Boards in Common Paper E1

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:	11 June 2026					
Title:	3.3 (Paper E1) Integrated Performance Report and Executive Summary					
Report presented by:	Richard Mitchell, Group CEO					
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						

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

Purpose of the Report

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

The executive summary is split into 3 parts

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

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
11 JUNE 2026

Main report detail

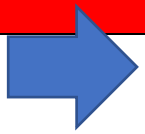
Key headlines in performance are summarised below:

Summary of UHL Performance: APRIL 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
 	
 
	April 2026 saw an increase of 1,119 Emergency Department attendances to plan, which at 22,415 is 8% higher than April 2025. Eye Casualty saw attendances 10% higher than plan.
	
	4-hour performance in April did not achieve the trajectory of 64.74% with performance of 63.10% (UHL only). Type 2 activity achieved 94.70% against a trajectory of 96.77%. The key challenge in delivery was due to the volume of attendances.
	
	LRI monthly ambulance handover improvement has been challenged during April however the month one trajectory has been met, and our performance has remained improved versus the same period last year. There were no extended delays on ambulances (over 8 hrs)
	
	The 12-hour performance (total time in dept) was 8.60% achieving trajectory of <10%
	
	Emergency admissions were over plan by 478 admissions again driving challenges in flow from the Emergency Department for patients waiting beds
	
	Actions for improvement in 2026/2027 include:
	
	Improve the quality of our services through:
	• Implement Modern Service Frameworks in Dementia and Frailty –
	• Paediatric Early Warning System by April 2027*
	• Review of Single Front Door in Paediatric ED
	• Implement the cardio-respiratory model
	• UEC Clinical Operating Standards (previously known as IPS
	
	Be more Productive by:
	• Reduce Inpatient LoS Adults and Children
	  ○ SHOP model
	  ○ Diagnostics access to SDEC and Emergency floor
	• Emergency SDEC expansion with booking slots (ED SDEC)

	• Implement Clinical Operational standards for first 72 hrs • Implement Model Emergency Department • Improve Discharge Process –Length of Stay reduction • Criteria Led Discharge ○ Building on work of Clinical Bed Bureau to develop Single Point of Access to UHL **Digitally Enabled through** Implementing E-Triage in ED, Implement ECDS V4 and further paper lite initiatives. **Capital projects** including build the Urgent Treatment Centre for opening in Quarter 2 - 2027/28. Plan for relocation of outpatient services from Emergency Floor, Review of estate to create inpatient bed capacity and extension of SDEC at GH **Continue to Work in partnership** on establishing a Mental Health emergency centres in ED, the development of Neighbourhood models, Primary care same day access, Single point of access for community referrals, early vaccination programme and Frailty pathways to optimise pathways
Elective Care **Referrals and Outpatient performance** **Elective activity** **Pathway Improvements** 	The number of 65week RTT waits were 49 in April, with the forecast for May being 58. The majority of breaches remain in Orthopaedics and ENT. Looking ahead to June the position is similar to this time in April for May, meaning the rate of improvement is not sufficient to enable the Trust to be near to clearing the cohort of 65 week waiting patients. However, the speciality breakdown has changed, showing improvement in some specialities and a smaller coalescence across fewer speciality services. Actions being taken are around putting in place extra capacity through appointing locum consultants in soft-tissue knee and orthopaedic anaesthetists to increase elective operating. Holding additional superclinics, above plan, to reduce the number of patients waiting for first outpatient appointment and exploring increased support from the Independent Sector. 52 week waits were slightly above plan in April along with total waiting list size. This is predominately due to the combined impact of Easter and Industrial action. CMGs are being asked to focus on recovering and over-performing against activity plan. April performance showed an over delivery on first outpatient appointments. However, inpatient and daycase activity combined is slightly below plan. This has been driven by Industrial Action and increased cancellations seen at the LRI due to emergency pressures. Productivity remains to track well across key indicators such as theatre session utilisation. However, more work needs to be done across both outpatients and theatres in-terms of session fill, backfilling clinics and theatres when consultants are on leave. Session fill rate is now being incorporated into performance packs with CMGs/specialities being challenged on low achievement. This links back to activity planning and maintain on or above target.
Cancer **Referrals** **2 week wait**	Referrals year to date have seen an increase of 3.9% compared to the previous year. Conversion rates year to date is 6.3% and is in line with the national average.

Faster Diagnosis Standard **62-day referral to treatment** 	In March performance improvements continued in two of the three standards compared to February. March FDS delivered 67.6%, a 6.9% deterioration from February. Breast continued to drive the variance due to the ongoing capacity gap in imaging, followed by ENT where backfill of workforce has been unsustainable, resulting in increased time to 1st appointment. Delivery is reliant on additional capacity, insourcing and recruitment. Improvement is not expected until June when vacancies and mitigation plans begin to take effect. 31-day performance continued to improve in March, rising to 88.2%. Radiotherapy continues to improve and drug performance has maintained above standard in the month. Surgical performance whilst improved in month remains variable, with theatre constraints and increased need for high-risk anaesthetic assessment impacting. 62-day performance improved by 10.8% in March to 63.8%, though remains below plan and highly sensitive to pathway pressures creating variability in month-on-month performance. There continues to be multiple challenges across tumour sites, including increased demand, more complex diagnostic requirements and delays in decision-making across radiology, pathology and MDT sequencing. These are compounded by waits to first outpatient appointment and ongoing constraints in surgical and oncology clinic capacity. Breast, Lower GI and Urology remain the principal tumour sites driving variance. The fragility of staffing levels and reliance on insourcing/outsourcing and uptake of waiting list initiatives particularly across breast radiology, pathology and ENT services, has limited the ability to mitigate these pressures at pace. Continued clinical engagement, alongside a sustained focus on reducing the backlog, streamlining pathways to aid more timely action of next steps, will be critical to supporting recovery and deliver improved performance in 2026/27.
Quality 	Performance this month reflects a stable position across most quality and safety indicators, with ongoing operational pressure. There were three Never Events reported, which are subject to full review with learning to be shared through established governance routes. Infection prevention performance shows one MRSA bacteraemia and seven MSSA cases this month. These are being reviewed through standard post-infection processes to identify learning and ensure appropriate oversight, consistent with established reporting and assurance arrangements. All other quality and safety indicators remain broadly stable. Operationally, it has been a busy period, with sustained demand impacting flow and service delivery. There has been improvement in complaints timeliness, reflecting strengthened oversight and more consistent management of response processes.
Finance 	The month 1 position for the Trust is a deficit of £3.9m which is £0.8m adverse to plan.

	This position includes £1.6m of costs related to industrial action. Excluding this, the Trust would be £0.8m better than plan. The cash position at the end of Month 1 was £20.8m, which is a decrease of £13.8m from March.
Workforce 	The overall Whole Time Equivalent (WTE) workforce in M1 was 18,251WTE which is 26WTEs above the plan (i.e a 0.14% variance to plan) driven by the high bank usage. • Agency staff usage decreased from previous month's usage by 7WTEs and was below plan by 3WTE. • Bank staff usage has decreased compared to the previous month by 111WTE but has remained above the planned target by 13.68% with usage recorded at 927WTE which is 112WTE above plan. Bank usage is mostly high in ESM, CHUGGS, E&F and Women's & Children with usage relatively high among registered and unregistered nursing staff and cleaning staff. Overall Bank spend is recorded at 7.60% (of the total pay bill) an increase from the previous month of March 2026. • Contracted Substantive staff was recorded at 17,294WTE (a variance of 83WTE) representing a positive variance of 0.47% below the planned position of 17,377WTEs. A further reduction of contracted substantive staff from previous month by 51WTE Workforce turnover has reduced from 7.6% to 7.5% in April against the 10% target. We now have one non-clinical agency work aligned to the capital programme and approved by NHSE. 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. We have 28 agency workers above price cap in the medical and AHP specialist roles such as Sonography, Radiography and Cardiac Physiotherapists. Agency usage remains controlled, approved, and time-limited, with clear exit actions in place. Agency reduction plans will be monitored through recruitment milestones during 2026,in line with training dependent roles. Mandatory training has slipped to 93% across the Trust with relative stability on compliance in terms of CMG and topics. The drop is not unusual for this time of year. Appraisal performance has improved by 0.4% to 83.6% against the 95% target. A refreshed appraisal approach is being developed, aligned to the MALD framework, with the MALD self-assessment forming part of the new

	process. The appraisal process will focus on meaningful conversations about performance, development and career progression and will place greater emphasis on development, reflection and supportive challenge. Sickness absence is reported a month in arrears, and we have seen a 0.40% reduction in March. Over the last 12 months, the highest levels of absence are in E&F (6.28%), W&C (5.52%) and CHUGGS (4.86%). Absences relating to cough / cold / flu have reduced by 2.62%, and plans are underway for the 2026 / 27 flu vaccination programme. 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 April, overall theatre utilisation was 81.8%, a slight improvement from March (81.4%), but remained below the 85% standard. Trust performance continues to be rated Green (Quartile 3) on Model Hospital System. For the week ending 3rd May 2026, utilisation was 82.3%, exceeding both the peer median of 80.5% and the national median of 81.6% Late starts for April were 22.2%, driven primarily by performance at LRI (38%). A new Theatre Service Manager is now in post at LRI and is providing active, on-the-ground operational support to address the underlying drivers of late starts and improve performance. Cancellations reduced from 9.7% to 8.37% in April, with performance primarily impacted by DNA activity (52 cases). This was alongside significant bed pressures and sustained emergency demand at LRI, resulting in 20 adult bed-related cancellations and emergency lists exceeding 24 hours on multiple occasions. Despite these pressures, improved grip on cancellations is being achieved through proactive fortnightly reviews and strengthened Board oversight. BADS performance continues to show sustained improvement month-on-month, reaching 81.2% in January 2026 compared to 68.9% in August 2025. However, this remains below the previously achieved peak of 84.2% in April 2025 prior to the PAS go-live. Ongoing work is focused on improving the accuracy of intended management recording within Nerve centre to support further gains. In parallel, pathway optimisation is progressing, with developments in the Gynaecology TLH pathway and early-stage work underway to establish day case pathways for hemi and parathyroidectomy. The GIRFT Hub Optimisation Week (HOW) is scheduled to take place w/c 18th May at the EMPCC. Planning has focused on reducing avoidable clinical cancellations through enhanced patient-level scheduling, including direct

involvement of anaesthetists and pre-assessment teams to clinically validate and confirm patient suitability in advance. In addition, EMPCC staff are undertaking proactive patient contact (excluding Ophthalmology, where this is already standard practice on this site) to confirm attendance and identify any short-term illness, such as coughs, colds or flu, that may result in on-the-day cancellation.

Following Super Week, a lessons learned review will be undertaken, prompted by only 53% of week one patient's being confirmed fit for surgery. This will identify bottlenecks in pre-assessment and booking processes and inform targeted actions to ensure P3/4 patients are optimised and confirmed fit prior to listing, reducing avoidable clinical cancellations

EMPCC hub accreditation work is currently underway, with coordination of evidence, development of the accreditation workbook, and engagement across specialties progressing to support submission. Preparation is focused on meeting GIRFT requirements across all domains, with planning in place for the formal GIRFT visit scheduled for 22nd June.

Outpatients

- Patient Initiated Follow-Up (PIFU) performance remained at 5.6% in April, unchanged from the previous month. This continues to exceed the national target of 5% and the local target of 5.5%. Targets will be reset in line with national benchmarks, and work will continue with clinical teams to deliver against these, including identifying further pathways where PIFU can be safely and appropriately implemented.

- The DNA rate remained at 6.0% in April, with the year-to-date position also at 6.0%. DNAs continue to be a significant area of focus due to the impact on patient access, clinic utilisation, and waiting times. A number of interventions are in progress to support improvement, including strengthening patient communications, enhancing reminder processes, and providing targeted support for patient groups who face greater barriers to attendance. Continued focus and close monitoring will be required to return DNA performance to target levels.

- Appointment Reminders:
  A revised Accurx reminder schedule—issuing reminders at 14, 7, and 3 or 1 days before appointments—is technically ready but currently paused due to dependencies linked to the Ambient Scribe rollout. Once these dependencies are resolved, implementation will be prioritised, as the enhanced reminder schedule is expected to support improved attendance and help reduce DNAs. Increased character limits will also allow for more personalised and informative messaging to patients.

  The rollout of Scribe will also introduce a live feed from Nervecentre to Accurx, which is expected to further improve and streamline communication with patients.

UEC

- 6,004 monthly SDEC attendance delivered in April (14% above monthly target)

	• 2,688 calls received to Clinical Bed Bureau in April. Down 1.3% to average in 25/26. 26/27 target to be agreed. • 24hour red line patients at 1.16% in April, comparatively to 1.6% in April 2025 • Average Ambulance Time 35 minutes, a 10-minute improvement from April 2025. • Interprofessional Standards Targets – E referrals - 68% closed within 15 minutes • Interprofessional Standards Targets – E referrals 65% closed within 60 mins • GP to Fracture Clinic Pathway Pilot continuing. Since 28th April 37 patients 23 redirected to Fracture clinic. 14 patients still seen ED, tweaking pathway to improve. • Cadding off IPAD now installed in 7 Areas to support faster ambulance handover (5 outstanding to be installed) • Digital Delivery governance now in place to deliver UEC EPR improvement works. • Equity of access to diagnostics pilot continuing at LRI, for CT scanning

Supporting documentation

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

The key changes to the IPR are:

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

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

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

No.	NHS Oversight Framework national mandated KPIs
1	Proportion of patients discharged from hospital to their usual place of residence
2	Available virtual ward capacity per 100k head of population
3	National Patient Safety Alerts not completed by deadline
4	Potential under-reporting of patient safety incidents
5	Overall CQC rating
6	Performance against relevant metrics for the target population cohort and five key clinical areas of health inequalities

7	Proportion of acute or maternity inpatient settings offering smoking cessation services
8	Proportion of patients who have a first consultation in a post-covid service within six weeks of referral
9	Proportion of people over 65 receiving a seasonal flu vaccination
10	Acting to improve safety - safety culture theme in the NHS staff survey
11	CQC well-led rating
12	Aggregate score for NHS staff survey questions that measure perception of leadership culture
13	Staff survey engagement theme score
14	Staff survey bullying and harassment score
15	Proportion of staff in senior leadership roles who are from a) a BME background or b) are women

UHL Oversight Framework Metrics

April 2026

Oversight Framework

Key Performance Indicator	Target	Feb-26	Mar-26	Apr-26	YTD	Assurance	Variation	Trend	Data Quality Assessment	Local or National Target?	Exec Lead
Clostridium Difficile per 100,000 Bed Days	167 Cases	19.3	21.3	1.3	1.3	?	L		Mar-24	Local	Chief Nurse and Medical Director
Methicillin Resistant Staphylococcus Aureus	0	1	1	1	1	?			Mar-24	Local	Chief Nurse and Medical Director
E-Coli per 100,000 Bed Days		17.2	27.2		1.5				TBC	No Target	Chief Nurse and Medical Director
Hospital Acquired Pressure Ulcers - All categories per 1000 bed days	1.7	2.1	1.3	1.3	1.3	?			Jun-21	Local	Chief Nurse and Medical Director
Sickness Absence	3%	4.9%	4.5%		4.8%	F	L		Mar-25	Local	Chief People Officer
30 Day Readmission Rate		10.8%	10.8%		10.5%		H		TBC	No Target	TBC
Published Summary Hospital-level Mortality Indicator (SHMI)	100				94 (Jan25 to Dec 25)	Assurance and variance not applicable			May-21	National	Chief Nurse and Medical Director
Emergency Department 4 hour waits UHL *	61%	63.0%	66.4%	65.7%	65.7%	?	H		Mar-23	National	Chief Operating Officer
% of 12 hour waits in the Emergency Department	10.3%	9.2%	7.3%	8.9%	8.9%	?			Mar-23	National	Chief Operating Officer
Referral to Treatment (RTT) 18 wk performance *	69.3%	55.7%	58.6%	58.0%		F	H		TBC	Local	Chief Operating Officer
Referral to Treatment (RTT) 52+ weeks as a % OF Total Incompletes *	0.9%	2.1%	2.0%	2.1%		F			TBC	Local	Chief Operating Officer
6 Week Diagnostic Test Waiting Times *	5%	14.3%	12.3%	14.4%		F	L		Jul-23	National	Chief Operating Officer
28 Day Faster Diagnosis Standard *	80%	74.5%	67.6%		71.0%	?			May-24	National	Chief Operating Officer
Cancer 62 Day Combined *	70%	53.0%	63.8%		55.4%	F			May-24	Local	Chief Operating Officer
Trust level control level performance	-£3.2m	-£1.9m	-£5.4m	-£3.9m	-£3.9m				Jun-22		Chief Financial Officer
Capital expenditure against plan	£2.9m	£8.3m	£39.6m	£3.4m	£3.4m				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).*

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.

