University Hospitals of Leicester NHS
NHS Trust

Paper F

Meeting title:	Public Trust Board Report					
Date of the meeting:	11 September 2026					
Title:	**Integrated Performance Report and Executive Summary**					
Report presented by:	Richard Mitchell, Chief Executive					
Report written by:	Sarah Taylor, Deputy COO Emergency Care and Kully Kaur, Assistant Director of BI and Information					
Action – this paper is for:	Decision/Approval		Assurance	X	Update	
Where this report has been discussed previously						

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

Impact assessment

Acronyms used

Purpose of the Report

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

The executive summary is split into 3 parts

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

Recommendation

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

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

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

Summary

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

Main report detail

Key headlines in performance are summarised below:

Summary of UHL Performance: JULY 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** 	July 2026 saw an increase of 1343 Emergency Department attendances to plan. Eye Casualty saw 76 more attendances than plan. This also represents an increase on July 2025 of 1492 attendances across type 1 and 2. 4-hour performance in July did not achieve the trajectory of 67.9% with a performance of 60.80% (UHL only). Type 2 activity achieved 92% against a trajectory of 95.9%. The key challenge in delivery was due to the volume of attendances and waits in ED for beds. LRI monthly ambulance handover improvement has been challenged during the first four months of the year, however, our performance has remained improved v's the same period last year and we met Month 4 trajectory with average handover at 28.35 minutes. We had 0 extended delays on ambulances (over 8 hrs). The 12-hour performance (total time in dept) was 9.36% therefore achieving trajectory of <10%. Emergency admissions were over plan by 531 admissions against plan and 643 more than the same period last year again driving challenges in flow from the Emergency Department for patients waiting for beds. Whilst not exhaustive some key improvement initiatives are: - • Work on LoS has commenced with April showing an improvement, July deteriorated from a trajectory of 7.0 days to 7.84 days. The majority of this in Specialist Medicine and early indications is that this is driven by the discharge of extended length of stay patients, the heat wave and overall increase in admissions. • The Urgent Treatment Centre building work is progressing and remains on track to open in August 2027. • The Children's and Young People same day emergency care proposal has been completed and funding confirmation is awaited from the ICB in August. • Acute Virtual ward funding has been approved, and the service will commence in October • UEC Clinical Operating standards have been fully rolled out, and monitoring mechanisms have been agreed for roll out in July and August. • SDEC continues to perform well overachieving trajectory.

Elective Care **Referrals and Outpatient performance** **Elective activity** **Pathway Improvements** 	Performance across Elective Care remains significantly challenged, particularly in relation to waiting list size, RTT standards, and long waiters (65 week and 52 week waits). Note that July figures are current forecasts, as the submission deadline for July has been extended by NHSE to Tuesday 25th August 2026. Total waiting list remains above plan and is a key area of focus. The Total Waiting List (including numbers awaiting triage) in June was 115,279 – adverse to plan (110,485). Current forecast for July is to achieve a TWL just under 115,000. The challenge is to recover the TWL numbers back to plan as quickly as possible and retain RTT performance in line with plan. The final June position for 65-week waits was 54 patients; with no improvement seen from the end of May. Current forecast for the end of July position is 74. An enhanced plan for managing the route to zero 65-week waits across all CMG specialties is now in place. Each CMG Head of Operations has been tasked to engage directly with their respective specialties to review patient cohorts and agree bespoke actions aimed at accelerating reductions, with an escalation meeting in place with CEO and COO. All specialties with a September cohort of less than 100 have been asked to ensure zero 65ww by the end of September, and Orthopaedics have been asked to be at zero by the end of December, with an improving month on month position. The June position for 52-week waits was 2,402 patients, equating to 2.1% of the total waiting list. The final July position is expected to be very similar. The plan for 26/27 is to deliver <1% of the total waiting list over 52 weeks by the end of March 27. **Productivity and activity:** Capped theatre utilisation reduced to 81.1% in July and is 82.3% year to date, whilst below the 85% target it still puts the Trust in the upper quartile nationally for theatre productivity. Outpatient clinic utilisation remained strong at 96.3%, above the 95% target. Patient Initiated Follow Up increased to 6.3% in July, with a 5.8% year-to-date position, while follow-up appointments without a procedure remained stable at 49.3%. **Outpatient performance and recovery:** The outpatient DNA rate was 7.0% in July and 6.5% year to date, above the 4.9% target. The increase followed the move to sourcing mobile numbers from NerveCentre for Accurx appointment reminders, which exposed data quality and clinic-list issues that prevented some reminders from being sent. The issues have been escalated to UHL IT, Data Quality, EPR and Accurx teams, with corrective work and close monitoring under way.
Cancer **Referrals** **2 week wait** **Faster Diagnosis Standard** **62-day referral to treatment** 	Referrals year to date have seen an increase of 1.4% compared to the previous year. Conversion rates year to date is 6.4% and is in line with the national average. June cancer performance showed a varied but improving position with improvements continuing in two of the three standards with the third only having a slight deterioration (0.4%) on the previous month. FDS delivered 73.7%. This was, a 1.1% improvement on May's position and confirms that the expected June recovery had started to materialise. Performance remains fragile, with the main constraints continuing to sit in Breast, Head & Neck and Colorectal. Breast showed a clear improvement in June, reaching 74.2%, supported by first appointment recovery and additional capacity measures. Head & Neck remain adverse to plan at 37.0%, although first appointment waits are now improving following the triage pilot and additional workforce support. Colorectal performance remained constrained by CTC reporting and pathway delays. The service is working through action plans to enact pathway changes to support recovery.

	31 Day performance remained strong in June at 89.4%, delivering 4.3% favourable to plan. This reflects sustained improvement across the standard. Radiotherapy and Drug treatments remain positive contributors, while surgical delivery continues to be affected by theatre and workforce constraints, particularly in Lung. The overall position remains favourable to plan but continued grip is required to maintain consistency where high-risk anaesthetic capacity, theatre availability and pathway sequencing affect treatment timing. 62-day performance remained steady delivering 61.2%. The standard remains below national expectation and continues to be most affected by Breast, Lower GI and Urology. The Trust backlog position remains static with 353 patients over 62 days and 94 over 104 days reported at the end of July. Breast, including screening, remains the largest source of variance at 30.1% of the backlog, followed by Lower GI at 16.5% and Urology at 13.9% with Urology continuing to reduce. Continued clinical prioritisation, backlog review and pathway-level recovery plans remain central to sustaining delivery. The improvement focus is now rightly shifting from short-term recovery actions to sustained pathway flow. Long term sustainability remains dependent on maintaining additional capacity, embedding pathway changes at pace and stabilising workforce gaps in the most challenged tumour sites. Priority actions include earlier clinical decision-making, greater use of parallel investigations, streamlined MDT processes, tighter management of time from result to action and targeted reductions in imaging and pathology turnaround times. Breast, Head & Neck, Colorectal and Urology remain the key recovery pathways.
Quality 	Quality performance during July 2026 remained mixed. Patient experience measures continue to perform relatively well, with Friends and Family Test scores remaining high at 94.4%, although below the Trust target. Complaint response performance has continued to improve, with compliance against local response times showing a sustained positive trajectory. Areas of concern remain within patient safety. Two Never Events were reported during the month, bringing the year-to-date total to six, and falls have increased above the upper control limit for the first time in 19 months, with seven incidents resulting in moderate or greater harm. Focused actions are underway through the Patient Safety Committee and divisional governance structures to strengthen learning, compliance and oversight. Infection prevention reviews have identified variation in compliance with key standards, including MRSA screening and decolonisation, ANTT practice and vascular access management. Targeted improvement actions are being implemented to strengthen compliance, reduce infection risk and improve assurance through enhanced audit and monitoring arrangements. Overall, while patient experience and complaint performance continue to improve, sustained focus is required on patient safety, infection prevention and harm reduction to ensure delivery of high-quality care and improved outcomes for patients.
Finance 	The month 4 position for the Trust is a deficit of £8.9m which is £0.3m better than plan. This position includes £1.6m of costs related to industrial action incurred during M1. The CIP target in Q1 was £9.5m. For Q2, this doubles to £20.2m so delivering plan will become significantly more challenging each month. If the current run rate continues and does not improve then the Trust will be significantly adverse to plan over Q2. It is imperative that plans are formulated and progressed asap - particularly on bank and agency run rate reduction.

