allows patients to request to cancel/rebook up to midnight the day before their appointment.	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. 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 6. Text fragments has increased to allow services to add bespoke messages to automated appointment reminders 7. Awaiting a decision from IT on whether to increase cancellation window in NHS App as there's a cost	• 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			
Feb 26	YTD	Feb Plan	Target
74.5%	71.3%	79.0%	80%

National Position & Overview

In February, UHL ranked 119 out of 141 Acute Trusts. The National average was 80.5%. 110 out of the 141 Acute Trusts achieved the target. UHL ranked 16 out of the 18 UHL Peer Trusts. The best value within our peer group was 86.0%, the worst value was 63.5% and the median value was 82.5%.
UHL's performance deterioration is due to a loss of capacity in Breast and ENT which has been unable to be mitigated.

Root Cause

The root cause is due to the loss of capacity in Breast since Q2 and ENT Q4.
There is a

- Demand & Capacity gap for 1st appointments in Breast (50 slots per week) usually covered with WLI/Insourcing. In addition to a decline in uptake of Breast WLI cover.
- ENT consultant gap which has been unable to be consistently backfilled

This has caused time to first appointment to extend for both tumour sites, resulting in a decline in FDS performance since Jul 25.
Without this loss of capacity, performance in February would have been above 80%.

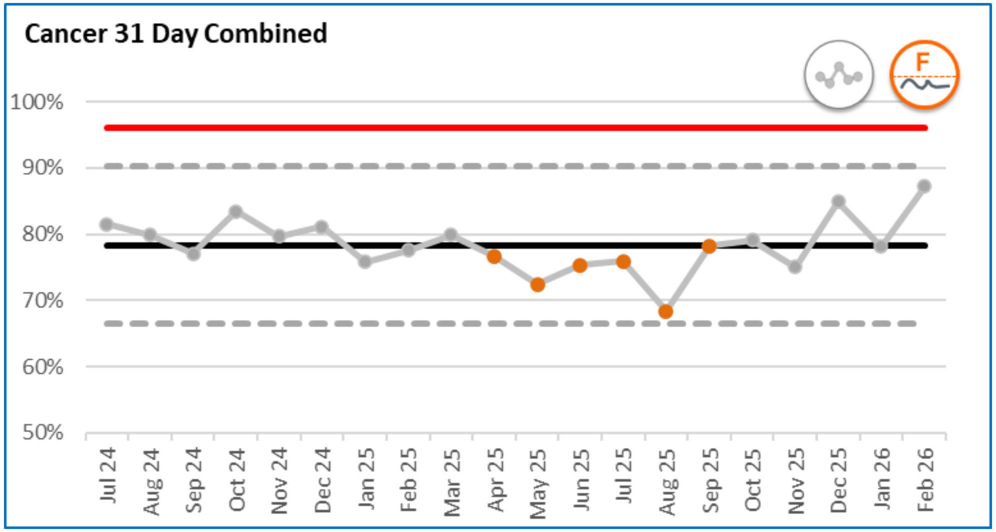
Actions

- Breast insourcing and bank/WLI to support 1st appt wait times.
- Mutual aid requests – have not been successful
- Recruit to ENT consultant gap and backfill with locums. Independent Sector being explored.
- Demand review for Breast & ENT pathways
- Days Matter Campaign: Breast, LOGI, Gynae, Urology. Improvements noted in Q4. Continue focus on turnaround times across all tumour sites.
- Working with clinicians on clarity of correspondence to clearly document if cancer confirmed or excluded at the earliest opportunity

Impact/Timescale

- Breast 1st appt waits improved to 3-4 weeks. Sustainable plan to convert ERF through planning in progress.
- ENT 1st Appt waiting times remain 6-7 weeks. Recruitment completed, with a delayed start date, therefore locum adverts continue.
- ENT triage pilot to risk stratify and support demand gained approval from ICB leads – planned go live June 26.
- Working with ICB leads to encourage increased use of breast pain pathway where more appropriate.
- Continued focus on imaging and OPA turnaround times across all tumour sites
- Skin performance remains above 90%

Responsive Cancer – Cancer 31 Day Combined



Current Performance			
Feb 26	**YTD**	**Feb Plan**	**Target**
87.2%	**77.5%**	**90.0%**	**96%**