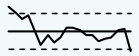
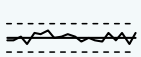
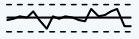
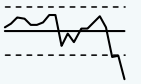
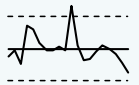
Integrated Performance Report

April 2026

Contents

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

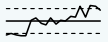
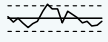
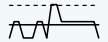
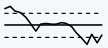
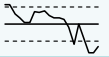
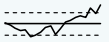
Performance Overview (Safe)

Domain	Key Performance Indicator	Target	Feb-26	Mar-26	Apr-26	YTD	Assurance	Variation	Trend	Data Quality Assessment	Local or National Target?	Exec Lead
Safe	Never events	0	0	0	3	3	?	H		Nov-22	National	Chief Nurse and Medical Director
	Clostridium Difficile per 100,000 Bed Days	167 Cases	19.3	21.3	1.3	1.3	?	L		Mar-24	Local	Chief Nurse and Medical Director
	Methicillin Resistant Staphylococcus Aureus	0	1	1	1	1	?			Mar-24	Local	Chief Nurse and Medical Director
	Methicillin-susceptible Staphylococcus Aureus	40	7	1	7	7	?			Mar-24	Local	Chief Nurse and Medical Director
	All falls reported per 1000 bed days	4.0	3.7	3.4		2.8	P			Aug-22	Local	Chief Nurse and Medical Director
	Rate of Moderate harm and above Falls per 1,000 bed days	0.19	0.17	0.09		0.07	?			Aug-22	Local	Chief Nurse and Medical Director
	Hospital Acquired Pressure Ulcers - All categories per 1000 bed days	1.7	2.1	1.3	1.3	1.3	?			Jun-21	Local	Chief Nurse and Medical Director
	% of all adults Venous Thromboembolism Risk Assessment on Admission	95%	97.2%	97.3%	96.6%	96.6%	P	L		Oct-21	National	Chief Nurse and Medical Director
	Number of Patient Safety Incident Investigations (PSIIs) commissioned		1	0	5	5	Awating more data for assurance and variance			Nov-24	No Target	Chief Nurse and Medical Director
	Number of reported Patient Safety Incidents		2348	2442	2218	2218				Nov-24	No Target	Chief Nurse and Medical Director
	Rate of reported Patient Safety Incidents (per 1000 inpatient, outpatient and ED attendances)		17.8	16.7	15.6	15.6				Nov-24	No Target	Chief Nurse and Medical Director

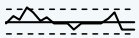
Performance Overview (Caring)

Domain	Key Performance Indicator	Target	Feb-26	Mar-26	Apr-26	YTD	Assurance	Variation	Trend	Data Quality Assessment	Local or National Target?	Exec Lead
Caring	Single Sex Breaches		36	15	25	25				Jul-22	No Target	Chief Nurse and Medical Director
	Inpatient and Day Case Friends & Family Test % Positive	96%	95%	96%	95%	95%				Jul-22	Local	Chief Nurse and Medical Director
	A&E Friends & Family Test % Positive	80%	88%	88%	88%	88%				Jul-22	Local	Chief Nurse and Medical Director
	% Complaints Responded to in Agreed Timeframe - 25 Working days	90%	54%	59%		54%				Jul-23	Local	Chief Nurse and Medical Director
	% Complaints Responded to in Agreed Timeframe - 60 Working days	90%	77%			75%				Jul-23	Local	Chief Nurse and Medical Director

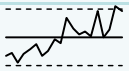
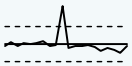
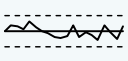
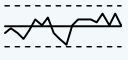
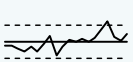
Performance Overview (Well Led)

Domain	Key Performance Indicator	Target	Feb-26	Mar-26	Apr-26	YTD	Assurance	Variation	Trend	Data Quality Assessment	Local or National Target?	Exec Lead
Well Led	Turnover Rate	10%	7.6%	7.6%	7.5%		P	H		Aug-22	Local	Chief People Officer
	Sickness Absence	3%	4.9%	4.5%		4.8%	F	L		Mar-25	Local	Chief People Officer
	% of Staff with Annual Appraisal	95%	83.1%	83.1%	83.6%		F			Mar-25	Local	Chief People Officer
	Statutory and Mandatory Training	95%	94%	94%	93%		F			Dec-22	Local	Chief People Officer
	Adult Nursing Vacancies	7%	5.3%	5.0%	5.5%		?			Dec-23	Local	Chief People Officer
	Paed Nursing Vacancies	10%	7.1%	4.3%	6.9%		?	L		Dec-23	Local	Chief People Officer
	Midwives Vacancies	7%	-4.4%	-4.4%	-2.6%		?	L		Dec-23	Local	Chief People Officer
	Health Care Assistants and Support Workers Vacancies - excluding Maternity	5%	9.0%	8.4%	12.3%		F			Dec-23	Local	Chief People Officer
	Health Care Assistants and Support Workers Vacancies - Maternity	5%	9.4%	6.4%	11.3%		P	H		Dec-23	Local	Chief People Officer
	% Bank spend of Pay Bill	8%	6.4%	6.7%	7.6%		P	H		TBC	National	Chief People Officer
	% Agency spend of Pay Bill	3.2%	0.4%	0.6%	0.4%		P	L		TBC	National	Chief People Officer
	Agency Off Framework activity- No. of shifts	0	0	0	0		Awating more data for assurance and variance			May-25	National	Chief People Officer
	Non Clinical Agency- No. of Staff	0	2	2	1		Awating more data for assurance and variance			May-25	National	Chief People Officer
	Agency Staff above Price cap	0	20	24	28		Awating more data for assurance and variance			May-25	National	Chief People Officer
	Agency shifts above £100/hr but not signed off by Chief Exec	0	0	0	0		Awating more data for assurance and variance			May-25	National	Chief People Officer
	Agency Shifts below £100/hr and is 50% above published price cap But not signed off by Chief Exec	0	0	0	0		Awating more data for assurance and variance			May-25	National	Chief People Officer
	Bank shifts above £100/hr but not signed off by Chief Exec	0	0	0	0		Awating more data for assurance and variance			TBC	National	Chief People Officer

Performance Overview (Effective)

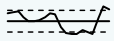
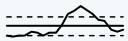
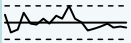
Domain	Key Performance Indicator	Target	Feb-26	Mar-26	Apr-26	YTD	Assurance	Variation	Trend	Data Quality Assessment	Local or National Target?	Exec Lead
Effective	Published Summary Hospital-level Mortality Indicator (SHMI)	100				94 (Jan25 to Dec 25)	Assurance and variance not applicable			May-21	National	Chief Nurse and Medical Director
	12 months Hospital Standardised Mortality Ratio (HSMR)	100				96 (Feb 25 to Jan 26)	Assurance and variance not applicable			May-21	National	Chief Nurse and Medical Director
	Crude Mortality Rate		0.8%	0.8%	0.8%	0.8%				May-21	No Target	Chief Nurse and Medical Director
	DNA Rate - IMD Deciles 1 and 2	5%	8.9%	8.8%	8.6%	8.6%				Feb-24	Local	Director of Health Equality and Inclusion
	DNA Rate - IMD Deciles 3 - 10	5%	5.4%	5.3%	5.3%	5.3%				Feb-24	Local	Director of Health Equality and Inclusion

Performance Overview (Responsive Emergency Care)

Domain	Key Performance Indicator	Target	Feb-26	Mar-26	Apr-26	YTD	Assurance	Variation	Trend	Data Quality Assessment	Local or National Target?	Exec Lead
Responsive (Emergency Care)	Emergency Department 4 hour waits LLR	78%	77.0%	79.5%	78.6%	78.6%	?	H		Mar-23	National	Chief Operating Officer
	Emergency Department 4 hour waits UHL	61%	63.0%	66.4%	65.7%	65.7%	?	H		Mar-23	National	Chief Operating Officer
	Mean Time to Initial Assessment	15	6.9	6.2	7.8	7.8	P	L		Nov-24	National	Chief Operating Officer
	% 12 hour trolley waits in Emergency Department (DTA)	10.3%	3.5%	2.5%	4.4%	4.4%	P			Mar-23	National	Chief Operating Officer
	% of 12 hour waits in the Emergency Department	10.3%	9.2%	7.3%	8.9%	8.9%	?			Mar-23	National	Chief Operating Officer
	Average Clinical Handover time for ambulance handovers (Minutes)	30	29	23	32	32	?			Data sourced externally	Local	Chief Operating Officer
	Non Elective Average Length of Stay	7.2	7.7	7.4	7.2	7.2	?			Aug-25	Local	Chief Operating Officer
	% of Patients Discharged on Discharge Ready Date	88.1%	87.9%	88.6%	88.6%	88.6%	?			Aug-25	Local	Chief Operating Officer
	Average Delay (Post Discharge Ready Date)	3.8	4.2	4.6	4.2	4.2	?	H		Aug-25	Local	Chief Operating Officer
	Trust Bed Occupancy	92.0%	91.5%	88.5%	90.5%		?			Dec-23	National	Chief Operating Officer
	Long Stay Patients (21+ days) as a % of G&A Bed Occupancy	10%	16.4%	15.7%	16.8%		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).

Performance Overview (Responsive Elective Care)

Domain	Key Performance Indicator	Target	Feb-26	Mar-26	Apr-26	YTD	Assurance	Variation	Trend	Data Quality Assessment	Local or National Target?	Exec Lead
Responsive (Elective Care)	Referral to Treatment Incompletes	96,243	117,449	113,973	114,992		F	H		Jun-23	Local	Chief Operating Officer
	Referral to Treatment (RTT) 18 wk performance	69.3%	55.7%	58.6%	58.0%		F	H		TBC	Local	Chief Operating Officer
	Referral to Treatment (RTT) – First Attendance - % waiting less than 18 weeks	75.1%	61.6%	61.0%	62.5%		Awating more data for assurance and variance			TBC	Local	Chief Operating Officer
	Referral to Treatment (RTT) 52+ weeks as a % OF Total Incompletes	0.9%	2.1%	2.0%	2.1%		F			TBC	Local	Chief Operating Officer
	6 Week Diagnostic Test Waiting Times	5%	14.3%	12.3%	14.4%		F	L		Jul-23	National	Chief Operating Officer
	Theatre Utilisation	85.0%	81.9%	81.4%	81.8%	81.8%	F			Dec-23	National	Chief Operating Officer
	Patient Initiated Follow Up	5.5%	5.1%	5.6%	5.7%	5.7%	?	L		Oct-23	Local	Chief Operating Officer
	% Outpatient Did Not Attend rate	4.9%	6.0%	6.0%	6.0%	6.0%	F	L		Apr-23	Local	Chief Operating Officer
	% Outpatient Non Face to Face	25%	27.1%	25.4%	25.7%	25.7%	P	L		Apr-23	National	Chief Operating Officer

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

Performance Overview (Responsive Cancer)

Domain	Key Performance Indicator	Target	Feb-26	Mar-26	Apr-26	YTD	Assurance	Variation	Trend	Data Quality Assessment	Local or National Target?	Exec Lead
Responsive (Cancer)	28 Day Faster Diagnosis Standard	80%	74.5%	67.6%		71.0%	?			May-24	National	Chief Operating Officer
	Cancer 31 Day Combined	96%	87.2%	88.2%		78.4%	F			May-24	National	Chief Operating Officer
	62 Day Backlog Combined	152	414	271	317		F	L		Dec-24	Local	Chief Operating Officer
	Cancer 62 Day Combined	70%	53.0%	63.8%		55.4%	F			May-24	Local	Chief Operating Officer

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

Performance Overview (Finance)

Domain	Key Performance Indicator	Target YTD	Feb-26	Mar-26	Apr-26	YTD	Assurance	Variation	Trend	Data Quality Assessment	Exec Lead
Finance	Trust level control level performance	-£3.2m	-£1.9m	-£5.4m	-£3.9m	-£3.9m				Jun-22	Chief Financial Officer
	Capital expenditure against plan	£2.9m	£8.3m	£39.6m	£3.4m	£3.4m				Jun-22	Chief Financial Officer
	Cost Improvement (Includes Productivity)	£2m	£7.4	£9.9m	£3.4m	£3.4m				Dec-23	Chief Financial Officer
	Cashflow	No Target	£27.8m	-£5.3m	-£13.8m	£20.8m				Jun-22	Chief Financial Officer
	Aged Debt	No Target	£14.1m	£15.3m	£13.3m					Feb-24	Chief Financial Officer
	Invoices paid within 30 days (value)	95%	94%	93%	95%					Feb-24	Chief Financial Officer
	Invoices paid within 30 days (volume)	95%	88%	86%	92%					Feb-24	Chief Financial Officer

Performance Overview (Activity)

Domain	Activity Type	Plan 26/27	Plan in Month (M1)	Activity In Month (M1)	Variance In Month (M1)	Plan YTD	Actual YTD	Variance YTD	YTD Variance to 19/20
Activity	New Outpatients (inc. NFTF)	271,564	21,735	23,060	1,325	21,735	23,060	1,325	1,211
	Follow Up Outpatients (inc. NFTF)	574,148	46,187	40,988	-5,198	46,187	40,988	-5,198	-7,710
	Outpatient Procedures	235,476	18,887	18,915	29	18,887	18,915	29	6,330
	Daycase	133,927	10,661	10,102	-559	10,661	10,102	-559	1,202
	Inpatient	22,774	1,867	2,111	244	1,867	2,111	244	456
	Emergency	116,814	9,402	9,880	478	9,402	9,880	478	1,626
	Non Elective	23,094	1,900	1,921	21	1,900	1,921	21	262
	Emergency Department (inc. Eye Casualty)	289,426	23,183	24,503	1,320	23,183	24,503	1,320	2,548
	Diagnostic Imaging (inc. Direct Access)	418,297	32,582	32,367	-216	32,582	32,367	-216	18,819
	Other	12,851,751	983,807	981,530	-2,277	983,807	981,530	-2,277	263,981
	TOTAL	14,937,271	1,150,212	1,145,379	-4,833	1,150,212	1,145,379	-4,833	288,726

**Source Early Cut and Forecasting File*

The DM01 plan for imaging activity for M1 was 679 below plan in month (26,119 vs 26,789) and was 679 below plan YTD (26,119 vs 26,789)

Performance Overview (Productivity Dashboard)