	The cash position at the end of Month 4 was £29.3m, which is an increase of £2m from June. If the Trust's financial position becomes adverse to plan then deficit support will be lost, which amounts to £4.7m per month. This will make the cash position even more challenged and creditor payments will need to be managed.
Workforce 	**Overall Workforce Plan** The overall Whole Time Equivalent (WTE) workforce in M4 was 18,285WTE which is 201WTEs above the plan (i.e a 1.11% variance to plan) driven by high Bank and Agency usage . • **Agency staff** usage increased from previous months by 10.63WTE and is above plan by 7WTEs. Agency Spend is 0.53% of the Total pay bill. Usage remains high within CSI recorded at 20WTEs (high usage remains within cost centre M22 Ultrasound department at LRI for AHPs). MSK was the second highest on agency usage for medical staff especially within cost centre W21 Maxillofacial and W11 ENT Medical Staff departments. • **Bank staff** usage increased compared to previous month by 51WTEs and is above the planned target by 44% with usage recorded at 953WTE which is 290WTE above plan. Usage continues to be high in ESM, E&F, W&C and CHUGGS with high usage mostly among Registered and Unregistered nursing staff and Medical Consultants. Overall Bank spend as a % of total pay bill is at 5.80%. • **Contracted Substantive staff** was recorded at 17,296WTE (a variance of 96WTE) representing a positive variance of 0.55% below the planned position of 17,392WTEs. **Vacancies** Registered nursing and midwifery vacancy levels are within the Trust target. HCSW vacancies have reduced to 5.2% against the 5% target. **Turnover and agency controls** Workforce turnover has seen a 0.2% reduction to 7.1% and remains below the 10% target. There is currently one non-clinical agency worker aligned to the capital programme, which has been approved by NHSE. Agency workers above the price cap have increased to 26 in July through the appointment of a physiotherapist and sonographer. Recruitment plans are in place to support the reduction of AHP agency workers. Medical agency demand is reducing through the adoption of the West Midlands rate card, and further substantive recruits are expected to start in the autumn. **Mandatory training and appraisal** Mandatory training compliance has remained at 93% across the Trust. 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. Appraisal performance has seen a reduction to 82.8%, against the 95% target. The appraisal process for all staff (excluding Doctors) has been reviewed and a revised process launched into UHL effective from 29 June. This will support greater focus on quality coaching led conversations including career aspirations. ESR will be trialled to be

	the main data platform for appraisals which will create administrative efficiencies and improve reporting capabilities. **Sickness absence and prevention** Sickness absence is reported one month in arrears and in June, we say a 0.30% increase. Over the last 12 months, the highest levels of absence are in E&F (6.21%), W&C (5.67%) and ITAPS (5.02%). A key priority within the NHS 10-Year Plan (2025) is the shift from sickness to prevention and one of the key areas of focus in the NHS Staff Standards is health and wellbeing. A UHL working group has reviewed the data to identify three key workstreams to support the achievement of the national 4.1% absence target set out in the 10-Year plan. **Governance and rating** Workforce performance continues to be reviewed through CMG Performance Review meetings, CMG Boards, Senior Leadership Teams and Specialty Reviews. Overall, an amber rating remains in place.
Tranformation & Productivity **Key Overview** **e.g Urgent and Emergency Care Elective, digital, Estates etc**	**<u>Theatres</u>** Overall theatre utilisation decreased to 81.2% in July, from 83.4% in June, primarily due to an increase in on-the-day cancellations (OTDCs), which rose from 8.3% to 8.9%. The increase was predominantly attributable to patient-related cancellations, DNAs (78). For the week ending 26th July, UHL ranked Green in Model Hospital (Quartile 3) with utilisation of 81.0%, performing slightly above both the national median (80.9%) and peer average (80.4%). EMPCC continues to sustain the improvements achieved through super week, with monthly utilisation of 89.4%. Performance has been supported by continued reductions in late starts (2.3%) and OTDCs, which remain below 5% at 4.18% **Key actions underway:** • Targeted improvement programmes are in place across Adult MSS, Gastro and Paediatrics, focusing on reducing cancellations, improving theatre flow, increasing utilisation, and addressing pathway inefficiencies. • UHLiC focus (Q1 average utilisation: 74%): Parallel working trials are underway within General Surgery and Plastics to reduce turnaround times and late starts, creating capacity for additional patients and maximising use of available theatre time. • Automation of patient theatre reminders is being progressed to replace the current manual process, which is dependent on admin capacity. This is expected to improve the consistency of patient communications and help reduce avoidable patient-related cancellations. BADS performance remains below the 85% target, with Model Hospital reporting 80.8% in April 2026 (Quartile 1), compared to peers (83.7%) and the national median (84.7%). Training on intended management coding was delivered through to July. A Day Case Review is scheduled for September through the Theatre Board to validate current performance, identify barriers to day case delivery and develop targeted improvement actions. **<u>Outpatients</u>** PIFU performance in July remains stable, with conversion rates increasing from 5.7% to 6.3% during the reporting period, equating to 5,819 patients moved to PIFU from 92,535 outpatient attendances. As a key enabler of specialty follow-up reduction plans, this

supports reduced routine follow-up demand. PIFU targets will be reviewed and reset in line with national benchmarks.

The DNA rate increased to 7.0**%** in July, with the year-to-date position at 6.5%. DNAs continue to be a significant area of focus due to their impact on patient access, clinic utilisation and waiting times.

The rollout of Ambient Scribe has had a significant impact on appointment reminders. Patient mobile numbers are now being sourced from Nervecentre rather than the Personal Demographics Service (PDS), exposing longstanding data quality issues within Nervecentre. As a result, a proportion of reminder messages have not been delivered to the intended recipients, and we have already seen a notable increase in DNA rates over the last 2 months. Work is underway to correct the underlying data quality issues, resolve the clinic list discrepancies and restore reliable appointment reminder functionality.

A revised Accurx reminder schedule—issuing reminders 14, 7 and either 3 or 1 day before appointments—is technically ready but remains on hold while the Nervecentre data quality issues are resolved. Once these dependencies have been addressed, implementation will be prioritised. The enhanced reminder schedule, together with increased character limits, will enable more personalised and informative patient communications, which are expected to support improved attendance and contribute to reducing DNAs.