National Position & Overview

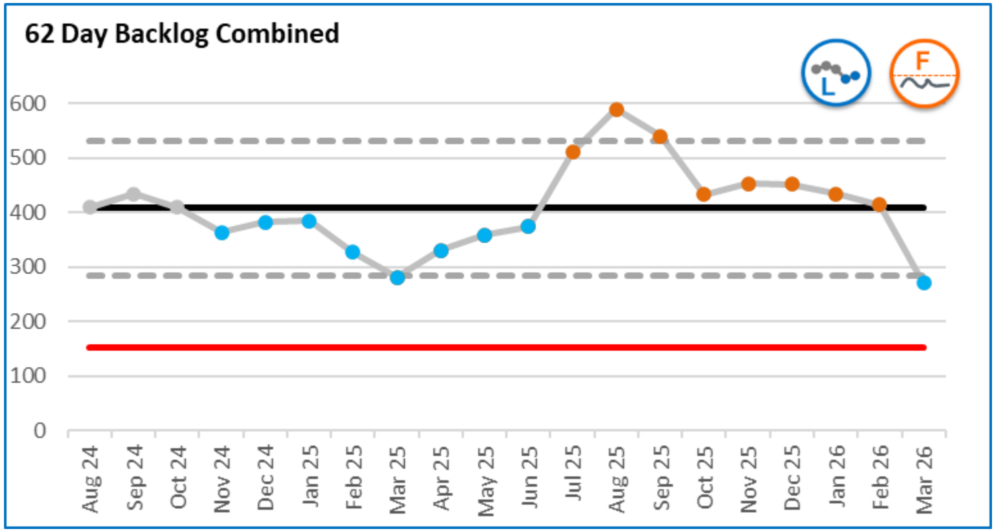
In February, UHL ranked 124 out of 138 Acute Trusts. The National average was 93.0%. 76 out of the 138 Acute Trusts achieved the target. UHL ranked 14 out of the 18 UHL Peer Trusts. The best value within our peer group was 97.0%, the worst value was 76.2% and the median value was 92.6%.

UHL's position is improving with significant improvements seen following investment into radiotherapy. Drug performance is above the national standard.

Root Cause	Actions	Impact/Timescale

Insufficient capacity within surgery and radiotherapy to meet demand.
• Within Radiotherapy this has resulted in a requirement for risk stratification and a waiting list for prostate patients following commencement of hormone therapy
• Within surgery there are
    • Theatre capacity constraints in Urology, Gynaecology and Lung inc. Robotic capacity with rising demand
    • Patient readiness to proceed with surgery impacting ability to date within 31 days
This has resulted in challenges to date patients within 31 days of a decision to treat.
	• Increased emphasis at PTL meetings to bring forward patients within target – weekly
	• Diligence in application of cancer wait time standards (medical and patient fitness or unavailability to proceed with first offer)
	• Offering alternative earlier surgical dates with colleagues where appropriate.
	• Increase theatre capacity
	    • 2nd Robot in Urology & Gynae – in place
	• Review of high risk anaesthetic (HRA) capacity to support surgical pathways – in progress
	• Collaboration with UHN – ongoing
		Radiotherapy
		• Increased capacity 5th linac. Prostate waits continue to improve.
		• Efficiency work programme underway to support & maximise capacity.
		• Paperless planning on all linacs has been achieved with full impact expected by end of Q1.
		Surgery
		• Improvements noted in Feb and Mar/Apr indicative results.
		• 2nd Urology robot supporting a reduction in waiting time. Gynae utilising from April to reduce waits.
		• HRA review to be completed by June.

Responsive Cancer – Cancer 62 Day Backlog



Current Performance		
Mar 26	YTD	Target
271	-	152 (by Mar26)