Productivity Dashboard v4.0 - UHL Trustwide	Last 12m Actuals													Assurance			
Metric	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	26/27 YTD	Variation	Assurance	26/27 Target	19/20 Baseline
Finance: CpWAU	4,037	4,163	4,089	4,128	4,071	4,126	4,135	4,085	4,013	4,019	3,934					-	4,250
Ops: Avg LoS for Elective Inpatients (nights)	3.06	3.06	3.58	3.21	2.84	2.98	3.00	3.23	3.03	3.05	3.13	3.42	3.42			-	3.37
Ops: Avg LoS for emergency admissions	3.62	3.47	3.40	3.65	3.39	3.54	3.33	3.47	3.44	3.58	3.46	3.44	3.44			-	3.85
Ops: Bed occupancy	85.4%	86.5%	89.3%	85.1%	87.4%	92.8%	87.4%	88.9%	93.4%	91.5%	88.4%	90.3%	90.3%			-	~
Ops: Do not meet Criteria to Reside (avg pts per day)	431	444	436	480	481	476	471	477	511	506	476	469	469			-	~
Theatres: Capped Utilisation	83.0%	82.7%	80.9%	80.7%	81.2%	80.7%	81.2%	80.9%	80.2%	82.0%	81.4%	81.8%	81.8%			85.0%	68.1%
Theatres: ACPL	2.00	1.97	1.97	1.99	1.99	1.98	1.92	1.96	1.90	1.96	1.98	1.92	1.92			-	2.06
Theatres: OTDC	7.9%	8.0%	8.4%	8.2%	8.3%	8.4%	8.5%	8.7%	9.4%	8.9%	9.7%	8.4%	8.4%			5.0%	8.5%
Diagnostics (Endoscopy): APPL	8.10	7.10	7.40	7.50	8.80	8.50	7.80	7.30	7.70	7.90	8.30	8.75	8.75			10.50	~
Outpatients: Clinic Utilisation	92.2%	92.0%	91.9%	97.0%	96.5%	96.6%	98.5%	96.7%	97.9%	97.7%	98.2%	100.4%	100.4%			95.0%	90.9%
Outpatients: DNA Rate	6.7%	6.5%	7.0%	6.4%	6.3%	5.9%	6.1%	6.1%	6.1%	6.0%	6.0%	6.0%	6.0%			5.0%	6.6%
Outpatients: % PIFU	6.2%	5.4%	4.5%	4.9%	4.8%	5.2%	5.5%	5.5%	5.5%	5.1%	5.7%	5.7%	5.7%			6.0%	~
Outpatient: % OPA Follow Up without procedure	55.3%	56.3%	54.1%	53.2%	52.9%	52.1%	51.2%	51.2%	51.5%	49.9%	49.5%	49.0%	49.0%			-	~
A&G: Specialist Advice Utilisation Rate	13.0	13.6	15.1	13.5	12.7	12.7	11.8	10.6	8.8							12.6	~
Diagnostics: MRI Machine Productivity (Adjusted)	76.4%	70.4%	70.1%	72.9%	70.4%	71.4%	68.9%	78.5%	72.2%	69.8%	72.7%	70.9%	70.9%			-	~
Diagnostics: MRI scans per hour	1.40	1.30	1.29	1.30	1.30	1.30	1.30	1.30	1.40	1.30	1.30	1.30	1.30			1.80	~
Diagnostics: MRI DNA rate	3.8%	3.4%	3.8%	4.1%	4.2%	3.9%	3.7%	4.1%	2.9%	3.4%	3.6%	3.7%	3.7%			3.0%	~
Diagnostics (Endoscopy): In session booked utilisation	94.3%	89.1%	90.5%	90.4%	92.5%	95.6%	93.4%	86.4%	83.4%	83.3%	90.2%	91.8%	91.8%			95.0%	~
Diagnostics (Endoscopy): In session actual utilisation	87.7%	81.6%	83.5%	80.3%	85.2%	86.0%	85.3%	79.1%	76.6%	76.3%	82.6%	83.9%	83.9%			85.0%	~
Diagnostics: CT Machine Productivity (Adjusted)	86.8%	78.4%	77.5%	74.3%	78.2%	82.0%	72.2%	72.0%	79.1%	90.4%	80.8%	80.6%	80.6%			-	~
Diagnostics: CT scans per hour	2.39	2.20	2.13	2.00	2.10	2.30	2.00	2.10	2.30	2.50	2.40	2.20	2.20			3.30	~
Diagnostics: CT DNA rate	3.0%	3.5%	3.0%	2.8%	2.7%	2.9%	2.6%	3.2%	1.8%	2.8%	2.9%	2.5%	2.5%			3.0%	~

Performance Overview (Productivity Dashboard Commentary)

Section	Commentary
Finance	Data to March 26. Note increase from previous numbers due to inclusion of impairment in month 12. Overall trend still improving compared to 2019/20 and year on year.
Ops & Clinical Productivity	Elective LoS has increased to 3.42 in April, above recent performance and plan, reflecting ongoing discharge and capacity pressures. The majority of the longest waiters on the admitted PTL are for in-patient stays. Emergency LoS remains stable at 3.44 and below the 19/20 baseline. Bed occupancy has risen to 90.3% and remains above optimal, continuing to constrain flow. Patients not meeting Criteria to Reside have reduced slightly to 469, continuing the improving trend, though volumes remain high.
Theatres	Theatre performance remains stable, with utilisation at 81.8% but still below the 85% target. ACPL has reduced to 1.92, indicating increase in case complexity . On-the-day cancellations have improved to 8.4% but remain well above the 5% target and continue to limit further gains. Reducing cancellations and improving list planning remain key priorities. Endoscopy APPL remains below target, however in April shows improvement for the second consecutive month.
Outpatients	Outpatient performance remains strong, with clinic utilisation increasing to 100.4% in April, reflecting continued optimisation of capacity. DNA rates remain stable at 6.0% but continue to sit above the 5% target, indicating ongoing opportunities for improvement. PIFU utilisation has stabilised at 5.7%, maintaining gains made in March but remaining slightly below ambition. Issues with nervecenter are limiting further gains in the take-up of PIFU- outstanding digital development/resolution is needed. Follow-up rates without procedure have continued to reduce to 49.0%, demonstrating progress in shifting toward more efficient pathways and supporting overall productivity improvement.
Diagnostics	MRI productivity (adjusted) remains below target in April, 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 April. Booked utilisation shows improvement as well. CT productivity is static compared to March 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.

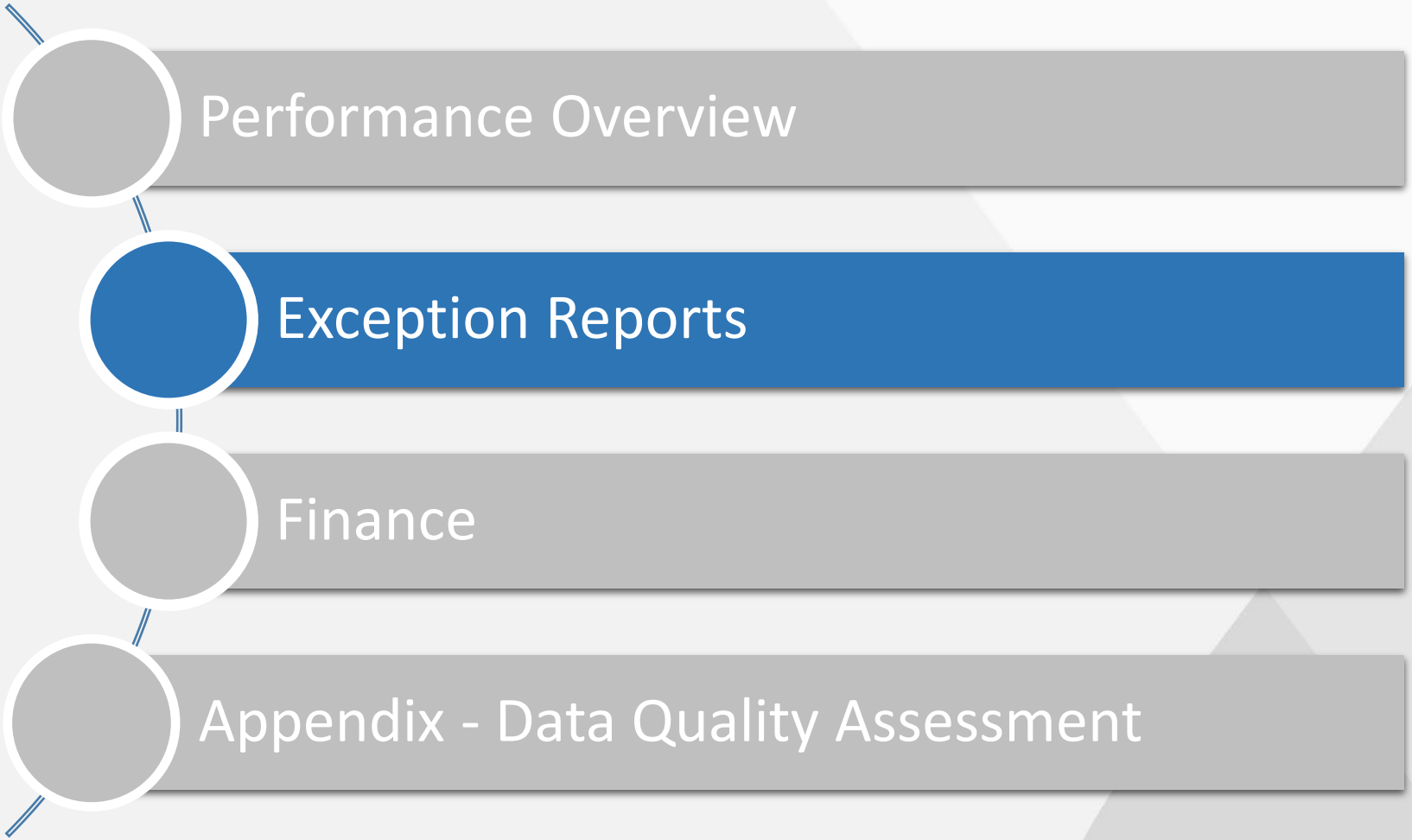
Performance Overview (Workforce Performance Overview)

Activity Type	WTE	Apr 26
Performance against the workforce plan (Contracted Substantive)	Planned in Month	17,377
	Actuals in Month	17,294
	Variance (Actual vs Plan)	-83
	% Variance (Actual vs Plan)	-0.47%

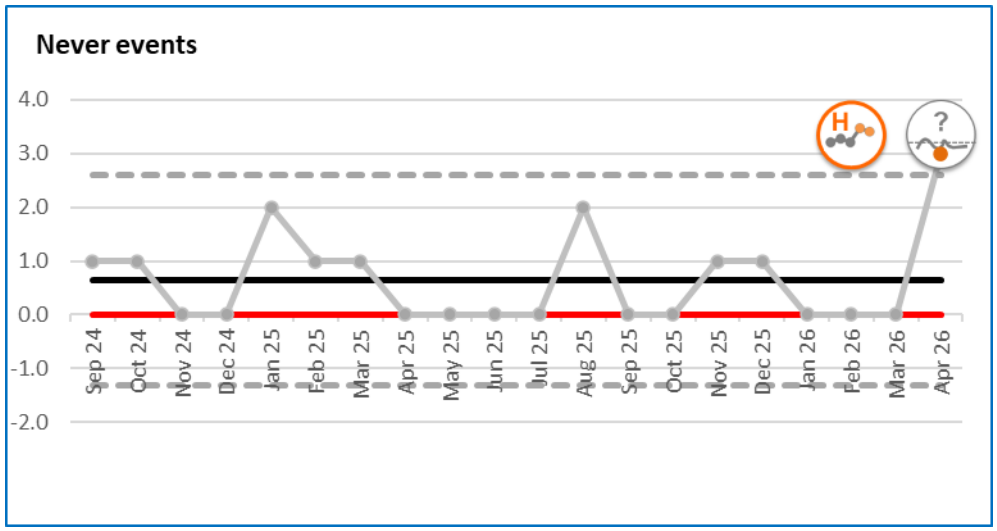
Planned data is from the NHSE submitted 26/27 workforce plan and the actuals are from a combination of the ESR and finance ledger figures.

Performance Overview (Monthly Trajectory Values)

	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sep 26	Oct 26	Nov 26	Dec 26	Jan 27	Feb 27	Mar 27
Emergency Department 4 hour waits UHL	64.7%	64.9%	66.7%	67.9%	68.6%	67.2%	68.4%	67.6%	66.0%	66.1%	67.0%	69.2%
Average Clinical Handover time for ambulance handovers (Minutes)	33	37	31	29	35	31	37	31	30	37	30	30
Non Elective Average Length of Stay	7.26208	7.05498	6.73911	6.7483	7.27459	6.81398	7.09846	6.79289	6.78775	7.11376	7.19993	7.21009
% of Patients Discharged on Discharge Ready Date	89.2%	89.5%	88.8%	87.6%	87.6%	86.7%	88.2%	87.2%	88.6%	87.9%	87.6%	88.1%
Trust Bed Occupancy	89.6%	86.4%	88.6%	90.6%	88.2%	89.5%	93.1%	90.2%	90.8%	94.5%	93.1%	94.1%
Referral to Treatment Incompletes	113367	112445	110485	109563	108930	106630	102732	100376	100207	99823	98054	96243
Referral to Treatment (RTT) 18 wk performance	57.0%	57.0%	59.0%	60.0%	61.0%	62.5%	64.0%	66.0%	66.0%	67.0%	68.0%	69.3%
Referral to Treatment (RTT) – First Attendance - % waiting less than 18 weeks	63.60%	64.60%	65.70%	66.70%	67.70%	68.80%	69.90%	70.90%	72.00%	73.00%	74.10%	75.10%
Referral to Treatment (RTT) 52+ weeks as a % OF Total Incompletes	2.0%	1.9%	1.8%	1.6%	1.5%	1.4%	1.3%	1.1%	1.0%	0.8%	0.7%	0.5%
6 Week Diagnostic Test Waiting Times	14.0%	13.5%	13.0%	12.5%	11.5%	11.0%	9.5%	8.0%	10.0%	9.0%	8.0%	7.0%
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	70.0%	72.0%	74.0%	76.0%	72.0%	74.0%	76.0%	78.0%	80.0%	76.0%	78.0%	80.0%
Cancer 31 Day Combined	80.0%	81.1%	85.1%	85.1%	78.1%	89.1%	89.0%	81.0%	90.1%	81.0%	87.1%	90.0%
Cancer 62 Day Combined	57.5%	60.0%	62.4%	60.0%	57.5%	60.0%	65.1%	67.5%	70.0%	67.5%	70.0%	70.0%


Performance Overview
Exception Reports
Finance
Appendix - Data Quality Assessment

Safe– Never Events



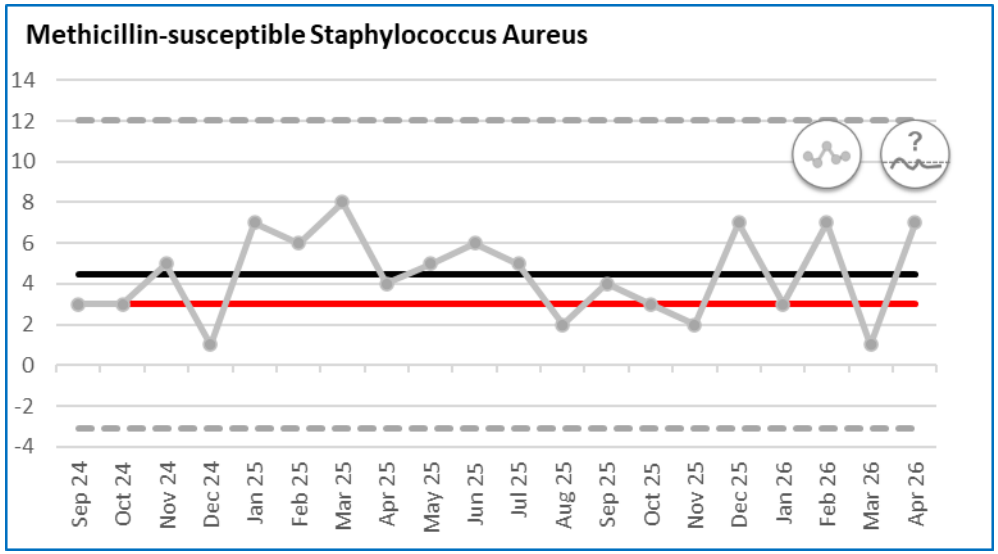
Current Performance		
Apr 26	YTD	Target
3	3	0

National Position & Overview

UHL reported 8 Never Events in 2022/2023
UHL reported 4 Never Events in 2023/2024
UHL reported 6 Never Events in 2024/2025
UHL reported 4 Never Events in 2025/2026