UEC

- 6265 monthly SDEC attendances delivered in July (3% above monthly target)
- 2402 calls received to Clinical Bed Bureau in July 4.9% above baseline average in 25/26. 26/27 target to be agreed. Data does not yet include CBB E-referral data. This is still being validated.
- 24hour red line patients at 2.3% in July, an deterioration of 1.5% from July 2025
- Average Ambulance Handover Time 29 minutes, a 1 minute improvement from previous month and a 5 minute improvement July 2025. With noted improvements at GH site where handover for July was 16 minutes.
- Interprofessional Standards/COS – E referrals - 69% closed within 15 minutes. A deterioration of 15% from same month previous year.
- Interprofessional Standards/COS– E referrals 64% closed within 60 mins. A deterioration of 4% from same month previous year.
- IPS/COS guidelines, SOP and Monitoring tool now in place per GIRFT.
- Ambulance Assessment staffing contract coming to an end, service to be provided by UHL staff via new model. Improved efficiency and financial position.
- Virtual ward (VW) utilisation rates vary from 69%-95% across those services not decommissioned by ICB. (Detail in VW updates)
- Capital plans for GH SDEC expansion now out to procurement. Will increase waiting and clinical space and pull 0LOS patients out of CDU.
- Urology UEC capital bid being edited to include Day Case works that enable SDEC expansion, following removal of Urology from CDC scope.
- T&O SDEC trial of using Surgical Day Ward Discharge lounge for outward patients awaiting discharge to increase SDEC capacity.

Supporting documentation

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

The key changed to the IPR are:

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

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

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

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

UHL Oversight Framework Metrics

July 2026

Oversight Framework

Key Performance Indicator	Target	May-26	Jun-26	Jul-26	YTD	Assurance	Variation	Trend	Data Quality Assessment	Local or National Target?	Exec Lead
Clostridium Difficile per 100,000 Bed Days	167 Cases	11.6	26.1	11.6	16.3	?			Mar-24	Local	Chief Nurse and Medical Director
Methicillin Resistant Staphylococcus Aureus	0	2	4	1	8	?	H		Mar-24	Local	Chief Nurse and Medical Director
E-Coli per 100,000 Bed Days		19.4	16.0		16.3				TBC	No Target	Chief Nurse and Medical Director
Hospital Acquired Pressure Ulcers - All categories per 1000 bed days	1.7	1.3	1.3	1.2	1.3	?			Jun-21	Local	Chief Nurse and Medical Director
Sickness Absence	3%	4.6%	4.9%		4.6%	F			Mar-25	Local	Chief People Officer
30 Day Readmission Rate		10.5%	9.8%		10.4%		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%	63.2%	64.5%	63.6%	64.2%	?	H		Mar-23	National	Chief Operating Officer
% of 12 hour waits in the Emergency Department	10.3%	10.2%	9.2%	10.6%	9.7%	?			Mar-23	National	Chief Operating Officer
Referral to Treatment (RTT) 18 wk performance *	69.3%	59.5%	60.1%			F	H		TBC	Local	Chief Operating Officer
Referral to Treatment (RTT) 52+ weeks as a % OF Total Incompletes *	0.9%	2.1%	2.1%			F			TBC	Local	Chief Operating Officer
6 Week Diagnostic Test Waiting Times *	5%	13.4%	12.7%	11.7%		F	L		Jul-23	National	Chief Operating Officer
28 Day Faster Diagnosis Standard *	80%	72.6%	73.7%		70.5%	?			May-24	National	Chief Operating Officer
Cancer 62 Day Combined *	70%	60.8%	61.2%		61.2%	F			May-24	Local	Chief Operating Officer
Trust level control level performance	-£9.2m	-£1.3m	-£1.9m	-£1.6m	-£8.9m				Jun-22		Chief Financial Officer
Capital expenditure against plan	£12.9m	£3.2m	£2.2m	£3.6m	£13.8m				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

July 2026

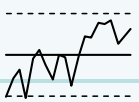
Contents

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

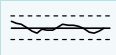
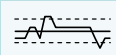
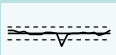
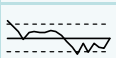
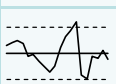
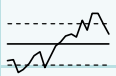
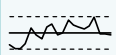
Performance Overview (Safe)

Domain	Key Performance Indicator	Target	May-26	Jun-26	Jul-26	YTD	Assurance	Variation	Trend	Data Quality Assessment	Local or National Target?	Exec Lead
Safe	Never events	0	1	0	2	6	?			Nov-22	National	Chief Nurse and Medical Director
	Clostridium Difficile per 100,000 Bed Days	167 Cases	11.6	26.1	11.6	16.3	?			Mar-24	Local	Chief Nurse and Medical Director
	Methicillin Resistant Staphylococcus Aureus	0	2	4	1	8	?	H		Mar-24	Local	Chief Nurse and Medical Director
	Methicillin-susceptible Staphylococcus Aureus	40	8	4	9	28	?			Mar-24	Local	Chief Nurse and Medical Director
	All falls reported per 1000 bed days	4.0	3.0	4.4		3.5	P			Aug-22	Local	Chief Nurse and Medical Director
	Rate of Moderate harm and above Falls per 1,000 bed days	0.19	0.07	0.09		0.10	?			Aug-22	Local	Chief Nurse and Medical Director
	Hospital Acquired Pressure Ulcers - All categories per 1000 bed days	1.7	1.3	1.3	1.2	1.3	?			Jun-21	Local	Chief Nurse and Medical Director
	% of all adults Venous Thromboembolism Risk Assessment on Admission	95%	96.8%	96.8%	96.7%	96.7%	P	L		Oct-21	National	Chief Nurse and Medical Director
	Number of Patient Safety Incident Investigations (PSIIs) commissioned		1	0	2	8	Awating more data for assurance and variance			Nov-24	No Target	Chief Nurse and Medical Director
	Number of reported Patient Safety Incidents		2399	2648	2422	9687				Nov-24	No Target	Chief Nurse and Medical Director
	Rate of reported Patient Safety Incidents (per 1000 inpatient, outpatient and ED attendances)		17.4	17.0	16.6	16.7				Nov-24	No Target	Chief Nurse and Medical Director

Performance Overview (Caring)

Domain	Key Performance Indicator	Target	May-26	Jun-26	Jul-26	YTD	Assurance	Variation	Trend	Data Quality Assessment	Local or National Target?	Exec Lead
Caring	Single Sex Breaches		29	30	71	155				Jul-22	No Target	Chief Nurse and Medical Director
	Inpatient and Day Case Friends & Family Test % Positive	95.5%	94.6%	94.7%	94.4%	94.7%				Jul-22	Local	Chief Nurse and Medical Director
	A&E Friends & Family Test % Positive	80.0%	85.8%	86.5%	87.3%	87.0%				Jul-22	Local	Chief Nurse and Medical Director
	% Complaints Responded to in Agreed Timeframe - 25 Working days	90.0%	67.5%	81.6%		65.6%				Jul-23	Local	Chief Nurse and Medical Director
	% Complaints Responded to in Agreed Timeframe - 60 Working days	90.0%	88.0%			75.6%				Jul-23	Local	Chief Nurse and Medical Director

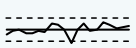
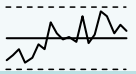
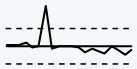
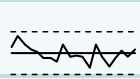
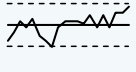
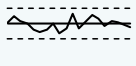
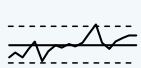
Performance Overview (Well Led)