National Position & Overview

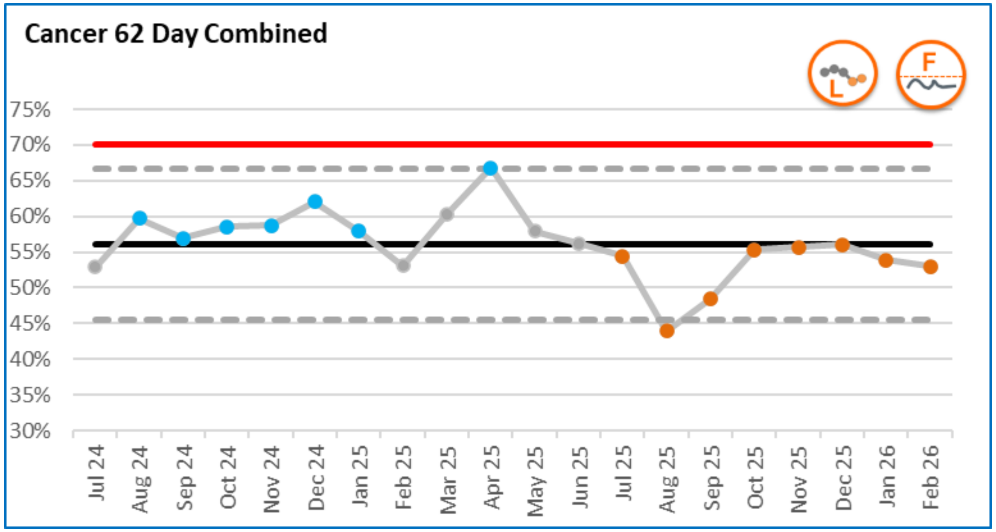
National data is not available. Midland's trend – decreases in backlog seen in all 11/11 systems over 4 week period to 22/03/26, with LLR having largest decrease (-114).

UHL end of March position:
- >62 day 119 behind plan.
- >104 day 67 behind plan.

At the end of March there were less patients over 62 days compared to the start of the year.

Root Cause	Actions	Impact/Timescale
• Breast, Colorectal and Urology drive the largest volume, holding 2/3 of the backlog. • Constraints include capacity, specifically outpatient, diagnostic and workforce. • There has been an increase in diagnostic tests required per patient, patient complexity and choice which have impacted pathway length • There are some bottlenecks in capacity within Oncology OPD capacity, theatre capacity for Urology and plastics capacity for skin, which are causing longer waits for some patients.	• Clinical review & prioritisation of all cancer patients over 42, 62 and 104 days. • Senior Cancer Centre daily backlog review, with additional focus on prioritising backlog patients for TCIs, OPAs and reporting • Focus on reducing delay from results available to action • Increased escalation to clinical leads and senior managers for support • Supporting timely clinical review outside of MDT where appropriate • Oncology improvement project to increase OPD capacity	• Diagnostic imaging project to identify and include cancer patients pre-treatment with the same urgency as pre-diagnosis • Review of test-to-report times for high-volume cancer pathways and identify improvement opportunities. • Urology 2nd robot supporting a reduction in waits – Q4 and Q1 of 26.27. • Oncology opportunities to improve OPD waits outlined, timescales for changes being confirmed. Impact not expected until Q2 26/27. • Plastics are working with UHN to increase LNR capacity.

Responsive Cancer – Cancer 62 Day Combined



Current Performance			
Feb 26	YTD	Feb Plan	Target
53.0%	54.6%	69.0%	70%

National Position & Overview

In February, UHL ranked 140 out of 146 Acute Trusts. The National average was 68.6%. 81 out of the 146 Acute Trusts achieved the target. UHL ranked 16 out of the 18 UHL Peer Trusts. The best value within our peer group was 80.4%, the worst value was 46.7% and the median value was 65.2%.

UHL last achieved the standard in 2014. Average days waits have shown improvements in 2025/26 across most tumour sites however due to remaining backlog this is not reflected in performance.

Root Cause	Actions	Impact/Timescale

• Capacity constraints across various points of the pathways
• There has been an 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
• Capacity OPD/Th constraints in some areas (Urology, Breast, H&N, Thoracic & Plastics)
• Performance impacted by clinical prioritisation of patients (i.e. higher clinical priority ahead of longer waits)
	• Clinical prioritisation of patients and emphasis to bring confirmed cancers within target – weekly PTLs
	• Regular audits of pathways - Areas of opportunity identified to
	    • Ensure results are acted on quickly
	    • Increase the use of straight-to-test and parallel investigations (where appropriate) and
	    • Reduce unnecessary repeat MDT discussion.
	• Additional capacity running, including use of insourcing/outsourcing where possible.
	• Strengthened clinical and operational management of pathways
		• Clinical comms emphasising ordering tests in parallel and progressing outside of MDTs discussed in April.
		• Pathology insource/outsourcing of urology & gynaecology supporting TAT – ongoing
		• Breast QI project improvements noted in 2nd test results and action.
		• Gynae improving performance through introduction of 'see&treat' clinics - anticipated uplift to Trust performance ~1.5%.
		• Additional capacity running where possible across services
		Improvements across the year are expected in line with plan

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

University Hospitals Leicester

Executive Summary

- The YTD position for the Trust is a deficit of £46.4m (subject to audit) against a plan of £0m. The main drivers are loss of DSF funding £25.9mA and non delivery of CIP £19.4mA. Excluding DSF, this position equates to a deficit of £85.3m, which is in line with the position notified to NHSE.