Root Cause	Actions	Impact/Timescale
• 1 x Wrong site surgery • 2 x Wrong implant/prosthesis	Apology given to all three patients and all informed of investigation into events and are being engaged and involved in the investigations	Completed (None of the patients have come to harm as a result of these incidents)
	Never Events are integrated within the PSIRF governance framework	Ongoing
	Patient Safety Incident Investigation (PSII) will incorporate review of previous similar incidents for themes, learning and actions	Ongoing

Safe – Methicillin-susceptible Staphylococcus Aureus

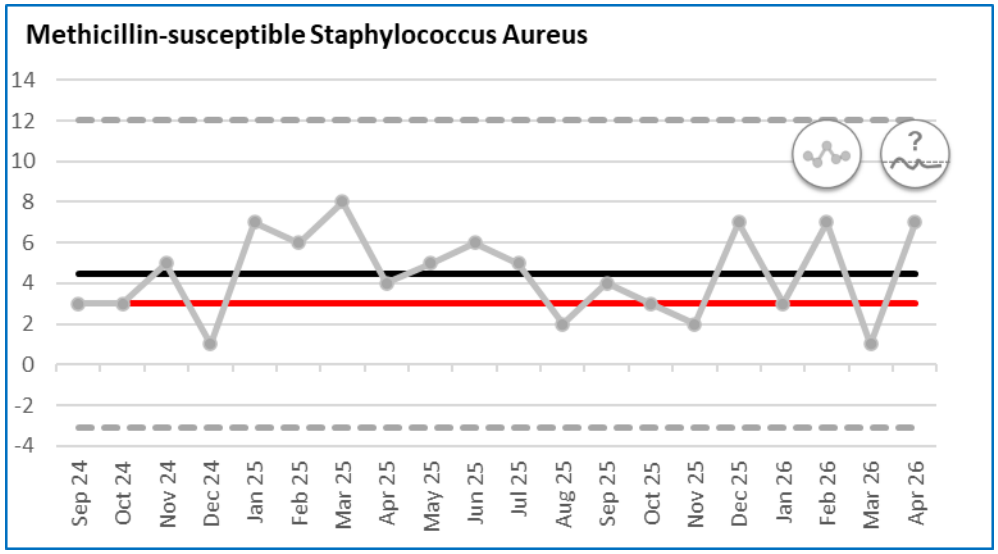


Current Performance		
Apr 26	YTD	Target
7	7	40

National Position & Overview			
	Apr 26	Total	
MSSA NHSE Threshold 25/26	3		
* Actual Infections (HOHA) 25/26	5	5	
* Actual Infections (COHA) 25/26	2	2	
*** Actual Infections Total (HOHA & COHA)** 25/26	7	7	
UHL 100,000 Bed Days (HOHA) 25/26	0.82	0.82	*YTD UKHSA Report
National Average	0.89		
National Highest	3.24		
National Lowest	0		

Root Cause	Actions	Impact/Timescale
• No new emerging themes locally from PSIRF or IP reviews or Nationally. • Reviews indicate devices inserted in most cases • UHL themes include: Issues with compliance of the PVAD and CVC management	• MSSA BSI actions are captured within the MRSA reduction plan • IP PSIRF have been reviewed to support a more detailed review. • PVAD/CVC audits action trackers continue to be monitored through TIPOG • Transformational Vascular Access Report is in draft. • Accountability framework for IPC to be reviewed and discussed through TIPOG and presented through TIPAC	• Transformation report due to go to TIPAC Q1.

Safe – Methicillin Resistant Staphylococcus Aureus

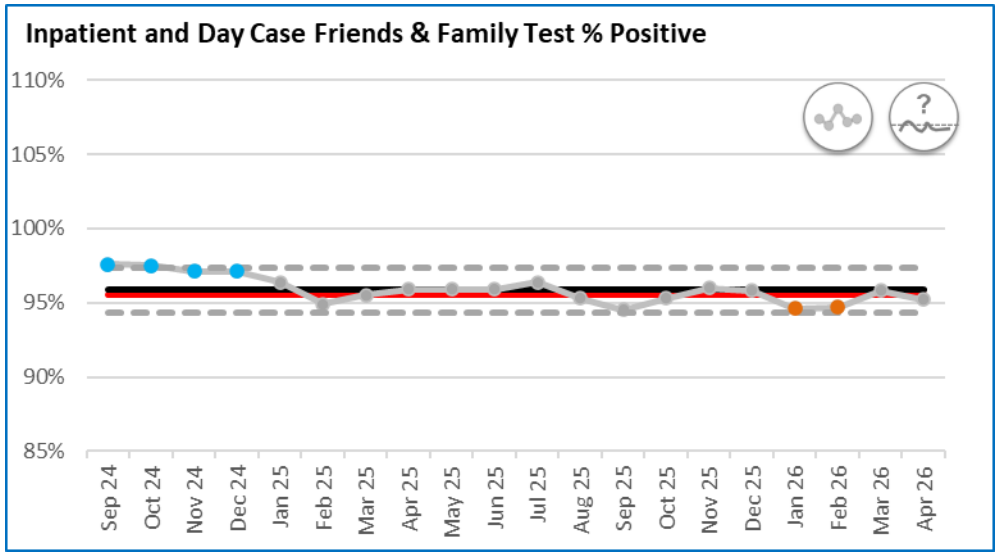


Current Performance		
Apr 26	YTD	Target
1	0	0

National Position & Overview			
	Apr 26	Total	
MSSA NHSE Threshold 26/27	0	0	
* Actual Infections (HOHA) 26/27	0	0	
* Actual Infections (COHA) 26/27	1	1	
*** Actual Infections Total (HOHA & COHA)** 26/27	1	1	
UHL 100,000 Bed Days (HOHA) 25/26	0.00	0.00	*YTD UKHSA Report
National Average	0.05		
National Highest	2.1		
National Lowest	0		

Root Cause	Actions	Impact/Timescale
• The review of this case concluded a MRSA BSI from a porta cath line infection. • Findings also found lack of adherence to UHL MRSA Policy as initial screening was not completed. • Please note this case was identified as a COHA however patient had a previous UHL admission within 4 weeks of result, and a previous other UK hospital admission which are in the sphere of a 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. • A Tabletop review has been arranged within the CMG to look at the human factors around why swabbing was not undertaken. • Accountability framework for IPC to be reviewed and discussed through TIPOG and presented through TIPAC	• CMG MRSA reduction plan will be discussed in TIPOG during Q1.

Caring – Inpatient and Day Case Friends and Family Test % Positive



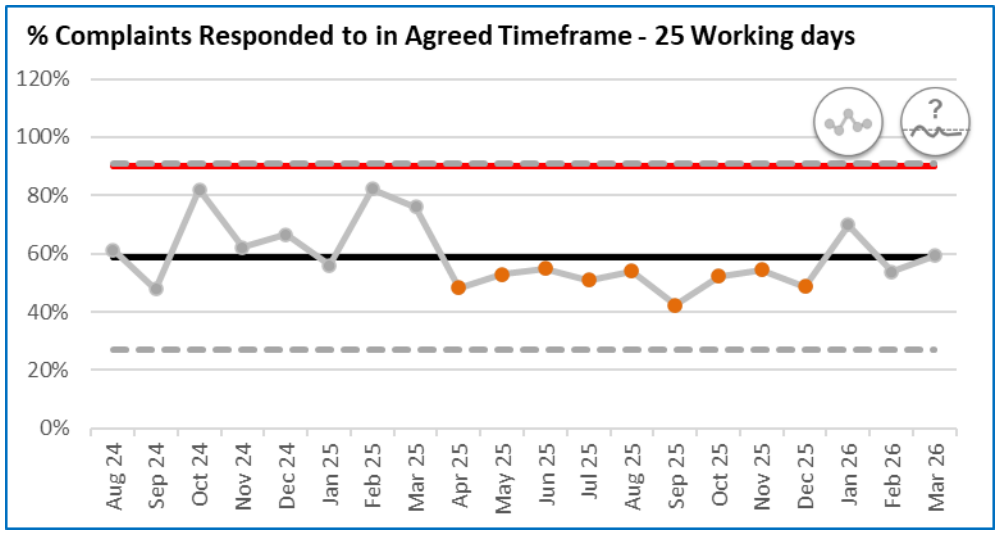
Current Performance		
Apr 26	YTD	Target
95.2%	95.2%	95.5%

National Position & Overview

National Inpatient % positive result in March 2026 (most recent available) was 94.6%. Trust Peer Group result for March 2026 was 95.3%.

Root Cause	Actions	Impact/Timescale
Patient feedback has highlighted themes with regard to waiting times, delays in treatment, and Patient flow Patient and relatives have raised themes with regard to poor communication, in particular with regard to discharge issues and understanding the plan of care. Additional themes highlighted relate to fundamentals of care with a focus on noise at night.	Improve **communication standards**, including regular patient updates, clearer discharge planning Focus on reducing waits, improving scheduling, and minimising corridor care or delayed discharges. Monitor effectiveness of fundamental of care programme	Reinforce communication expectations, introduce regular patient updates, and address basic care issues and improve patient flow processes. Expected impact is improved patient experience scores, fewer complaints related to communication and delays, and recovery toward FFT % positive target.

Caring – % Complaints Responded to in Agreed Timeframes



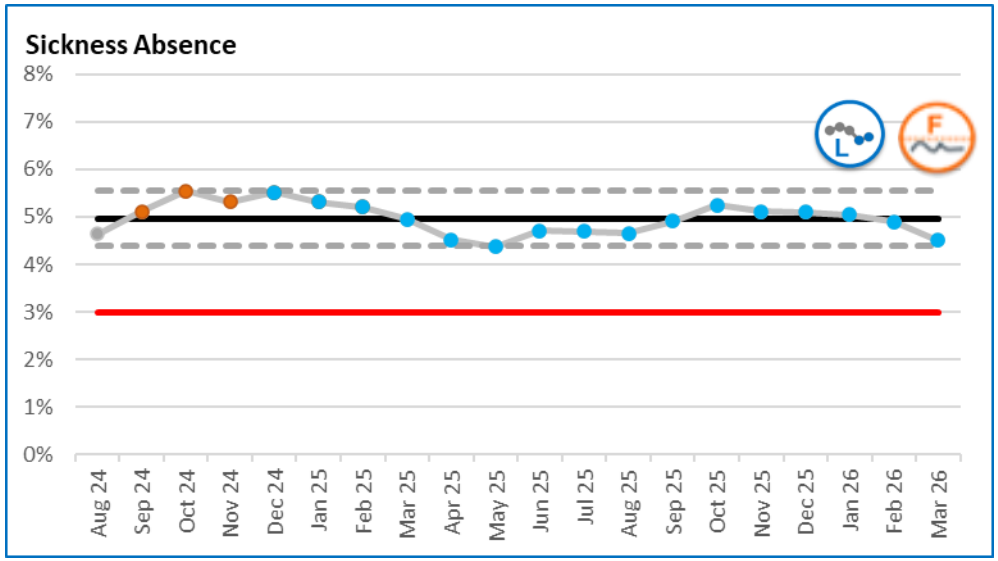
25 Working Days		
Mar 26	YTD	Target
59.2%	53.5%	90%

60 Working Days		
Feb 26	YTD	Target
76.9%	74.9%	90%

National Position & Overview

Root Cause	Actions	Impact/Timescale
• Slight increase in complaints responded to within 25 working day timescale from Feb 26 • 60 working day timescale at 77%	• Continuation in monitoring of complaint response times and positive actions to support the services • Current 3 month trial with CHUGGS whereby complaints are not triaged in first instance by the Complaint managers. The complaints are sent to the appropriate staff to respond to and the senior signatory decides on the themes. The CMG can alter the response timeframes if felt to be required • If this trial, is successful, there are plans to eventually roll out to the remaining CMG's	• Continued improvement of % complaint response times

Well Led – Sickness Absence



Current Performance		
Mar 26	YTD	Target
4.5%	4.8%	3%

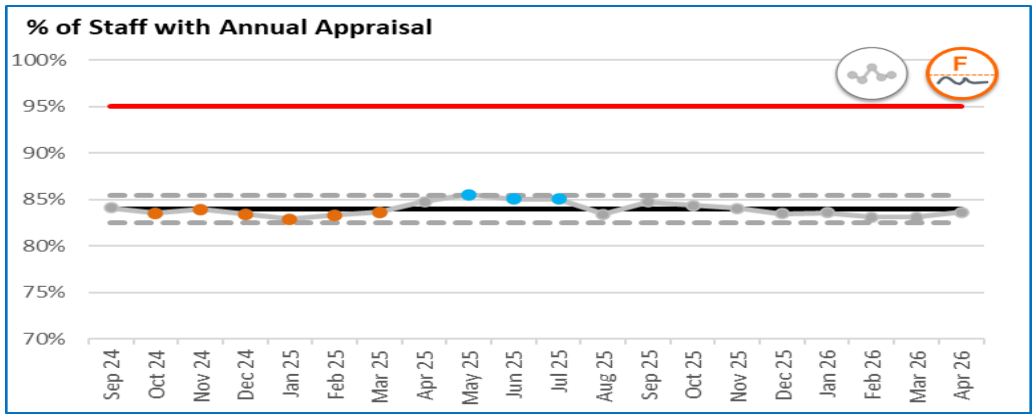
National Position & Overview

Peer data not available.

The March sickness absences rates show a reduction of 0.40% to the previous month.

Root Cause	Actions	Impact/Timescale
• Clinical CMG's have seen a 0.31% reduction and Corporate Directorates a 0.76% reduction in March from the previous month. • Over the last 12 months, the highest levels of absence are in E&F (6.28%), W&C (5.52%) and CHUGGS (4.86%). • The areas achieving the 3% target are within the Corporate Directorates • The top 3 reasons for sickness absence are anxiety/stress/depression (22.82%), Other known reasons (12.22%) and Musculo skeletal problems (10.6%). Cough/cold/flu has seen a reduction from 10.85% in February to 8.23% in March.	• 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 an established staff group specific working group to review sickness absence and improve attendance. • 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 2026-27 Flu Programme is in its preparatory phase.	• 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 'unknown' reason for recording reasons for sickness absence.