Domain	Key Performance Indicator	Target	May-26	Jun-26	Jul-26	YTD	Assurance	Variation	Trend	Data Quality Assessment	Local or National Target?	Exec Lead
Well Led	Turnover Rate	10%	7.2%	7.3%	7.1%		?	H		Aug-22	Local	Chief People Officer
	Sickness Absence	3%	4.6%	4.9%		4.6%	F			Mar-25	Local	Chief People Officer
	% of Staff with Annual Appraisal	95%	83.1%	83.2%	82.8%		F	L		Mar-25	Local	Chief People Officer
	Statutory and Mandatory Training	95%	92%	93%	93%		F			Dec-22	Local	Chief People Officer
	Adult Nursing Vacancies	7%	3.8%	5.0%	6.5%		?			Dec-23	Local	Chief People Officer
	Paed Nursing Vacancies	10%	5.8%	5.3%	8.4%		?	L		Dec-23	Local	Chief People Officer
	Midwives Vacancies	7%	-4.3%	1.3%	1.1%		?	L		Dec-23	Local	Chief People Officer
	Health Care Assistants and Support Workers Vacancies - excluding Maternity	5%	12.0%	13.4%	11.8%		F			Dec-23	Local	Chief People Officer
	Health Care Assistants and Support Workers Vacancies - Maternity	5%	11.3%	8.3%	5.2%		?	H		Dec-23	Local	Chief People Officer
	% Bank spend of Pay Bill	8%	5.9%	5.9%	5.8%		P			TBC	National	Chief People Officer
	% Agency spend of Pay Bill	3.2%	0.5%	0.5%	0.5%		P			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	1	1	1		Awating more data for assurance and variance			May-25	National	Chief People Officer
	Agency Staff above Price cap	0	25	24	26		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	May-26	Jun-26	Jul-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		0.9%	0.8%	0.8%	0.8%				May-21	No Target	Chief Nurse and Medical Director
	DNA Rate - IMD Deciles 1 and 2	5%	8.5%	10.5%	9.8%	9.4%				Feb-24	Local	Director of Health Equality and Inclusion
	DNA Rate - IMD Deciles 3 - 10	5%	5.5%	6.8%	6.3%	6.0%				Feb-24	Local	Director of Health Equality and Inclusion

Performance Overview (Responsive Emergency Care)

Domain	Key Performance Indicator	Target	May-26	Jun-26	Jul-26	YTD	Assurance	Variation	Trend	Data Quality Assessment	Local or National Target?	Exec Lead
Responsive (Emergency Care)	Emergency Department 4 hour waits LLR	78%	77.3%	77.8%	78.1%	78.0%	?	H		Mar-23	National	Chief Operating Officer
	Emergency Department 4 hour waits UHL	61%	63.2%	64.5%	63.6%	64.2%	?	H		Mar-23	National	Chief Operating Officer
	Mean Time to Initial Assessment	15	7	6.1	7.0	7.0	P	L		Nov-24	National	Chief Operating Officer
	% 12 hour trolley waits in Emergency Department (DTA)	10.3%	4.1%	3.6%	3.8%	4.0%	?			Mar-23	National	Chief Operating Officer
	% of 12 hour waits in the Emergency Department	10.3%	10.2%	9.2%	10.6%	9.7%	?			Mar-23	National	Chief Operating Officer
	Average Clinical Handover time for ambulance handovers (Minutes)	30	33	28	29	30	?	L		Data sourced externally	Local	Chief Operating Officer
	Non Elective Average Length of Stay	7.2	7.5	7.7	7.8	7.6	?			Aug-25	Local	Chief Operating Officer
	% of Patients Discharged on Discharge Ready Date	88.1%	88.3%	87.7%	87.5%	88.0%	?			Aug-25	Local	Chief Operating Officer
	Average Delay (Post Discharge Ready Date)	3.8	4.7	4.7	4.9	4.6	?			Aug-25	Local	Chief Operating Officer
	Trust Bed Occupancy	92.0%	89.9%	88.7%	87.9%		?			Dec-23	National	Chief Operating Officer
	Long Stay Patients (21+ days) as a % of G&A Bed Occupancy	10%	17.1%	17.5%	17.4%		F			Apr-23	Local	Chief Operating Officer

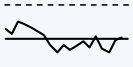
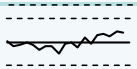
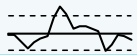
Please note the in month RAG ratings are based on trajectories for some of the indicators (see slide 15).

Performance Overview (Responsive Elective Care)

Domain	Key Performance Indicator	Target	May-26	Jun-26	Jul-26	YTD	Assurance	Variation	Trend	Data Quality Assessment	Local or National Target?	Exec Lead
Responsive (Elective Care)	Referral to Treatment Incompletes	105,500	116,019	115,279			F	H		Jun-23	Local	Chief Operating Officer
	Referral to Treatment (RTT) 18 wk performance	62.3%	59.5%	60.1%			F	H		TBC	Local	Chief Operating Officer
	Referral to Treatment (RTT) – First Attendance - % waiting less than 18 weeks	68.1%	64.4%	63.8%			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%	2.1%			F			TBC	Local	Chief Operating Officer
	6 Week Diagnostic Test Waiting Times	5%	13.4%	12.7%	11.7%		F	L		Jul-23	National	Chief Operating Officer
	Theatre Utilisation	85.0%	82.7%	83.3%	81.2%	82.3%	F	H		Dec-23	National	Chief Operating Officer
	Patient Initiated Follow Up	5.5%	5.5%	6.0%	6.3%	5.8%	?			Oct-23	Local	Chief Operating Officer
	% Outpatient Did Not Attend rate	4.9%	6.0%	7.4%	7.0%	6.5%	F			Apr-23	Local	Chief Operating Officer
	% Outpatient Non Face to Face	25%	26.9%	27.5%	25.8%	26.9%	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	May-26	Jun-26	Jul-26	YTD	Assurance	Variation	Trend	Data Quality Assessment	Local or National Target?	Exec Lead
Responsive (Cancer)	28 Day Faster Diagnosis Standard	80%	72.6%	73.7%		70.5%				May-24	National	Chief Operating Officer
	Cancer 31 Day Combined	96%	89.8%	89.4%		88.3%				May-24	National	Chief Operating Officer
	62 Day Backlog Combined	152	388	377	353					Dec-24	Local	Chief Operating Officer
	Cancer 62 Day Combined	70%	60.8%	61.2%		61.2%				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	May-26	Jun-26	Jul-26	YTD	Assurance	Variation	Trend	Data Quality Assessment	Exec Lead
Finance	Trust level control level performance	-£9.2m	-£1.3m	-£1.9m	-£1.6m	-£8.9m				Jun-22	Chief Financial Officer
	Capital expenditure against plan	£12.9m	£3.2m	£2.2m	£3.6m	£13.8m				Jun-22	Chief Financial Officer
	Cost Improvement (Includes Productivity)	£14.9m	£4.5m	£5.6m	£4.3m	£17.8m				Dec-23	Chief Financial Officer
	Cashflow	No Target	£7.9m	-£1.4m	£2m	£29.3m				Jun-22	Chief Financial Officer
	Aged Debt	No Target	£13.2m	£14.9m	£17.3m					Feb-24	Chief Financial Officer
	Invoices paid within 30 days (value)	95%	96%	96%	96%					Feb-24	Chief Financial Officer
	Invoices paid within 30 days (volume)	95%	93%	94%	91%					Feb-24	Chief Financial Officer