- Emergency/Non Elective inpatient activity continues to over-perform; at M12 the additional activity over the year equated to £28m of income that won't be received due to the block arrangement however the cost of delivery will be in the Trust's non-pay.

- The Trust committed net capital expenditure of £92.7m to Month 12 resulting in an underspend of £0.5m against its revised CDEL target.

- The cash position at the end of Month 12 was £34.7m, which is a decrease of £5.3m from M11.

Summary Financial Position – YTD M12

	I&E YTD			
	Plan	Actual	Adjustment for Pension	Variance to Plan
	£'000	£'000		£'000
NHS Patient-Rel Income	1,615,174	1,662,907	(64,957)	(17,224)
Other Operating Income	184,373	181,923		(2,450)
Total Income	**1,799,547**	**1,844,830**	**(64,957)**	**(19,674)**
Pay	(1,110,961)	(1,204,917)	64,957	(28,999)
Non Pay	(595,403)	(609,420)		(14,017)
Total Costs	**(1,706,364)**	**(1,814,337)**	**64,957**	**(43,016)**
EBITDA	**93,182**	**30,493**	**0**	**(62,690)**
Non Operating Costs	(88,646)	(171,239)		(82,592)
Retained Surplus/(Deficit)	**4,536**	**(140,746)**	**0**	**(145,282)**
Donated Assets	(4,536)	(2,666)		1,870
Impairments		97,026		97,026
Control Total Surplus/(Deficit)	**(0)**	**(46,386)**	**0**	**(46,386)**

Comments – YTD Variance to Plan

Total Income: £19.7mA:
- PCI £12F driven by £6.2mF for IA and £2.5m for winter flow and other contract variations
- Other income driven by £2.2mA donated assets, CSI £1.9mA (mainly relating to pathology, pharmacy, imaging), reduced E&F income £1.4mA mainly relating to car parking/catering/CIP non delivery offset by £2mF corporate
- Passthrough **excluded drugs and devices** lower than plan £3.3mA. This includes a reduction of £1.4m relating to hybrid loops.

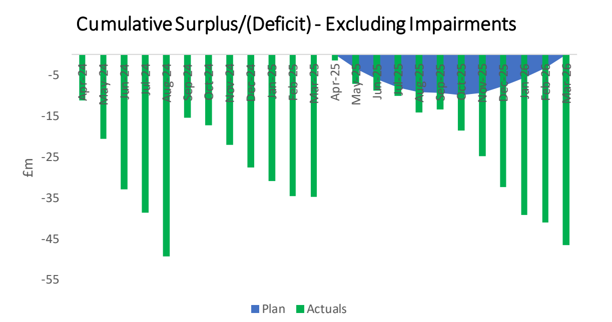
Pay: £29.0mA:
- Medical and dental £23mA of which £3.4m is due to industrial action (IA) and the balance linked to undelivered CIP and medical gaps in RRCV (£6.7mA), CHUGGS (£3.9mA), ESM (£3.7mA) and W&C (£4.6mA).
- Nursing, midwife and health visitor staffing is driven mainly by vacancies across ITAPS (£2.7mF) offset by undelivered CIP and a provision for band 5 to 6 job role review.
- Other clinical driven by small overspends across multiple CMGs.
- Non-clinical mainly driven by vacancies in E&F £2.4mF, ESM £1.3mF and W&C £1.3mF

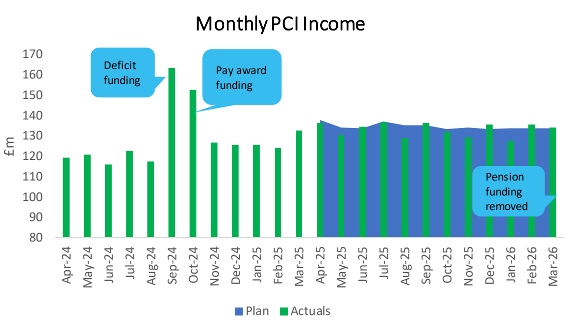
Bank (£72.8m) and Agency (£4.3m) spend YTD amounts to £77.1m which is 6.8% of total pay.