Well Led – % of Staff with Annual Appraisal



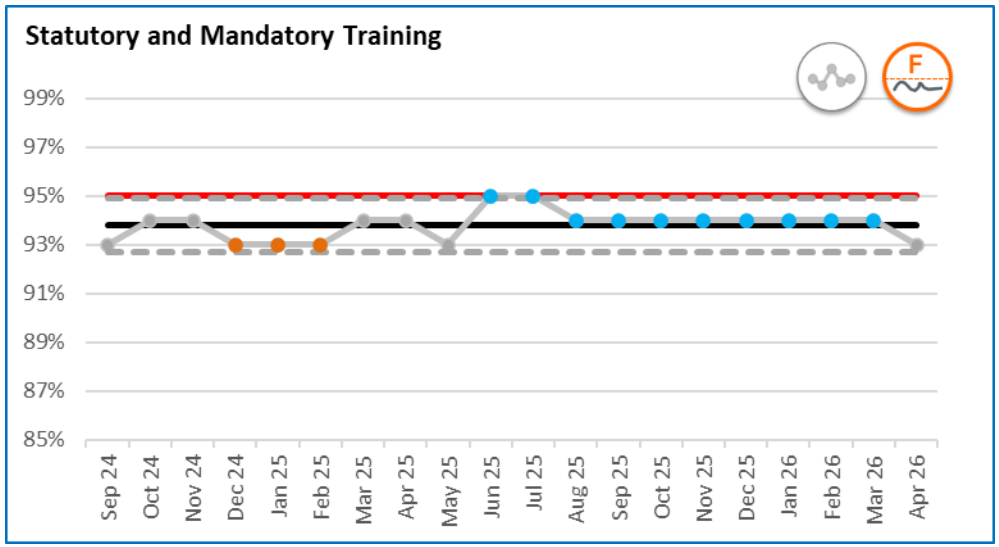
Current Performance		
Apr 26	YTD	Target
83.6%	-	95%

National Position & Overview

Peer data not available.
The April figure shows an improved position on the previous month. We are now 11.4% 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 areas with ITAPS and the Reconfiguration Directorate meeting compliance.	• 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 still underway now planned for June 2026 Trust wide. • Line managers are asked to review appraisal performance and identify any additional targeted support required	• In April 2025 Appraisal performance was at 84.8%, an increase in compliance on the previous month of March 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 and continued focus will need to shift to support talent conversations. • 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



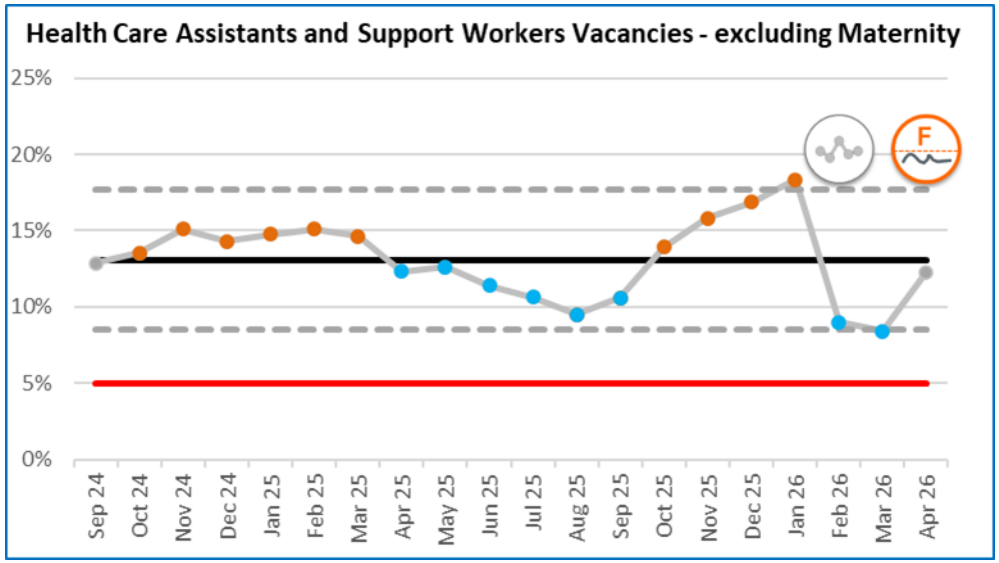
Current Performance		
Apr 26	YTD	Target
93%	-	95%

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 93% is higher than many other NHS organisations nationally and is not an immediate risk, however the target of 95% is desirable. A slight lowering of the compliance levels at this time of year is not unusual, as staff complete training from April to March. 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		
Apr 26	YTD	Target
12.3%	-	5%

National Position & Overview

Recent changes to Skilled Worker visa rules, specifically the removal of eligibility for Healthcare Support Worker roles unless they meet the £25,000 salary threshold, may be limiting the pool of candidates and reducing overall applicant supply.

Root Cause	Actions	Impact/Timescale
• The reduction in HCA vacancy rate is primarily driven by changes in workforce demand following the Nursing and Midwifery Establishment Review (NMAER), which increased the proportion of Registered Nurses on duty. • Changes to visa and immigration requirements have restricted access to international candidates and increased compliance complexity, slowing recruitment pipelines. • Attraction challenges persist, with strong competition from other sectors offering comparable roles, impacting the Trust's ability to recruit and retain HCAs.	• The Nursing Workforce Recruitment and Retention Plan for Financial Year 26-27 at NMAHPCs (Apr-26). o This includes the aim to recruit HCAs 40WTE per quarter. • The Nursing and Midwifery bi-annual establishment reviews have identified no changes to current staffing establishments. The report is scheduled for submission to the Trust Board in June 2026. As a result, there are no anticipated changes to the required HCA WTE in the foreseeable future.	Recruitment drive progress: • Band 2-3 pathway: • **Jan-26** drive: Vacancy 12 hc (2 x ready for start date, 10 x commenced in post). • **Mar-26** drive: 16 hc (all within pre-employment checks). • **May-26** drive**:** 50wte VCP escalation approved, advert due to go live. • Band 3 HCA: • **Nov-25** drive: 23wte (22 commenced in post). • **Mar-26** drive: 29 hc offers (37 rejected due to sponsorship, 9 in reserves). • **May-26** drive**:** 20wte (T-Level Student advert.)

Well Led – Non Clinical Agency- No. of Staff

Current Performance		
Apr 26	YTD	Target
1	1	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
• The service has confirmed that the agency workers are assigned to working on delivery of the capital programme which has been approved by NHSE. These workers are funded from the capital and not revenue.	• 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. • The service has been requested to advise on exit plans but confirmation that the agency worker is required due the delivery of the projects which are NHSE funded projects, eg Estates Safety and OFH	Service has indicated that the agency worker will be required for the foreseeable future.

Well Led – Agency Staff above Price cap

Awaiting more data for SPC chart

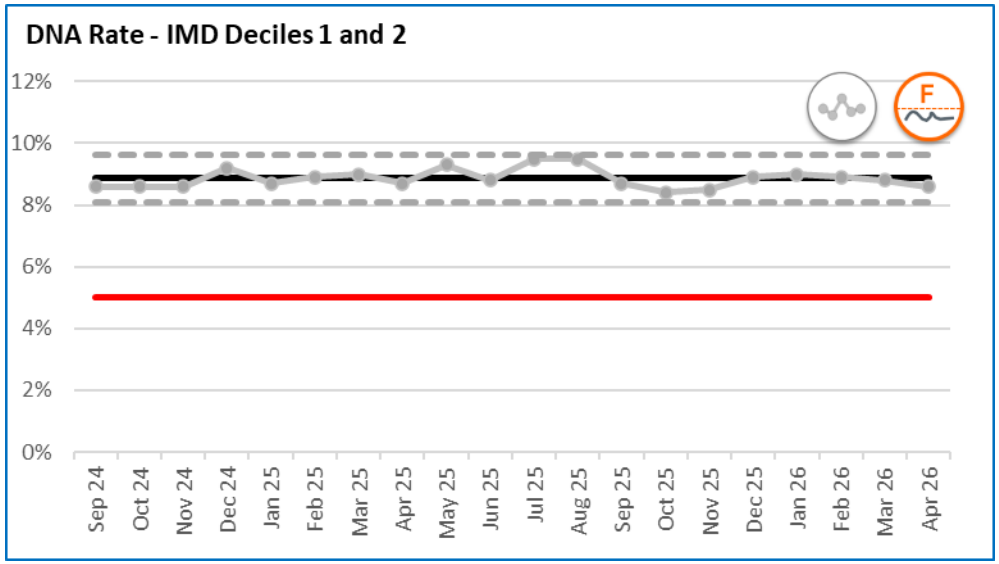
Current Performance		
Apr 26	YTD	Target
28	28	0

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.	Agency usage remains controlled, approved, and time-limited, with clear exit actions in place. Constraints are driven primarily by national labour market shortages, not a lack of local mitigation. Price cap compliance remains on regional agendas with trajectories to reach price cap compliance with each staff group documented and reviewed.	The agency reduction plan will be monitored through recruitment milestones and MoC implementation dates, with expected reductions as substantive staff commence from summer to autumn 2026, and further reductions into late 2026 for training-dependent roles The 2 AHP specialities are being managed through the Agency Rate reduction plan, commencing in May for UHL as our rates were lower than other Trusts. Medics are managed against the West Midlands rate card.

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



DNA Rate – IMD Deciles 1-2			DNA Rate – IMD Deciles 3-10		
Apr 26	YTD	Target	Apr 26	YTD	Target
8.6%	8.6%	5%	5.3%	5.3%	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	Actions	Impact/Timescale
• 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: • Patients or carers tried to contact UHL to cancel but could not get through. • Patients had a mobility issue that meant they were unable to access the sites. • Patients had a medical or health reason for not attending on the day.	• 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 programme. • Trialing of AI to support re-booking. • Work starting in Community services. • Work starting in 2WW pathways.	IMDs 1 & 2 have an average DNA rate of **8.6%** for Apr 26. Disaggregated by contact these rates are: **IMD1** • Patients contacted DNA rate 4.6% • Patients not contacted DNA rate 12.2% **IMD2:** • Patients contacted DNA rate 4.5% • Patients not contacted DNA rate 12.8% **Inclusion Healthcare:** • DNA rate for those contacted 27.3% • DNA rate for those not contacted 83.3% **Paediatric Outpatients** • WNB rate contacted 4.5% • WNB rate not contacted 20.7%

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

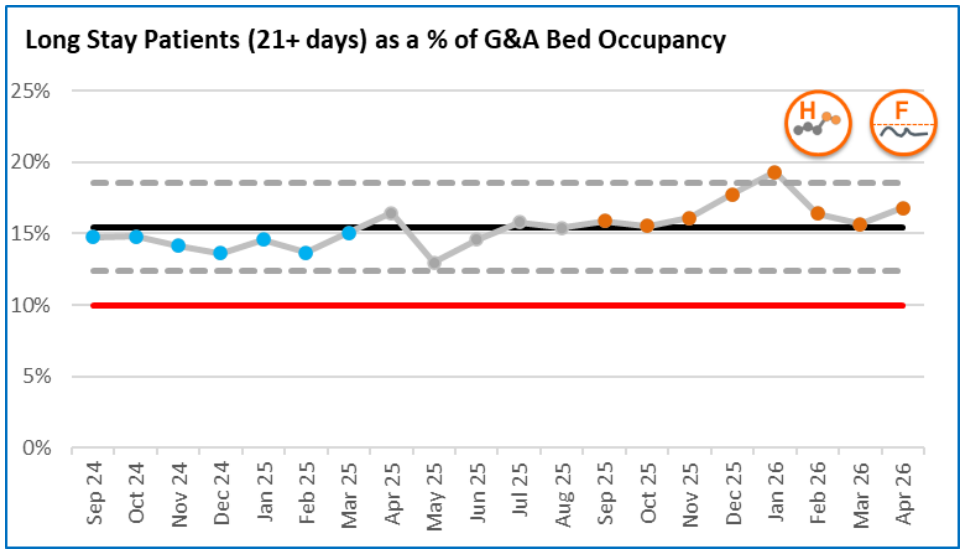
Current Performance		
Apr 26	YTD	Target
4.2	4.2	3.8

National Position & Overview

In March, UHL ranked 27 out of 118 Acute Trusts that submitted acceptable data. The National average was 6.2. 19 out of the 118 Acute Trusts achieved the target. UHL ranked 5 out of the 18 UHL Peer Trusts. The best value within our peer group was 3.2 and the worst value was 9.3.

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) **236 complex patients stayed an additional night in hospital in April 50 patients less than March (286))** • **LLR system discharge hub interface and capacity delays** continue to impact the ability to provide timely P1-3 discharge plans . **128 Patients waiting at the end of April.** • **Deterioration in LOS from MOFD to discharge for P1 (1 day from March)**	•**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 40% April, (38% March,39% February) through targeted engagement and process improvements. •**Share learning from LEAF and wider discharge QI projects** to inform approach to practice. •Plan for further ward 'SHOP' roll out.	• 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



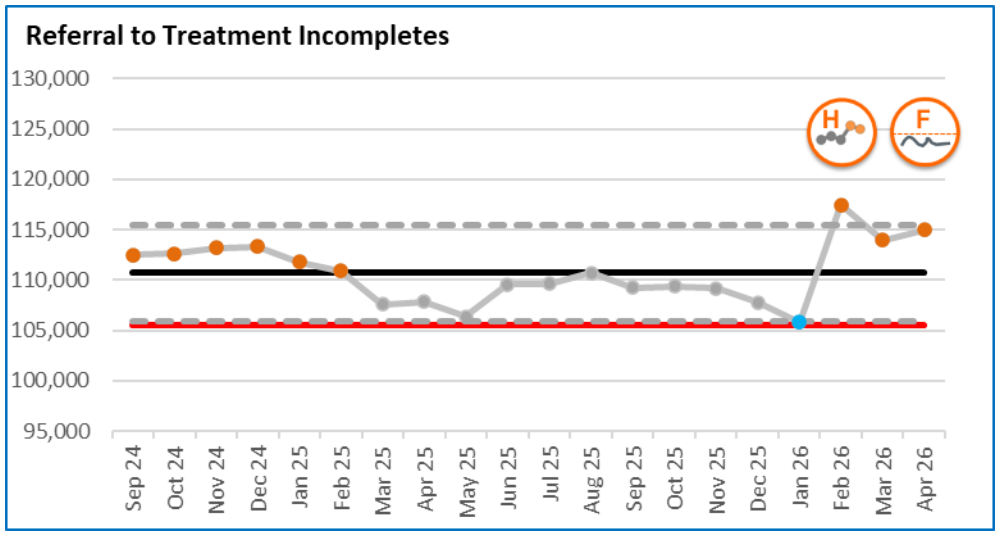
Current Performance		
Apr 26	YTD	Target
16.8%	-	10%

National Position & Overview

- 77 (306) Patients (25%) 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 (35 patients).
- 108 Patients (35%) are medically optimised complex patients awaiting discharge with no reason to stay in an Acute Trust.
- Approx. 42 (14%) patients data quality issue (not In Pt)

Root Cause	Actions	Impact/Timescale
• **LLR system discharge hub interface and capacity delays** As of the end of April there were circa 108 patients with a length of stay over 21 days awaiting a confirmed discharge outcome from LLR. • **Data quality issues (Approx. 42) continue** to arise following PAS changes. These include the system pulling pre-admission codes, delays in discharge coding, and missing outcomes.	**Throughout May 2026:** **Work with health and social care system partners to:** • Maximise the use of P1/ P2/P3 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. (**40% April,** 38% March 39% February, 32% January). • Maintain Weekly CMG reviews of > 21 day patients and top 100 day patients • Improve occupancy of Virtual Wards and use of Criteria Led Discharge • Plan for further roll out of SHOP model • Continue to work collaborate with Nervecentre to resolve the system fault that is preventing discharge coding from being completed after three months and CMG's to ensure correct .	• 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) – RTT Incompletes



Current Performance		
Apr 26	Apr 26 Plan	Mar 27 Target
114,992	113,367	96,243

National Position & Overview

At the end of March, UHL ranked 14 out of 17 trusts in its peer group with a total waiting list size of 113957 patients. The best value within our peer group was 65266, the worst value was 165568 and the median value was 83878. (Source: NHSE published monthly report)

Root Cause

- Continued growth in demand against a significant number of specialities
- Industrial action- loss of activity
- Continued workforce challenges within ITAPS reducing theatre capacity
- Estate: lack of theatre capacity and outpatient capacity to increase sessions and also age of estate leading to problems with losing capacity for maintenance work
- Emergency pressures resulting in elective cancellations.
- PAS productivity – the PAS roll out has had a bigger impact on productivity than anticipated.
- Workforce controls impacting on ability to maintain baseline and undertake additional activity through WLIs.
- The total waiting list now includes all patients waiting clinical e-triage (previously excluded). This is the cause of the significant upward spike seen in Feb. There are c11,000 pathways awaiting triage on the PTL. Approximately 10% of all patients waiting e-triage of referrals will be rejected back to referrer and previously would never have been recorded as part of the TWL.
- Validation efforts focus on over 18 weeks predominately due to impact on performance.