Performance Overview (Activity)

Domain	Activity Type	Plan 26/27	Plan in Month (M4)	Activity In Month (M4)	Variance In Month (M4)	Plan YTD	Actual YTD	Variance YTD	YTD Variance to 19/20
Activity	New Outpatients (inc. NFTF)	271,664	23,693	24,532	839	90,803	96,065	5,263	5,295
	Follow Up Outpatients (inc. NFTF)	574,448	49,119	41,980	-7,139	190,849	169,016	-21,833	-31,227
	Outpatient Procedures	235,076	20,685	20,256	-428	78,532	78,758	226	27,859
	Daycase	133,927	11,439	11,756	316	44,222	43,893	-329	7,301
	Inpatient	23,088	2,018	2,056	38	7,799	8,418	619	1,686
	Emergency	117,020	9,502	9,814	312	38,051	39,904	1,853	6,936
	Non Elective	23,094	1,960	2,179	219	7,723	8,104	382	977
	Emergency Department (inc. Eye Casualty)	289,426	23,065	24,485	1,420	95,848	100,730	4,882	13,446
	Diagnostic Imaging (inc. Direct Access)	418,297	36,173	35,100	-1,073	137,425	135,904	-1,522	80,257
	Other	12,855,542	1,095,623	1,155,891	60,268	4,124,367	4,356,540	232,173	1,352,929
	TOTAL	14,941,583	1,273,277	1,328,049	54,772	4,815,618	5,037,332	221,714	1,465,459

**Source Early Cut and Forecasting File*

The DM01 plan for imaging activity for M4 was 1,380 below plan in month (27,347 vs 28,727) and was 2,027 below plan YTD (108,128 vs 110,155)

Performance Overview (Workforce Performance Overview)

Activity Type	WTE	Apr 26	May 26	Jun 26	Jul 26
Performance against the workforce plan (Contracted Substantive)	Planned in Month	17,377	17,389	17,392	17,392
	Actuals in Month	17,294	17,293	17,284	17,296
	Variance (Actual vs Plan)	-83	-96	-108	-96
	% Variance (Actual vs Plan)	-0.47%	-0.55%	-0.62%	-0.55%

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 (Productivity Dashboard)

	Productivity Dashboard v4.0 - UHL Trustwide	25/26								26/27					Assurance				
	Metric	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	26/27 YTD	Variation	Assurance	Average	26/27 Target	19/20 Baseline
£	Finance: CpWAU	4,128	4,071	4,126	4,135	4,085	4,013	4,019	3,934								4,139	-	4,250
Ops & Clinical Productivity	Ops: Avg LoS for Elective Inpatients (nights)	3.21	2.83	2.96	3.00	3.23	2.99	2.92	3.08	3.17	3.51	3.06	3.22	3.24			3.08	-	3.37
	Ops: Avg LoS for emergency admissions	3.65	3.39	3.54	3.33	3.47	3.44	3.58	3.46	3.44	3.52	3.57	3.69	3.56			3.74	-	3.85
	Ops: Bed occupancy	85.1%	87.4%	92.8%	87.4%	88.9%	93.4%	91.5%	88.4%	90.3%	89.9%	88.7%	87.9%	89.2%			89.1%	-	~
	Ops: Do not meet Criteria to Reside (avg pts per day)	480	481	476	471	477	511	506	476	469	479	491	488	482			460	-	~
Theatres	Theatres: Capped Utilisation	80.7%	81.2%	80.7%	81.2%	80.9%	80.2%	82.0%	81.4%	81.8%	82.7%	83.4%	81.1%	82.3%			78.5%	85.0%	68.1%
	Theatres: ACPL	1.99	1.99	1.98	1.92	1.96	1.90	1.96	1.98	1.92	2.04	2.02	2.03	2.00			1.93	-	2.06
	% Theatre Sessions Utilised	77.3%	88.7%	93.6%	79.9%	83.9%	88.4%	81.9%	90.9%	81.3%	81.6%	91.2%	89.9%	86.0%			84.5%	-	
	Theatres: OTDC	8.2%	8.3%	8.4%	8.5%	8.7%	9.4%	8.9%	9.7%	8.4%	8.4%	8.4%	8.9%	8.5%			8.8%	5.0%	8.5%
	Diagnostics (Endoscopy): APPL	7.50	8.80	8.50	7.80	7.30	7.70	7.90	8.30	8.75	8.70	9.80	11.00	9.56			7.76	10.50	~
Outpatients	Outpatients: Clinic Utilisation	97.1%	96.5%	96.6%	98.6%	96.7%	98.0%	97.7%	98.2%	100.3%	97.6%	96.3%	95.2%	97.4%			93.1%	95.0%	90.9%
	Outpatients: DNA Rate	6.4%	6.3%	5.9%	6.1%	6.1%	6.1%	6.0%	6.0%	6.0%	6.1%	7.6%	7.0%	6.7%			6.7%	5.0%	6.6%
	Outpatients: % PIFU	4.9%	4.8%	5.2%	5.5%	5.5%	5.7%	5.3%	5.7%	5.7%	5.6%	6.1%	6.3%	5.9%			4.9%	6.5%	~
	Outpatient: % OPA Follow Up without procedure	53.4%	52.9%	52.1%	51.3%	51.1%	50.6%	49.5%	49.5%	49.0%	49.3%	49.3%	48.6%	49.0%			54.5%	-	~
	A&G: Specialist Advice Utilisation Rate	13.6	12.9	13.1	12.2	11.5	11.5	11.4	10.9	9.1	9.9			9.5			11.2	12.6	~
Diagnostics	Diagnostics: MRI Machine Productivity (Adjusted)	72.9%	70.4%	71.4%	68.9%	78.5%	72.2%	69.8%	72.7%	70.9%	77.5%	70.8%	69.2%	72.1%			71.7%	-	~
	Diagnostics: MRI scans per hour	1.30	1.30	1.30	1.30	1.30	1.40	1.30	1.30	1.30	1.40	1.30	1.30	1.33			1.34	1.80	~
	Diagnostics: MRI DNA rate	4.1%	4.2%	3.9%	3.7%	4.1%	2.9%	3.4%	3.6%	3.7%	2.7%	3.4%	3.8%	3.4%			3.9%	3.0%	~
	Diagnostics (Endoscopy): In session booked utilisation	90.4%	92.5%	95.6%	93.4%	86.4%	83.4%	83.3%	90.2%	91.8%	92.5%	94.0%	93.0%	92.8%			90.0%	95.0%	~
	Diagnostics (Endoscopy): In session actual utilisation	80.3%	85.2%	86.0%	85.3%	79.1%	76.6%	76.3%	82.6%	83.9%	83.0%	85.5%	85.0%	84.4%			81.2%	85.0%	~
	Diagnostics: CT Machine Productivity (Adjusted)	74.3%	78.2%	82.0%	72.2%	72.0%	79.1%	90.4%	80.8%	80.6%	87.3%	88.1%	86.5%	85.6%			76.3%	-	~
	Diagnostics: CT scans per hour	2.00	2.10	2.30	2.00	2.10	2.30	2.50	2.40	2.20	2.40	2.40	2.40	2.35			2.26	3.30	~
	Diagnostics: CT DNA rate	2.8%	2.7%	2.9%	2.6%	3.2%	1.8%	2.8%	2.9%	2.5%	2.3%	1.9%	2.0%	2.2%			3.1%	3.0%	~