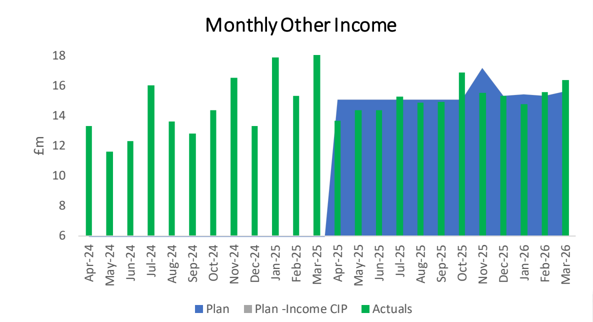
Non-Pay: £14.0mA:
- Clinical Negligence £2.4mF relating to the maternity incentive scheme rebate.
- Clinical supplies £7.2mA driven by increased activity and non-delivery of CIP
- Drugs £5.7mA due to block drugs overspends and non delivered CIP: £1.2mA mainly in CHUGGS Haematology/Oncology, £1.5mA ITAPS in sleep/theatres, £1.3mA RRCV relating to renal and respiratory and £1.4mA W&C.
- Other is driven mainly by CHUGGS reduced Gastroenterology insourcing usage and closure of Vanguard unit (£1.5mF), CSI/CDC unit from lower level of activity (£1.2mF), E&F mainly from the review of prior year food provision and energy credits (£3.1mF).
- Premises & Fixed plant driven in the main by undelivered CIP and addition expenditure in M12 for IT projects (£2.1m) and bed purchases in E&F (£0.7m)

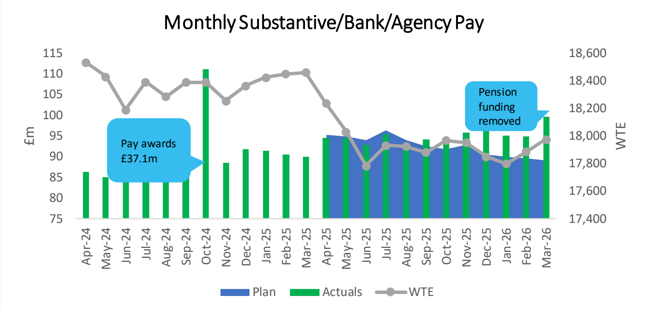
Non Operating Costs: £82.6mA:
- Modern equivalent asset valuation has generated impairment costs of £97m, reduced depreciation of £5m and reduced PDC of £4m
- Interest payable has reduced due to reassessment of IFRS16 assets