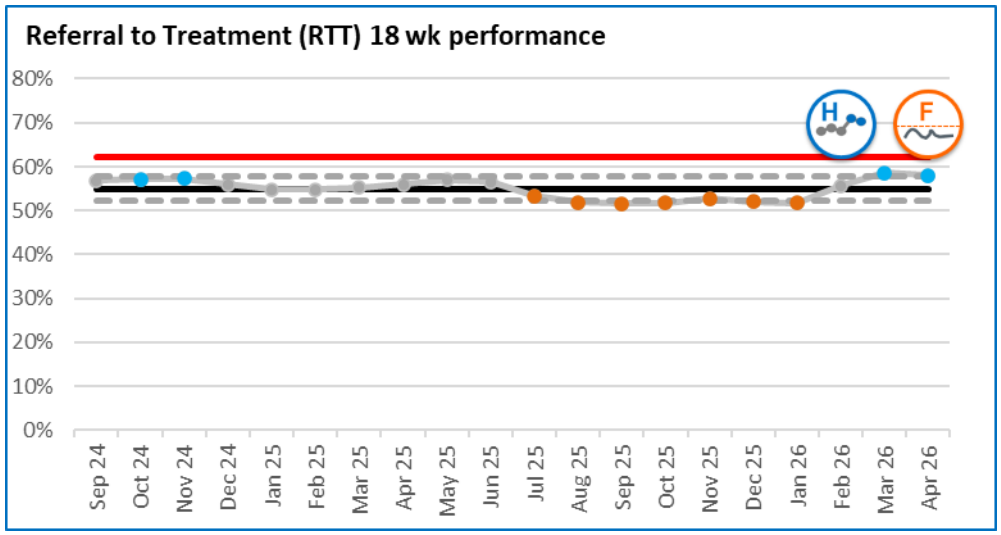
Actions

- Theatre productivity and outpatient transformation workstreams to improve productivity and increase capacity.
- Sharing session fill-rate for theatres with CMGs and active challenge on backfilling clinical activity
- Improvement plan to reduce total WL with 4 workstreams: Validation, Appointment Outcomes, Triage and Increased activity
- Planned additional data quality validation each month to support overall reduction of WL.
- Focused actions with the CMGs regarding meeting activity plans in the EMPCC, CDC and Endoscopy unit.
- Continued learning and fix finding in new PAS
- Specialities asked to provide recovery plans to reduce numbers of patients awaiting clinical triage. Figures are now being regularly reported to Senior Clinical Cabinet.

Impact/Timescale

- Increased ACPL on theatre lists- improving activity through existing resource- ongoing.
- Outpatient clinic template standardisation- to increase the number of new and follow-up appointments within clinic templates- ongoing.
- Increased number of theatre sessions delivered. Improving activity through existing resource.

Responsive (Elective Care) – RTT 18 Week Performance



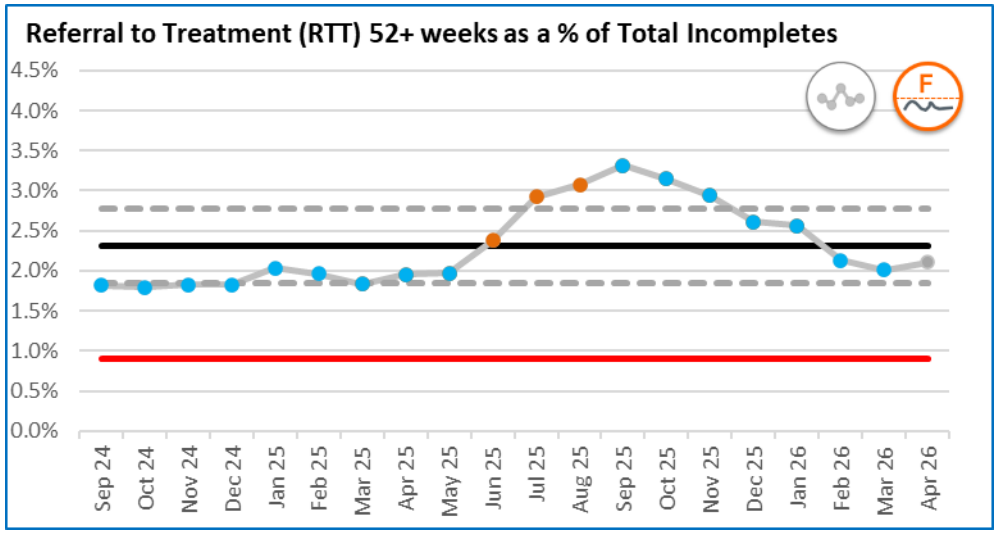
18 Week Performance			First Attendance - 18 Week Performance		
Apr 26	Apr 26 Plan	Mar 27 Target	Apr 26	Apr 26 Plan	Mar 27 Target
58.0%	57.0%	69.3%	62.5%	63.6%	75.1%

National Position & Overview

At the end of March, UHL ranked 14 out of 17 trusts in its peer group with RTT 18 Week Performance at 59.1%. The best value within our peer group was 72.5%, the worst value was 56.3% and the median value was 63.2%. (Source: NHSE published monthly report)

Root Cause	Actions	Impact/Timescale
• Continued growth in demand against a significant number of specialities • Emergency pressures resulting in elective cancellations, with specialities at the LRI site particularly challenged. • PAS productivity – the PAS roll out has had a bigger impact on productivity than anticipated. • Industrial Action- has led to reduced activity in April • Workforce controls impacting on ability to maintain baseline and undertake additional activity through WLIs. • High levels of administrative vacancies and reduction of bank due to workforce controls has led to a reduction in staff able to book clinics, reducing productivity and activity levels. • Several specialities have very poor performance against 18-week standard with significant issue in demand v capacity. Some specialties are delivering only 35% of treatment/discharge within 18 weeks.	• Development of trajectories to support 7% improvement or achievement of 69% (which ever is greater). • Assessment of demand for elective treatment by specialty to understand where maximum impact for UHL can be delivered to support 18wk standard improvements. • Theatre productivity and outpatient transformation workstreams to improve productivity and increase capacity. • Support CMGs/specialties to deliver as much activity as possible, ustilising ERF funding where needed. • Fortnightly escalation meetings chaired by Director for Planned Care with CMGs on long waiting RTT patients and overall delivery of 18-week performance. • Activity reported through monthly PRM. • Focus on validation on those pathways who will be over 18 weeks by the end of each month. • Deliver automated calling and booking solution.	• Targeted validation in the sprint periods and month end processes to maximise removals of the longest waiters and those waiting over 18 weeks. • Increased ACPL on theatre lists- improving activity through existing resource- ongoing. • Outpatient clinic standardisation plans . This will support an increase in outpatient clinic appointments and in turn improved 18ww performance. • Additional funding supported through ERF where specialities are able to deliver above activity plan to improve performance, e.g. superclinics, additional theatre lists at the weekend etc. • Additional activity delivered above plan. Number of new outpatients in April was above planned levels. • Automated calling and booking. Predicted benefits to include: increasing access for patients i.e. calls can be made out of normal business hours, reducing DNA/DNB rates, improving clinic utilisation and increasing administration efficiencies. Currently in 8-week discovery phase with supplier

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



Current Performance		
Apr 26	Apr 26 Plan	Mar 27 Target
2.1%	2.0%	0.9%

National Position & Overview

At the end of March UHL ranked 13 out of the 17 Trusts in it's peer group with 2.0% of patients on the waiting list waiting over 52+ weeks. The best value within our peer group was 0.1%, the worst value was 3.5% and the median value was 1.5%. (Source: NHSE published monthly report)

Root Cause

- Challenged Cancer position and urgent priority patients requiring treatment
- Workforce challenges in anaesthetics leading to cancellations of theatre lists
- Emergency pressures resulting in elective cancellations, with specialities at the LRI site particularly challenged.
- Increased volumes of patients on waiting list (increased demand).
- High levels of administrative vacancies and reduction of bank due to workforce controls has led to a reduction in staff able to book clinics, reducing productivity and activity levels.

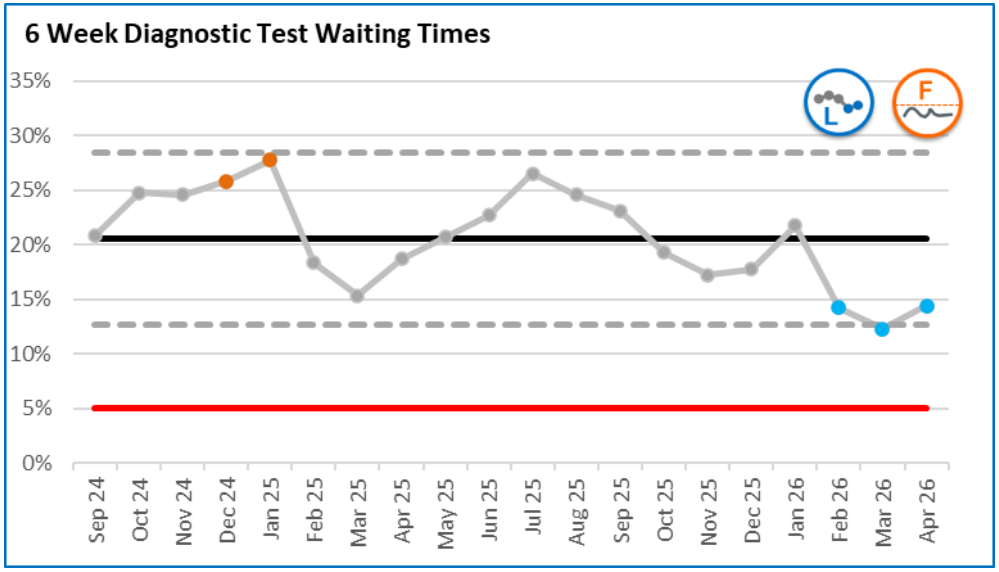
Actions

- Super-clinics to increase capacity to see new outpatients.
- Continued roll-out and focus on PIFU and DNA processes to increase capacity for new patients
- Focus on productivity to increase capacity and reduce waits.
- Weekly escalation meetings chaired by COO/ Director for Planned Care with CMGs with the bulk of long waiters (65ww and 52wws)
- Increased use of mutual aid and independent sector support, particularly within Orthopedics
- 52ww and 65ww forecasting models for specialties with large volumes of long waiters
- Support CMGs/specialties to deliver as much activity as possible, ustilising ERF funding where needed.
- Advertising for a locum to support the Orthopaedic position also looking for a locum to support trauma to allow substantive trauma consultant to do more elective.
- Additional insourced clinics planned for May and June in Maxfac. Also approaching insourcing company to see if can put on additional theatre lists in June.

Impact/Timescale

- Actions agreed with CMG leads weekly in challenge and support meetings.
- Zero 65+ week waiters not achieved. April final position was 49. Escalation meetings continue with CMGs. Current forecast for end May is 58, with a small number also forecast for June for complex/challenged specialties with patients booked TCIs into July.
- Additional activity delivered above plan. Number of new outpatients in April was above planned levels.
- Interviews scheduled beginning of June.
- Reduction in 52w+ waits within Maxfac.

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



Current Performance		
Apr 26	**Apr Plan**	**Target**
14.4%	**14%**	**7.0%**

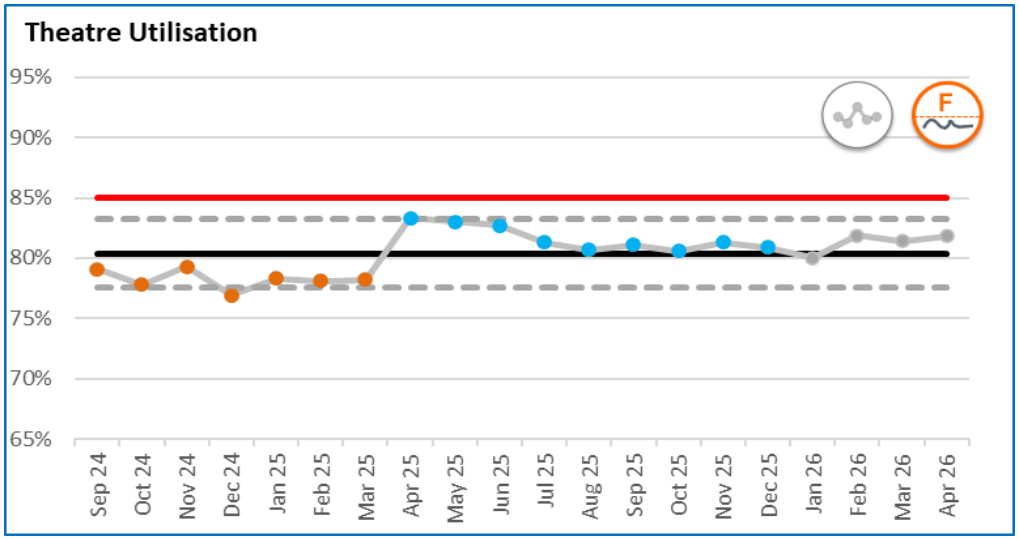
National Position & Overview

Published National data at the end of March 2026 shows 1.91m patients on the diagnostic waiting list with 21.2% waiting over 6 weeks. For April 2026, UHL with 24.574 patients would comparatively rank as the 16th highest waiting list. The 6-week trajectory for April was set to deliver 14%, the actual was 14.4%, 0.4% behind plan, driven by Cystoscopy, Audiology and Echo. There were 3,547 patients waiting >6 weeks, a deterioration of 645 patients from March '26.

Root Cause	Actions	Impact/Timescale

Diagnostics pressure areas are in the main:
• Audiology
• Echocardiography
• Cystoscopy
• Endoscopy – although on plan in M1
 	
Root cause
• Clinical & administration workforce gaps
• Reporting and increased need for manual validation
• Pressure from emergency, cancer and elective long wait pathways
• Industrial action in April
	• WLMDS Data Quality training & reporting review - ongoing
	• Improve productivity & utilisation
	  ◦ Hinckley CDC to reach 90% by June
	• Increase capacity
	  ◦ Additional lists (Echo, Audiology, Cystoscopy)
	• Review demand data with ICB
	• Redesign of pathways
	  ◦ Sleep
	• Expand direct access diagnostics
	• Increase straight to test pathways to support Cancer/RTT
	• CDC expansion to include 5 year MRI/CT D&C plan, and opportunities for one-stop streamlined pathways.
		• Validation & DQ – work in progress with Digital/NC support.
		• Productivity - CT/MRI static. Endoscopy in-session, booking utilisation and APPL improved. Sleep paediatric, Cystoscopy and Urodynamics utilisation remain above 90%.
		• Audiology – additional activity & workforce review - recovery expected by Q2
		• Echo – insourcing & additional activity required to support recovery.
		• Cystoscopy – additional activity - recovery by Q2
		• Endoscopy – Recovery actions focus on workforce, booking, utilisation and DQ. DM01 on plan for month 1.
		• Sleep – QI project support, actions include group clinics, redesign of pathway - recovery expected in Q2 due to focus on RTT.