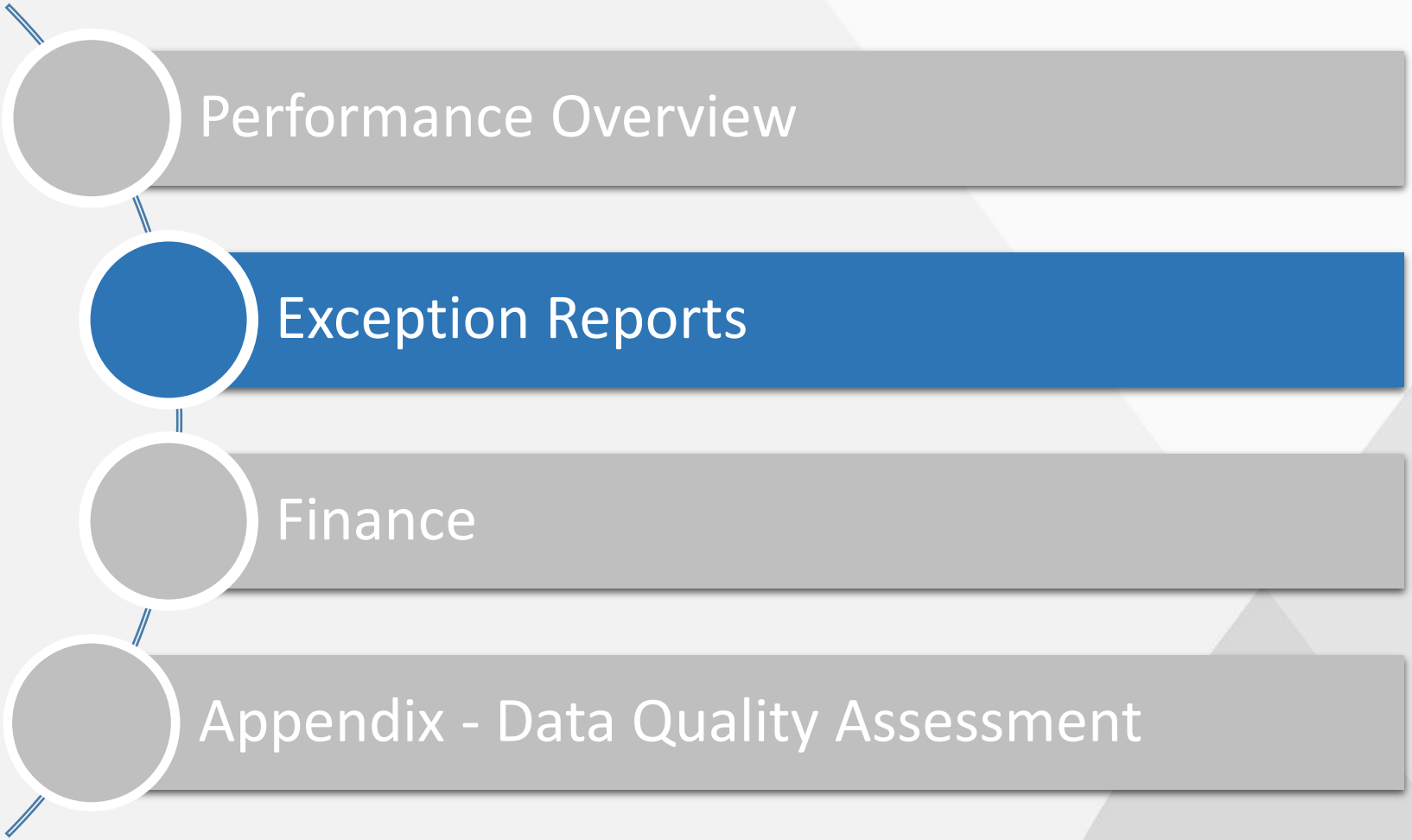
Variation/assurance icons are based on Statistical Process Control (SPC) charts and use data from April 2023 (where available) to latest reported month.
No recalculations are currently applied to any metrics.

Performance Overview (Productivity Dashboard Commentary)

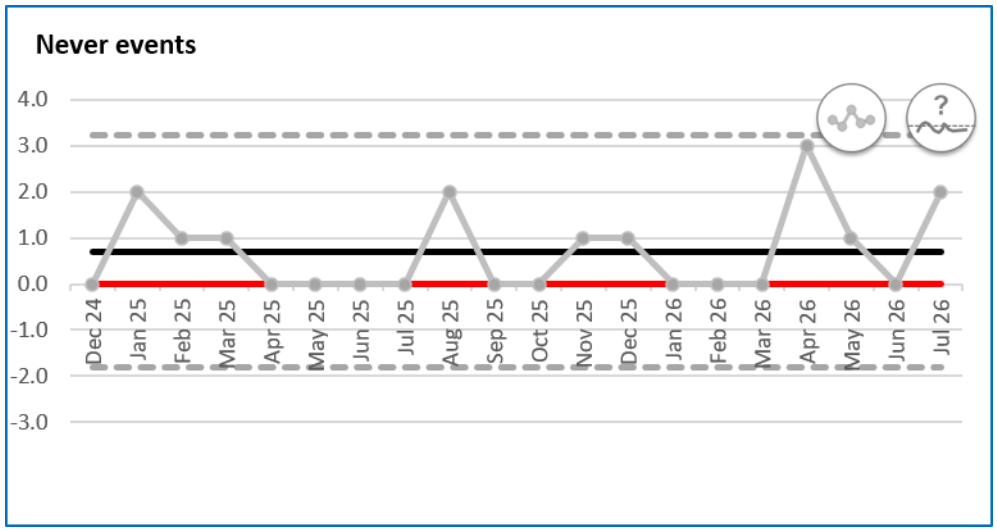
Section	Commentary
Finance	Data to March 26. Note increase from previous numbers due to inclusion of impairment in month 12. Overall improvement trend year on year.
Ops & Clinical Productivity	Operational performance remained mixed in July. Elective and emergency length of stay remained below 19/20 baselines, while bed occupancy fell to 87.9%, its lowest since August 2025. However, 488 patients per day did not meet Criteria to Reside, remaining above the 26/27 average and indicating continued flow and discharge pressures.
Theatres	Theatre performance remained broadly stable in July. Capped utilisation was 81.1%, sustaining performance above 80% and the 19/20 baseline, but remaining below the 85% assurance target. ACPL remained stable at 2.03, supporting consistent throughput, while theatre session utilisation was strong at 89.9%. OTDC remained persistently above the 5% target at 8.9%, highlighting the continuing need to reduce short-notice cancellations and strengthen list planning. Endoscopy APPL reached 11.0, achieving target and continuing the sustained improvement seen since April.
Outpatients	Overall, outpatient performance remained strong in July. Clinic utilisation was 95.2%, remaining above the 95% target and 19/20 baseline. PIFU was strong at 6.3%, close to the 6.5% year-end target, while follow-ups without procedure reduced to 48.6%, continuing the positive downward trend. DNA rates remained elevated at 7.0%, with Nervecentre EPR data quality issues continuing to affect SMS reminders. Recovery is expected in August/September
Diagnostics	Diagnostic productivity remained mixed in July. Endoscopy booked utilisation remained strong at 93.0%, while actual utilisation was 85.0%, on target, maintaining recent improved performance. CT productivity remained comparatively strong at 86.5%, supported by stable throughput and a consistently low DNA rate. MRI performance remained constrained, with productivity at 69.2%, scans per hour static at 1.3 and DNA at 3.8%. Recruitment to booking-team vacancies, increased CDC activity and delivery of the recovery plan remain key to improving MRI capacity and sustaining diagnostic performance.