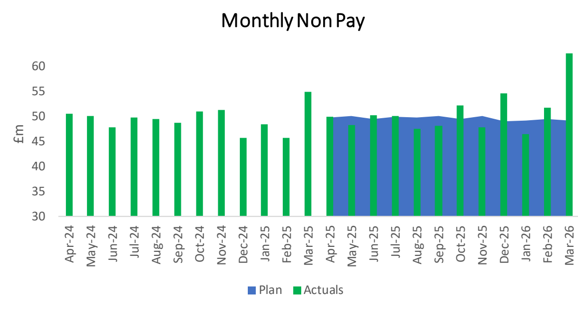
Month 12 I&E Dashboards

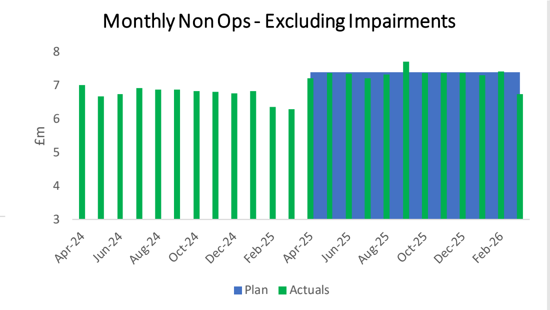




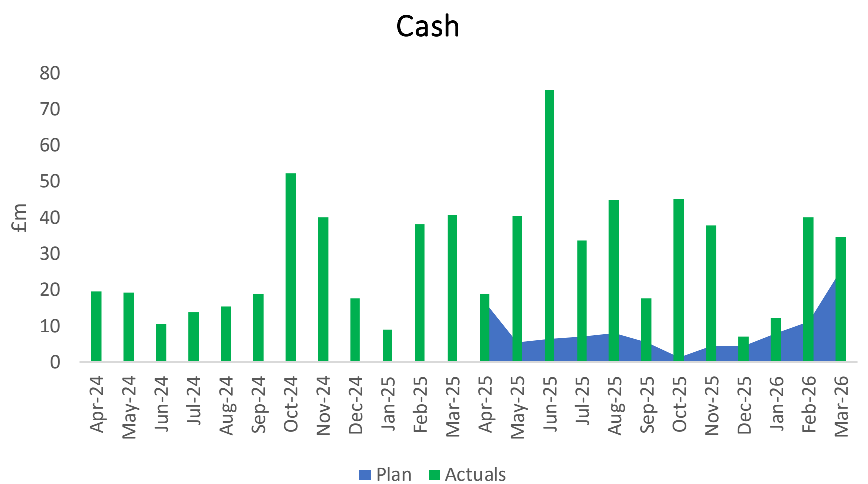


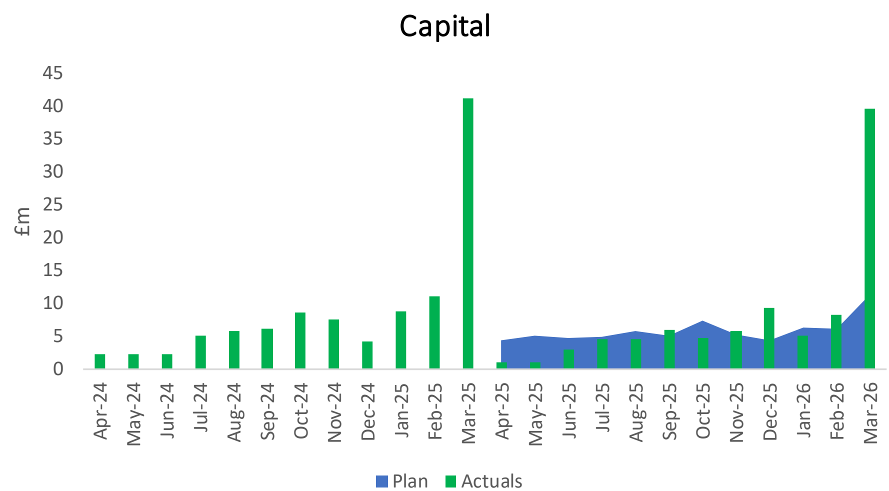


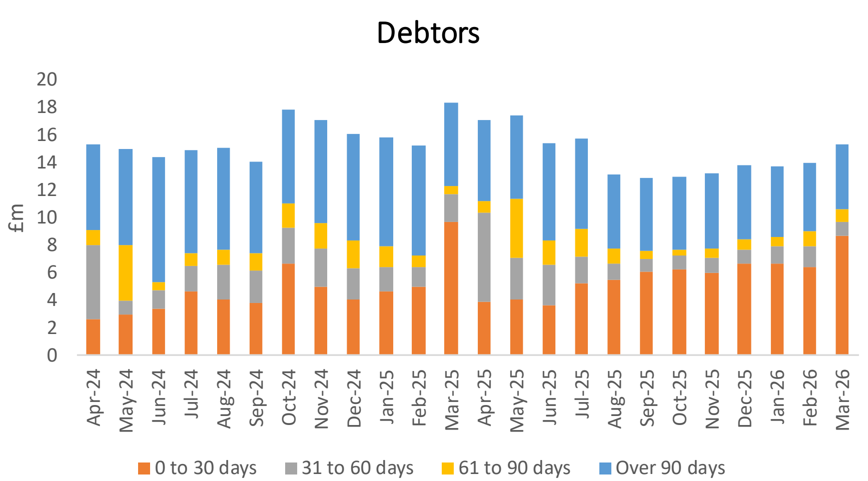


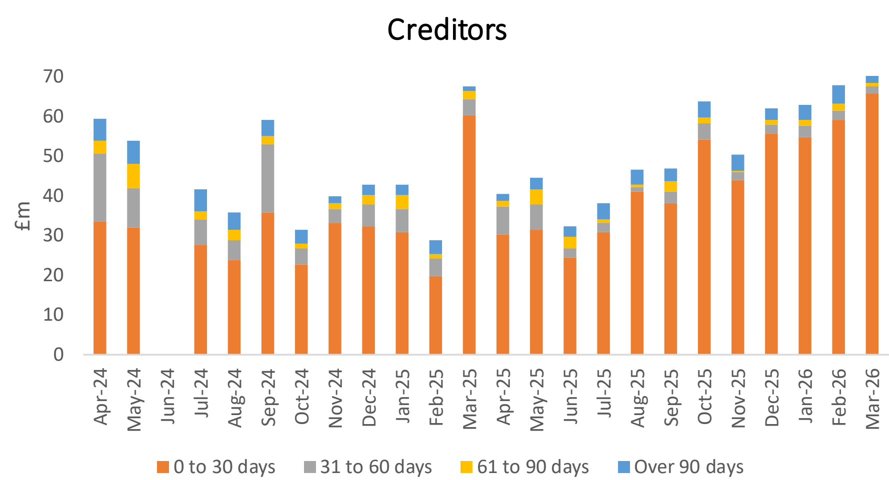


Month 12 Balance Sheet Dashboards









Statement of Financial Position

- **Non-Current Assets -** The value of non-current assets reduced by £106.9m, of which £141.6m relates to the MEA property; offset by the net impact of additions (£40m) and depreciation (£5.3m) in M12.
- **Trade and other receivables –** Trade and other receivables contracted by £14.2m overall, of which accrued income relating to PCI income reduced by £17.7m following its receipt in M12. Prepayments also reduced by £6.4m mainly due to the timing of the CNST premium and other maintenance contracts..
- **Trade and other payables and accruals** – Trade and other payables increased by £22.3m, of which £10.9m relates to registered invoices in month and £9.2m of increased GRNs, largely driven by the acceleration of the capital programme in March.
- **Deferred Income** – Reduced by £17.0m as PCI income was released into the position.
- **Dividend Payable –** Reduced by £9.4m as the second bi-annual installment was paid to DHSC in March.
- **Income and Expenditure Reserve –** The deterioration in the I&E reserve of £101.7m is explained by the I&E impairment relating to the revision to the opening MEA property valuation (£97.0m) and the M12 in month I&E deficit.
- **Public Dividend Capital** - £33.7m increase in PDC due to capital drawn down (£3.7m) and revenue cash support (£30m).