Responsive (Elective Care) – Theatre Utilisation



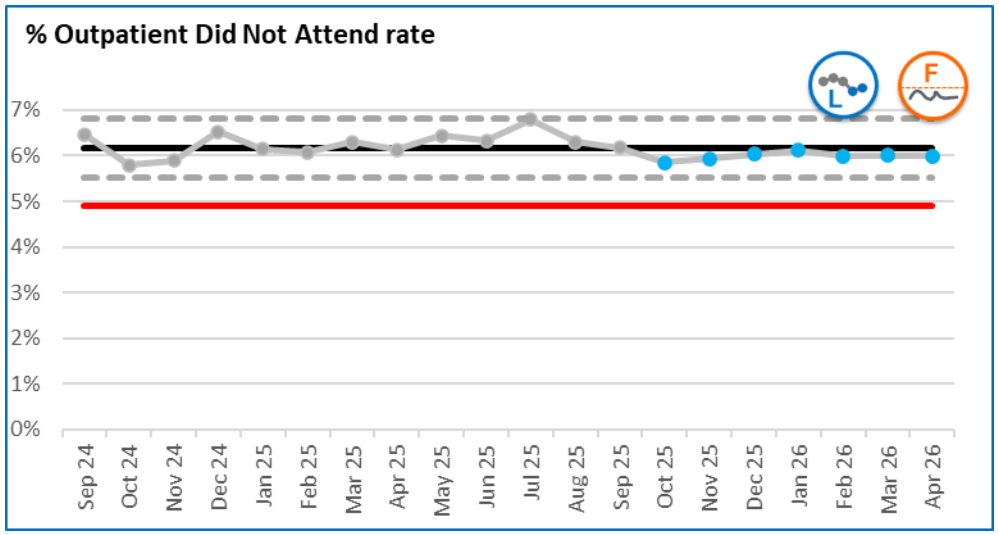
Current Performance		
Apr 26	YTD	Target
81.8%	81.8%	85%

National Position & Overview

Overall theatre utilisation in April was 81.8%, a slight improvement from March (81.4%), but remained below the 85% standard. Trust performance continues to be rated Green (Quartile 3) on Model Hospital System. For the week ending 3rd May 2026, utilisation was 82.3%, exceeding both the peer median of 80.5% and the national median of 81.6%

Root Cause	Actions	Impact/Timescale
• **LRI**, utilisation increased to 76.6% (from 75.5%).Late starts remain significant (38%). OTDC improved (11.7% to 10.1%) but remain double the 5% target. Increase in cancellations seen due to bed issues. Paediatric utilisation (69.9% to 71.6%) continues to disproportionately impact site performance. Adult utilisation rose to 78.5%, despite emergency/ bed pressures and >24-hour emergency theatre waits impacting elective lists. • **EMPCC**, utilisation was 78.1%, with improvement in OTDCs (8.2% to 6.1%). 4/7 specialties achieved >80% utilisation; however, significant session underruns impacted performance, particularly in gynae (71.6%) and ENT (71.0%) driven by procedure time variation between planned (booked >100%) and actual case durations. • **UHLiC**, utilisation reduced to 80.9% (from 82.3%), reflecting wide specialty variation (93% - 75%). OTDC increased (6% to 10%) primarily due to unavoidable estate failure (lift breakdown at the Loughborough site), resulting in the cancellation of 6 patients.	• Request paediatric QI support to deliver end-to-end emergency and elective pathway redesign. • EMPCC Super Week (w/c 18 May): Added dedicated additional scheduled session involving anaesthetists and POA to confirm patient and list readiness. EMPCC staff proactively contacting patients pre-admission to confirm attendance and fitness for procedure (reduce on-the-day risk). • Complete a lessons-learnt review of EMPCC Super Week preparation following only 53% of week-1 patients being passed fit, to identify bottlenecks causing late pre-assessment and implement changes to ensure P3/4 patients are fit to proceed prior to listing. • Implement revised ENT & Gynae procedure timings at EMPCC based on actual case durations. • Strengthen OTDC grip via Monthly TPAB and weekly performance meetings with clear specialty ownership • 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).	• Establishes a shared, system-wide view of paediatric flow, enabling targeted improvements that increase theatre utilisation and recovery in overall LRI performance. • EMPCC - Maximises productivity during Super Week, achieving >85% utilisation on all lists and treating more patients by eliminating avoidable cancellations. • Ensures learning is translated into improvements within booking discipline, developing targeted actions to increase the proportion of patients fit for procedure and improving list reliability. • Reduces session underruns and improves list fill and utilisation at EMPCC, with revised ENT timings live from 11th May. • Strengthens grip on cancellations through proactive review and Board oversight, supporting sustained utilisation >85%. • New Service Manager is now in post, providing active on-the-ground support through fortnightly service reviews to address late starts at LRI.

Responsive (Elective Care) – Outpatient DNA Rate

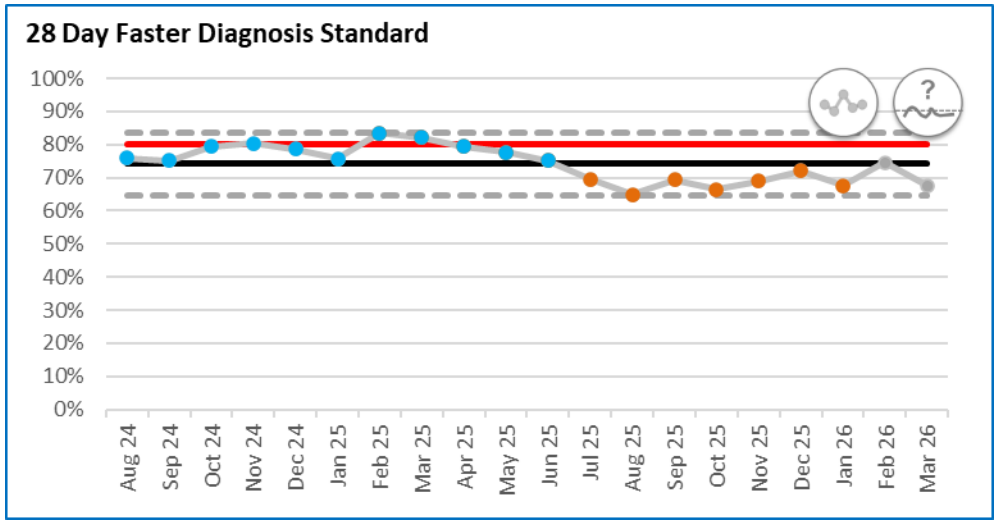


Current Performance		
Apr 26	YTD	Target
6.0%	6.0%	4.9%

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 upto 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			
Mar 26	YTD	Mar Plan	Target
67.6%	71.0%	80.0%	80%

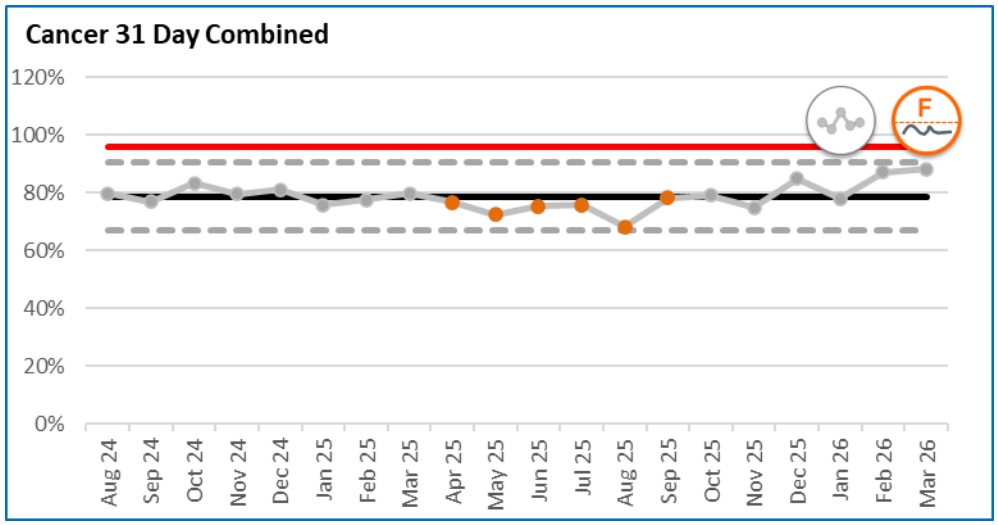
National Position & Overview

In March, UHL ranked 130 out of 141 Acute Trusts. The National average was 79.4%. 106 out of the 141 Acute Trusts achieved the target. UHL ranked 17 out of the 18 UHL Peer Trusts. The best value within our peer group was 86.5%, the worst value was 65.8% and the median value was 81.5%.

Specific capacity constraints in Breast & ENT have affected performance.

Root Cause	Actions	Impact/Timescale
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 with a decline in uptake. • ENT consultant gap with inability to consistently backfill with locums 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 March would have been 80%.	• Breast insourcing and bank/WLI to support 1st appt wait times. • Mutual aid requests for Breast & ENT have not been successful • Re-recruit to locum in ENT & advertise role for ACP. • Triage ENT referrals to risk stratify demand • Continued focus on 'Days Matter' 1st waits, imaging turnaround times & acting on results • Ongoing work to improve letter clarity for confirmed or excluded cancers.	• Breast first appointment remain at 3-4 weeks. Expect to hold and improve symptomatic performance from June. • ENT first appointment waits remain 6-7 weeks. Recruitment is complete with delayed start date, locum recruitment continues to backfill. ACP role approved, out to advert in May. • ENT triage pilot planned go live June 26. • Increased communication to primary care to encourage use of breast pain pathway. • 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			
Mar 26	YTD	Mar Plan	Target
88.2%	78.4%	90.0%	96%

National Position & Overview

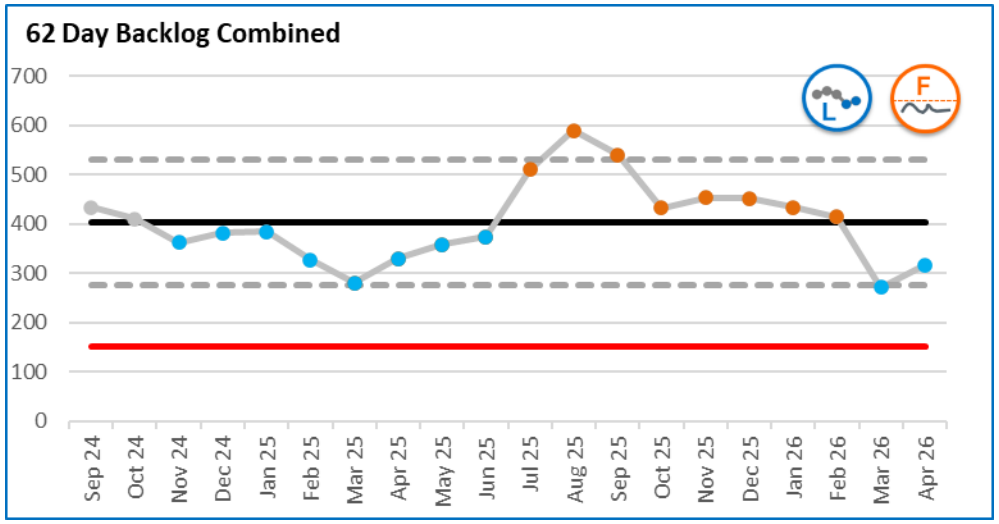
In March, UHL ranked 119 out of 138 Acute Trusts. The National average was 92.8%. 75 out of the 138 Acute Trusts achieved the target. UHL ranked 12 out of the 18 UHL Peer Trusts. The best value within our peer group was 98.5%, the worst value was 75.5% and the median value was 92.7%.

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

Root Cause	Actions	Impact/Timescale

Insufficient capacity within radiotherapy and surgery 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.
		Radiotherapy
		• Increased capacity 5th linac. Prostate waits continue to improve.
		• Efficiency work prrogramme continues. Paperless planning is in place with full impact expected by end of Q1.
		Surgery
		• Improvements noted in March
		• 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		
Apr 26	YTD	Target
317	-	152 (by March 26)

National Position & Overview

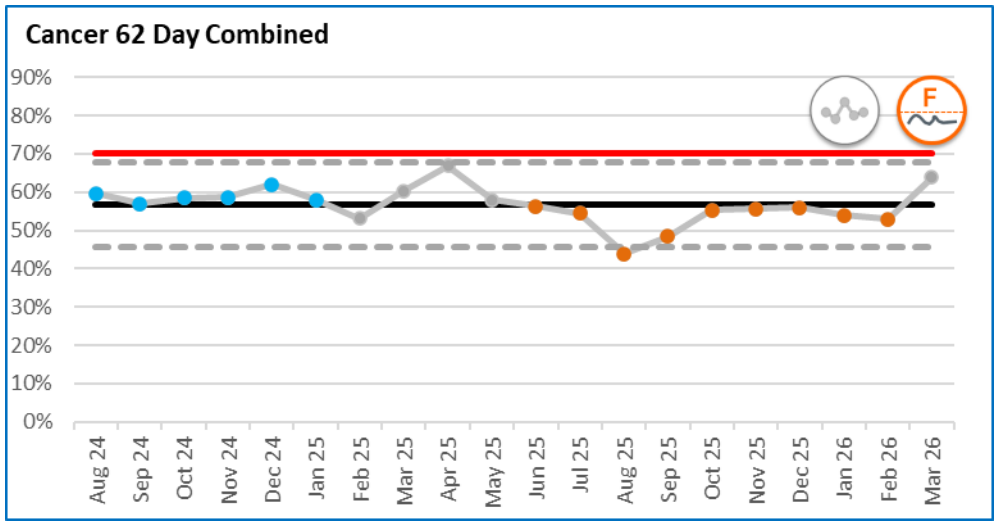
National and Midlands data is no longer available.

UHL end of April position:
>62 day 41 behind plan.
>104 day 7 ahead of plan.

Urology and Gynaecology are both ahead of trajectory.

Root Cause	Actions	Impact/Timescale
• Breast, Colorectal and Urology drive the largest volume, with Breast alone holding 30% of 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 – improvements noted in Q4. • Oncology improvement actions to start to impact from late July. • Plastics are working with UHN to increase LNR capacity in addition are reviewing SLNB scheduling.

Responsive Cancer – Cancer 62 Day Combined



Current Performance			
Mar 26	YTD	Mar Plan	Target
63.8%	55.4%	70.1%	70%

National Position & Overview

In March, UHL ranked 127 out of 146 Acute Trusts. The National average was 72.8%. 104 out of the 146 Acute Trusts achieved the target. UHL ranked 14 out of the 18 UHL Peer Trusts. The best value within our peer group was 84.1%, the worst value was 56.0% and the median value was 71.0%.

Improved performance compared to previous month. UHL last achieved the standard in 2014. Average days waits have shown slight improvement in 2025/26 alongside increased referrals (3.9%) and treatment (3.1%).

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 with focus on top volume tumour sites (Breast, LOGI, Urology, Skin) • Key actions include 'Days Matter', parallel investigations, streamlining MDT and time to act on results. • Strengthened clinical and operational management of pathways. • Urology – Trial of Galeas from 18th May to support the Bladder pathway.	• Clinical comms emphasising ordering tests in parallel, progressing outside of MDTs and speed to act on results. • Pathology insource/outsourcing of urology & gynaecology supporting TAT – ongoing • Imaging TAT plans to increase uptake of WLIs for reporting – impact from late May/June • Gynae, Skin show improved performance, Lung holding. Improvements across the year are expected in line with plan for all tumour sites, with largest risk for 62 days held in Breast.

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

Executive Summary

- The month 1 position for the Trust is a deficit of £3.9m which is £0.8m adverse to plan. This position includes £1.6m of costs related to industrial action. Excluding this, the Trust would be £0.8m better than plan.

- The cash position at the end of Month 1 was £20.8m, which is a decrease of £13.8m from March.

Summary Financial Position – YTD M1

I&E

	I&E YTD Plan £'000	I&E YTD Actual £'000	I&E YTD Variance to Plan £'000
NHS Patient-Rel Income	135,084	135,584	499
Other Operating Income	14,696	14,036	(660)
Total Income	**149,780**	**149,619**	**(161)**
Pay	(96,312)	(96,882)	(570)
Non Pay	(48,902)	(49,191)	(289)
Total Costs	**(145,214)**	**(146,073)**	**(859)**
EBITDA	**4,566**	**3,546**	**(1,020)**
Non Operating Costs	(7,732)	(7,636)	96
Retained Surplus/(Deficit)	**(3,166)**	**(4,090)**	**(924)**
Donated Assets	(52)	118	170
Impairments			
Control Total Surplus/(Deficit)	**(3,218)**	**(3,971)**	**(753)**

Comments – YTD Variance to Plan

Total Income: £0.2mA

- PCI income excludes any recognition of UEC overperformance as contract negotiations are still on-going. Additionally, £0.4m of income has been lost due to industrial action.

- Other income driven by £0.3m of under-recovery of catering and car park income, £0.2m of donated asset income shortfall and an incorrect budget phasing that will be resolved for M2

Pay: £0.6mA:

- Medical costs include £1.2m of additional costs due to industrial action.
- Nursing and Other Clinical underspends are driven by vacancies

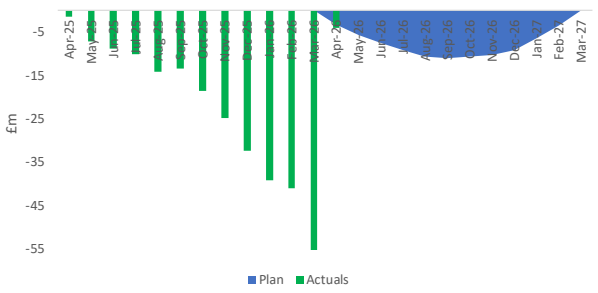
Bank (£7.4m) and Agency (£0.4m) spend YTD amounts to £7.8m which is 8% of total pay.