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		
Jul 26	YTD	Target
2	6	0

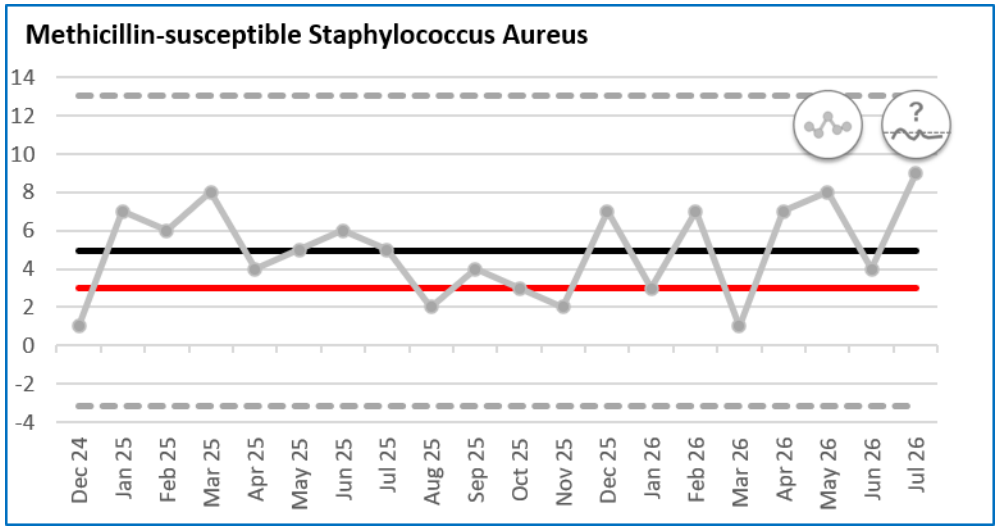
National Position & Overview

Peer data not available

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
• Wrong site surgery	Apology given to the patients and informed of investigation into events and patients are being engaged and involved in the investigations	Completed
	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
• Retained foreign object post procedure	To strengthen oversight of the Safe Surgery work programme, regular reporting will commence through a re-established governance forum, and routine review of progress, risks, and compliance to ensure timely action and continuous improvement. This will report into Patient Safety Committee.	Ongoing

Safe – Methicillin-susceptible Staphylococcus Aureus



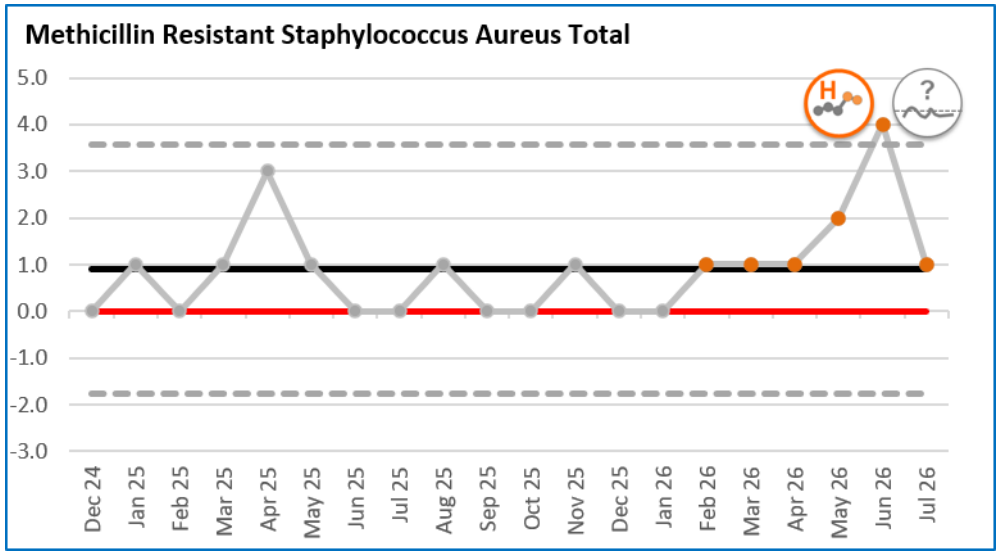
Current Performance		
Jul 26	YTD	Target
9	28	40

National Position & Overview

	July 26	Total	
MSSA NHSE Threshold 26/27	3	40	
* Actual Infections (HOHA) 26/27	9		
* Actual Infections (COHA) 26/27	0		
*** Actual Infections Total (HOHA & COHA)** 26/27	9		
UHL 100,000 Bed Days (HOHA) 26/27	17.45	11.75	*YTD UKHSA Report
National Average	12.11		
National Highest	88.19		
National Lowest	0		

Root Cause	Actions	Impact/Timescale
• Vascular access devices were present in the majority of reviewed cases, indicating device management as a significant contributory factor. • Recurring themes include inconsistent compliance with PVAD and CVC management standards.	• ANTT guideline revised as a formal Trust policy and embedded within mandatory Infection Prevention training. • Expansion of ANTT assessor capacity and competency assessment programme to increase the proportion of staff assessed as competent. • Enhanced practical training programme through Clinical Skills, with targeted engagement of senior medical leaders to strengthen multidisciplinary compliance. • Introduction of revised cannulation packs and review of disinfection processes, including transition to peracetic acid, to support safer and more standardised practice. • Implementation of routine audit and surveillance of vascular access practice, including care bundle compliance, device necessity reviews and device-related infection monitoring. • Development of a Trust-wide vascular access dashboard Strengthened governance through regular review by TLT and Quality Committee, with escalation where compliance or outcomes fall below expected	Expected Impact • Increased ANTT competency and compliance • Improved reliability of PVAD and CVC management • Reduction in unwarranted variation across wards and specialties • Earlier identification and mitigation of vascular access risks • Sustained reduction in device-related infection and avoidable harm • Enhanced Board assurance through measurable outcome and compliance indicators.

Safe – Methicillin Resistant Staphylococcus Aureus

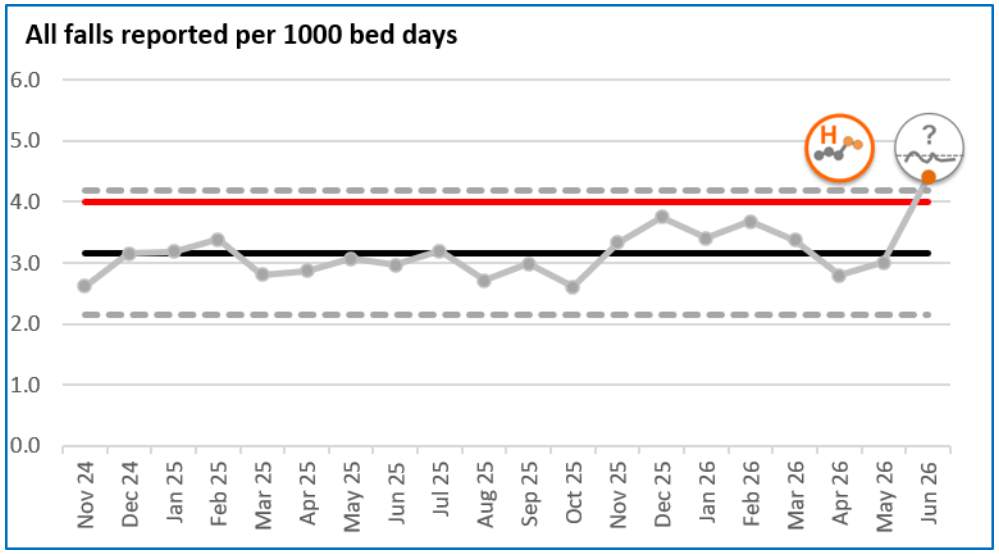


Current Performance		
July 26	YTD	Target
1	6	0

National Position & Overview			
	July26	Total	
MSSA NHSE Threshold 26/27	0	0	
* Actual Infections (HOHA) 26/27	1		
* Actual Infections (COHA) 26/27	0		
*** Actual Infections Total (HOHA & COHA)** 26/27	1	6	
UHL 100,000 Bed Days (HOHA) 26/27	1.94	2.46	*YTD UKHSA Report
National Average	0.74		
National Highest	10.75		
National Lowest	0		