- **Revaluation reserve** – reduced by £49.4m in relation to the impact of the MEA property valuation on asset values.

Statement of Financial Position

£m	31-Mar-25	28-Feb-26	31-Mar-26	In Month Movement	YTD Movement
Non Current Assets					
Intangible assets	31.1	31.3	33.9	2.6	2.9
Property, plant and equipment	776.0	774.9	665.6	(109.3)	(110.4)
Other non-current assets	4.4	4.7	4.6	(0.1)	0.2
Total non-current assets	**811.5**	**810.9**	**704.1**	**(106.9)**	**(107.4)**
Current Assets					
Inventories	28.6	27.6	27.8	0.2	(0.8)
Trade and other receivables	41.2	58.7	44.6	(14.2)	3.4
Cash and cash equivalents	40.7	40.0	34.7	(5.3)	(6.0)
Total Current Assets	**110.4**	**126.3**	**107.0**	**(19.3)**	**(3.4)**
Current Liabilities				0.0	0.0
Trade and other payables	(147.8)	(146.4)	(168.7)	(22.3)	(20.9)
Leases < 1 Year	(9.0)	(7.3)	(12.3)	(5.0)	(3.3)
Accruals	(19.8)	(25.9)	(23.1)	2.8	(3.3)
Deferred income	(4.7)	(21.9)	(4.9)	17.0	(0.3)
Dividend payable	0.0	(9.4)	0.0	9.4	0.0
Provisions < 1 year	(9.3)	(6.6)	(9.1)	(2.5)	0.2
Total Current Liabilities	**(190.6)**	**(217.4)**	**(218.1)**	**(0.7)**	**(27.5)**
Net Current Assets / (Liabilities)	**(80.1)**	**(91.1)**	**(111.1)**	**(20.0)**	**(31.0)**
Leases > 1 Year	(43.3)	(44.7)	(35.8)	8.9	7.4
Provisions for liabilities & charges	(3.6)	(3.6)	(3.0)	0.6	0.6
Total non-current liabilities	**(46.9)**	**(48.3)**	**(38.9)**	**9.5**	**8.0**
Total Assets/(Liabilities)	**684.5**	**671.5**	**554.1**	**(117.4)**	**(130.4)**
Public dividend capital	(924.8)	(950.9)	(984.6)	(33.7)	(59.8)
Revaluation reserve	(223.7)	(223.7)	(174.3)	49.4	49.4
Income and expenditure reserve	464.0	503.1	604.8	101.7	140.7
Total Capital & Reserves	**(684.5)**	**(671.5)**	**(554.1)**	**117.4**	**130.4**