Non-Pay: £0.3mA:

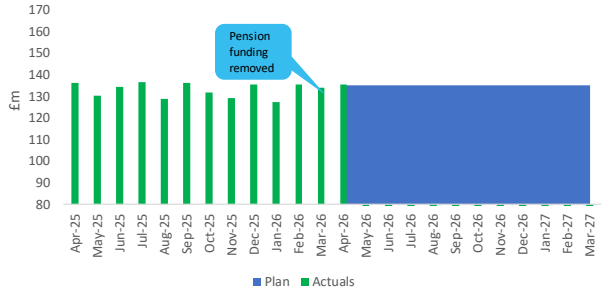
- Clinical Negligence £0.7mF relating to the maternity incentive scheme rebate.
- Premises & Fixed plant (£0.5m) driven in the main by additional spend in IT and reduced VAT recovery

Month 1 I&E Dashboards

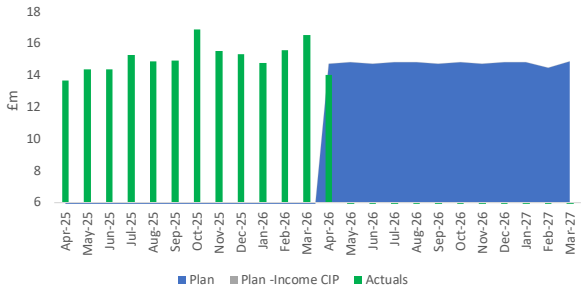
Cumulative Surplus/(Deficit) - Excluding Impairments



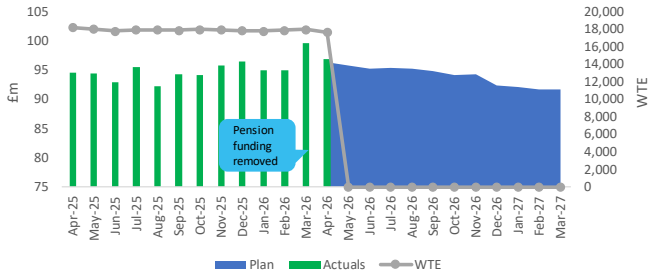
Monthly PCI Income



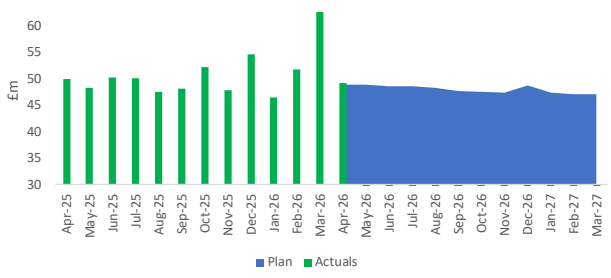
Monthly Other Income



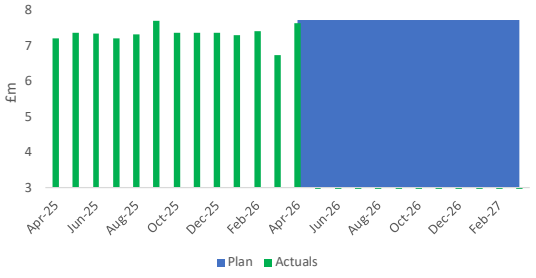
Monthly Substantive/Bank/Agency Pay



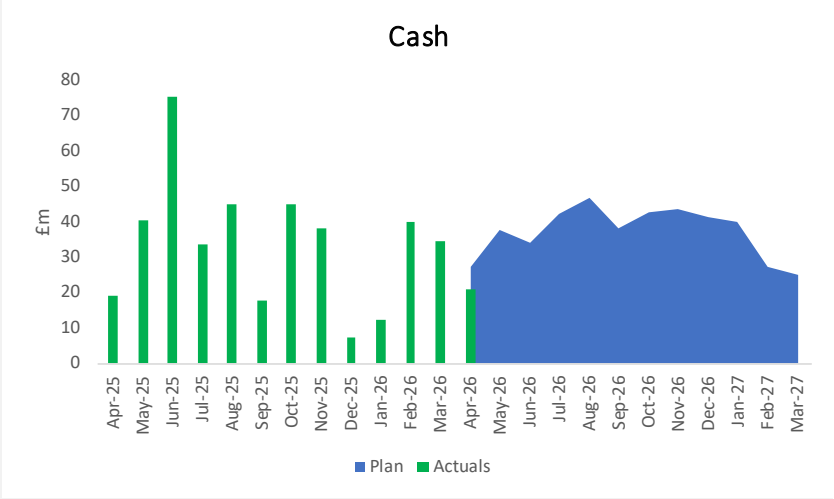
Monthly Non Pay

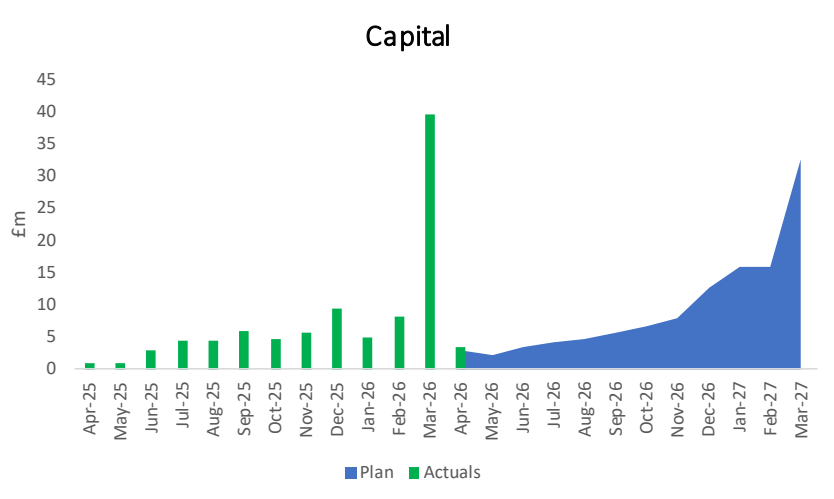


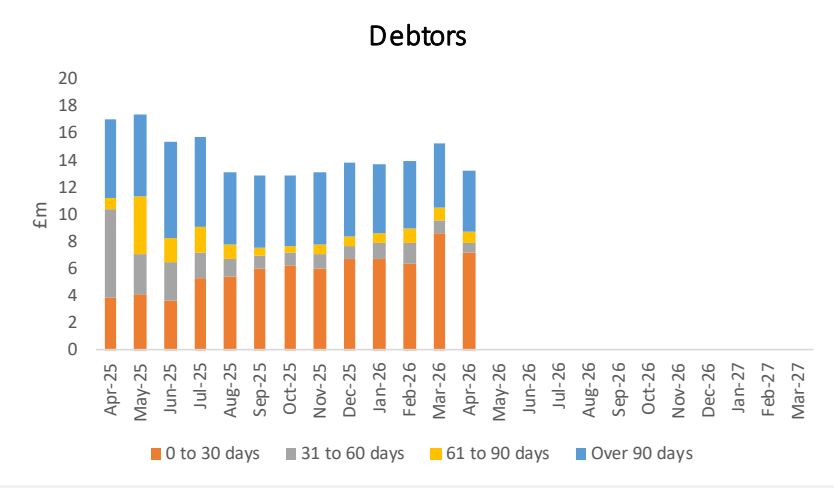
Monthly Non Ops - Excluding Impairments

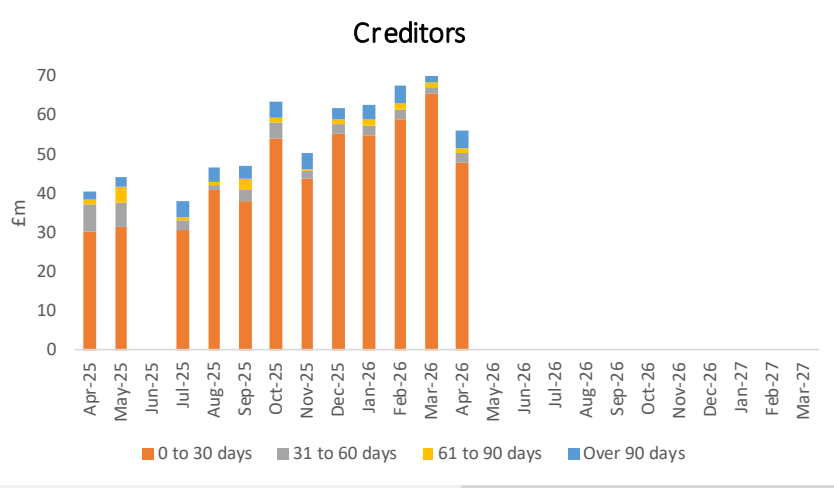


Month 1 Balance Sheet Dashboards









Statement of Financial Position

- **Non-Current Assets (-£2.2m):** Depreciation of £5.6m in M1 offset asset additions of £3.7m.
- **Trade and other receivables (+£4.3m**): Increase driven by £5.7m in NHS accruals and £2.8m in Digital and Data contract prepayments. These gains were partially offset by a reduction in VAT receivables (£2.7m) and NHS receivables (£1.5m).
- **Cash (-£13.9m) –** Refer liquidity and cash slide
- **Trade and other payables and accruals (-£25.8m):** Reduction resulting from processing of year end creditors.
- **Deferred Income (+17.4m) :** increased due to the deferral of patient care income, which will be released to match future period activity performance (ie effectively it's a payment in advance).
- **Dividend Payable (+** £2m): In line with plan and represents the accrual of PDC dividend payable at M1.
- **Income and Expenditure Reserve(+£4.1m) –** movement reflects the in year reported adverse income and expenditure position.

Statement of Financial Position

£m	31-Mar-26	Apr-26	In Month Movement	YTD Movement
Non Current Assets				
Intangible assets	33.9	33.3	(0.6)	(0.6)
Property, plant and equipment	665.6	664.0	(1.6)	(1.6)
Other non-current assets	4.6	4.6	(0.0)	(0.0)
Total non-current assets	**704.1**	**701.8**	**(2.2)**	**(2.2)**
Current Assets				
Inventories	27.8	27.7	(0.1)	(0.1)
Trade and other receivables	44.6	48.9	4.3	4.3
Cash and cash equivalents	34.7	20.8	(13.9)	(13.9)
Total Current Assets	**107.0**	**97.3**	**(9.7)**	**(9.7)**
Current Liabilities				
Trade and other payables	(168.7)	(142.9)	25.8	25.8
Leases < 1 Year	(12.3)	(13.2)	(0.9)	(0.9)
Accruals	(23.1)	(20.9)	2.1	2.1
Deferred income	(4.9)	(22.3)	(17.4)	(17.4)
Dividend payable	0.0	(2.0)	(2.0)	(2.0)
Provisions < 1 year	(9.1)	(9.1)	(0.0)	(0.0)
Total Current Liabilities	**(218.1)**	**(210.5)**	**7.6**	**7.6**
Net Current Assets / (Liabilities)	**(111.1)**	**(113.1)**	**(2.0)**	**(2.0)**
Leases > 1 Year	(35.8)	(35.7)	0.2	0.2
Provisions for liabilities & charges	(3.0)	(3.0)	0.0	0.0
Total non-current liabilities	**(38.9)**	**(38.7)**	**0.2**	**0.2**
Total Assets/(Liabilities)	**554.1**	**550.0**	**(4.1)**	**(4.1)**
Public dividend capital	(984.6)	(984.6)	0.0	0.0
Revaluation reserve	(174.3)	(174.3)	0.0	0.0
Income and expenditure reserve	604.8	608.9	4.1	4.1
Total Capital & Reserves	**(554.1)**	**(550.0)**	**4.1**	**4.1**

Liquidity and Cash Position – Month 1

- Cash balance at end of April: £20.8m (£18.1m for the Trust). Year End Forecast of £25.6m.
- In-month reduction of £13.9m, as year end capital and revenue payables were transacted.
- M1 BPPC of 95% by value, 92% by volume.

Receivables & Payables

- Total debt: £13.3m, of which >90 days £4.6m .
  - Overseas visitors >90 days: £1.5m (partially in write-off/collection processes).

Payables reduced by £17m to £56.0m mainly as a result of capital creditor payments.

	Month 1						Month 12					
	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	**10,399**	5,456	608	677	3,658	35%	**10,947**	6,011	832	521	3,583	33%
NHS receivables	**2,876**	1,781	107	76	912	32%	**4,328**	2,666	137	377	1,148	27%
Total receivables	**13,275**	**7,237**	**715**	**754**	**4,569**	**34%**	**15,275**	**8,677**	**969**	**898**	**4,731**	**31%**
Non-NHS payables	**49,799**	43,109	2,187	999	3,504	7%	**64,564**	59,519	1,245	1,255	2,545	4%
NHS payables	**6,255**	5,043	227	57	928	15%	**8,402**	6,217	453	(126)	1,857	22%
Total payables	**56,054**	**48,152**	**2,413**	**1,056**	**4,433**	**8%**	**72,967**	**65,737**	**1,698**	**1,130**	**4,402**	**6%**

Capital Programme - 26/27 M1 Position

Summary

- Opening capital plan: **£115.7m**
- Ahead of plan at M1 by **£0.5m**
- Plan includes proposed core operational allocations and agreed developments and Return to Constitutional Standards (RtCS) plans. All RtCS proposed schemes were classified as green and have been supported by NHSE, subject to business case submission.
- The key risk will be the management of the allocation for CDC expansion in 26/27 of c£15.8m. As presented in the table below, this will require an element of *'teeming and lading'* across the financial years and across national and core operational allocations to accommodate the profile of spend, which will either involve the bringing forward of spend (for example in 26/27) from future years or deferment into future years as appropriate (as in 27/28).

	2026/27	2027/28	2028/29	2029/30	TOTAL
	£000s	£000s	£000s	£000s	£000s
RTCS - Original	17,250	12,500	12,750	8,500	**51,000**
Core Operational Allocation	50,771	55,143	56,188	57,234	**219,336**
Total Original	**68,021**	**67,643**	**68,938**	**65,734**	**270,336**
Revised Spend Profile	61,031	76,503	71,226	61,577	**270,336**
(Under) /Over Committment Against Allocation	**(6,990)**	**8,860**	**2,288**	**(4,158)**	**0**
Bring Forward Core	6,990	(6,990)		0	**0**
Defer RtCS	0	(1,870)	(2,288)	4,158	**0**
	6,990	**(8,860)**	**(2,288)**	**4,158**	**0**
Revised (Under) /Over Comittment Against Allocation	**0**	**0**	**0**	**0**	**0**

	M1 Plan	M1 Actual	Variance to M1 Plan
	YTD	YTD	YTD
	£'000	£'000	£'000
Gross capital expenditure including IFRS impact:	3,058	3,405	347
Less: Book value of asset disposals inc IFRS16 Disposals	0	(5)	(5)
Less: Capital grants/donations received	(192)	0	192
Charge against the Capital Resource Limit (CRL) incl IFRS impact	**2,866**	**3,399**	**533**

The overriding aim of the core operational allocations has been to secure an equitable split of the constrained funding available. This was a risk based approach, to ensure that schemes are prioritised across the core infrastructure areas, according to relative risk. Refer separate capital risk report, which sets out the rationale for schemes included and not included in the plan

Sources of Funding	Annual Plan 26/27 £'000
System Capital	
System Operational Capital	**44,047**
Operational IFRS16 leases	6,725
Total System Capital	**50,772**
National PDC Allocations	
Estates Safety (CIR)	9,039
Estates Safety (CIR - Theatre Refurbishment)	300
Diagnostics (RtCS)	15,250
UEC (RtCS)	2,000
NHS Fees	1,112
NHP	25,459
NHP LRI Enabling Works	9,228
Total National Programme	**62,388**
Charity/Grant Funded Schemes	2,500
Charity/Grant Funded Schemes	**2,500**
Total Capital Programme	**115,659**

University Hospitals Leicester

April 2026

Performance Overview

Exception Reports

Finance

Appendix - Data Quality Assessment

Data Quality Assessment

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

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

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