University Hospitals Leicester

Liquidity and Cash Position – Month 12

• Cash balance at end of March: £34.7m (£33.0m for the Trust). Year End Forecast at M11 was £24.4m.
• In-month reduction of £5.5m.
• The Trust received the £30m PDC revenue cash support in March.
• BPPC impacted in March as YTD performance reduced to 93% by value, 86% by volume, as a result of payment rationing, prior to receipt of the £30m cash support

Receivables & Payables

•Total debt: £15.3m, of which >90 days £4.7m .
  ➢ Overseas visitors >90 days: £1.9m (partially in write-off/collection processes).
  ➢ Salary overpayments >90 days: £0.3m, with recovery actions underway.
• Payables increased by £5.2m to £73.0m (£19m relates to Capital), although >60-day items reduced by £0.7m to £5.5m.

	Month 12						Month 11					
	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	**10,947**	6,011	832	521	3,583	33%	**9,704**	4,470	654	478	4,102	42%
NHS receivables	**4,328**	2,666	137	377	1,148	27%	**4,388**	1,951	875	670	892	20%
Total receivables	**15,275**	**8,677**	**969**	**898**	**4,731**	**31%**	**14,092**	**6,421**	**1,529**	**1,148**	**4,993**	**35%**
Non-NHS payables	**64,564**	59,519	1,245	1,255	2,545	4%	**56,376**	50,280	1,903	1,770	2,423	4%
NHS payables	**8,402**	6,217	453	(126)	1,857	22%	**11,378**	8,761	589	(38)	2,066	18%
Total payables	**72,967**	**65,737**	**1,698**	**1,130**	**4,402**	**6%**	**67,754**	**59,041**	**2,492**	**1,732**	**4,488**	**7%**

University Hospitals Leicester

Capital Programme - 25/26 Position

Summary

• Opening gross capital plan: **£77.1m**

• Net increase of **£20.7m** → revised plan **£97.5m**

• Significant additional allocations mainly received in last quarter.

•**£40m** capex committed in m12.

• Underspend of £500k against M11 forecast and revised plan.

• The late notification of allocations presented challenges to commit the funding by 31 March 2026, but was achieved by flexible management of allocations across financial years (bringing forward and deferring), requiring c£2m adjustment to the 26/27 plan. There was a scheme slippage of c£4.1m. The Trust approved funding schemes in 25/26 in mitigation of the £4.1m, including £2.1m of bring forward schemes (for which appropriate reductions have been made to capital plans in 26/27).

•Despite hitting the year end target, there were some compensating under and overspends against the M11 forecast on individual lines, but not sufficiently material to impact on 26/27 capital expenditure plans.

Programme Area	M11 Forecast 25/26	M12 Actuals £000s	(Over) / Under Forecast £'000
IM&T	19,135	19,978	(843)
Estates	26,681	25,490	1,191
MEE	3,150	3,263	(113)
Capex Credits	(2,326)	(1,779)	(547)
IFRS16	6,013	5,860	153
Donated Exp	3,767	4,128	(361)
MES	16,930	16,789	141
NHP	13,333	13,251	82
Operations	10,845	10,449	396
Gross Capex	**97,528**	**97,427**	**100**
Donated Income	(3,767)	(4,128)	361
Disposals	(521)	(560)	39
Net Capex (Against CDEL)	**93,240**	**92,739**	**500**

Performance Overview

Exception Reports

Finance

Appendix - Data Quality Assessment

University Hospitals Leicester

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.