Root Cause	Actions	Impact/Timescale
• Variation in compliance with MRSA screening and decolonisation policy, with missed opportunities to mitigate infection risk in high-risk patients. • Variable completion of VIP and RAID assessments reduces assurance regarding safe ongoing management of vascular access devices. • ANTT compliance remains below the expected standard and requires urgent improvement to reduce infection risk. • Delayed escalation for specialist vascular access assessment resulted in multiple peripheral cannulations where PICC or midline devices may have been more appropriate.	• Deliver MSSA actions on ANTT and vascular access. • Complete MRSA compliance audit (Aug/Sep 2026). • Review progress through TIPOG action tracker. • Expand access to Stellisept prescribing / decolonisation. • Review findings with Vascular Access Team. • Accelerate implementation of PVAD documentation within Nervecentre.	Expected Impact: • Improved MRSA screening and decolonisation compliance. • Increased ANTT compliance. • Earlier escalation to PICC/midline devices. • Reduced repeat peripheral cannulation. • Strengthened surveillance and assurance of vascular access practice.

Safe – All falls reported per 1000 bed days



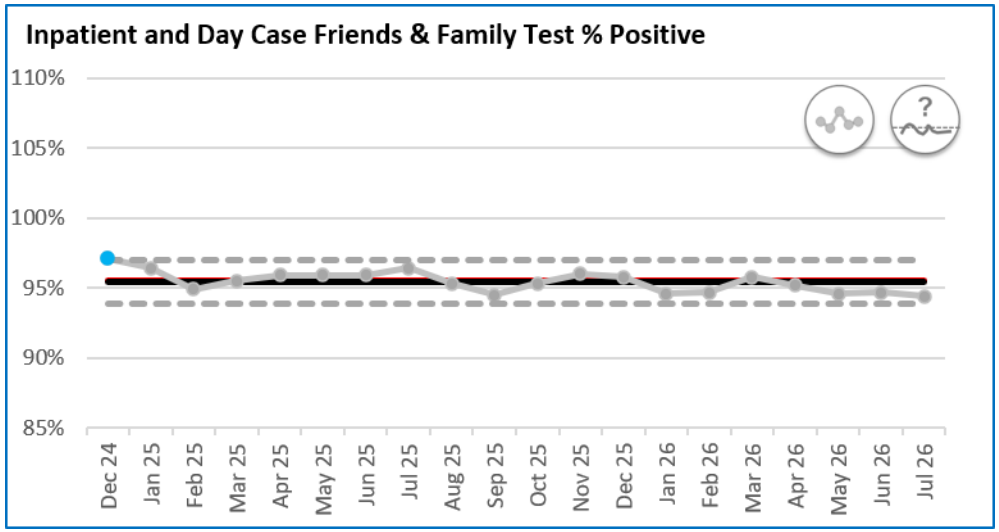
Current Performance		
Jun 26	YTD	Target
4.4	3.5	4.0

National Position & Overview

Peer data not available.

Root Cause	Actions	Impact/Timescale
• Increase of 70 falls from May to June, predominately in three CMG's: SM, EM and MSS. 7 of these have caused moderate harm and above • The rate of falls had previously remained below UCL for previous 19 months • Patients with multiple falls identified in CMGs with increased overall numbers • Behavioral challenges identified as contributary factor for patients with multiple falls	• Ensure completion and quality assurance of multifactorial falls risk assessments and care plans for all at-risk patients. • Target enhanced supervision, bed/chair sensors and other preventative interventions to patients identified as highest risk. • Review all patients experiencing repeat falls to identify contributory factors, learning and escalation requirements. • Undertake thematic analysis of falls, particularly in high-volume wards and areas with moderate or greater harm. • Complete focused review of the seven harm falls to identify common themes and system-wide improvement actions. • Implement seasonal measures to mitigate the impact of heat, dehydration and delirium during periods of high temperatures.	Expected Impact: • Reduction in falls resulting in moderate or severe harm. • Reduction in repeat falls. • Improved compliance with falls risk assessment and care planning. • Earlier identification of high-risk patients. • Improved patient safety and reduction in avoidable harm.

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



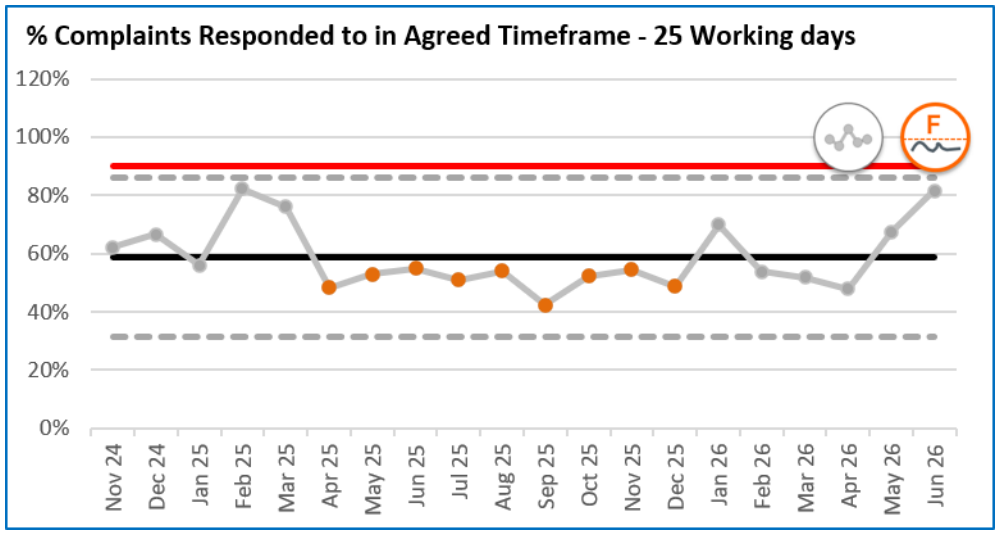
Current Performance		
Jul 26	YTD	Target
94.4%	94.7%	95.5%

National Position & Overview

National Inpatient % positive result in June 2026 (most recent available) was 94.4%. Trust Peer Group result for June 2026 was 94.7%.

Root Cause	Actions	Impact/Timescale
• Whilst overall patient experience remains positive, communication, responsiveness and discharge coordination continue to be the key drivers of dissatisfaction. • Operational pressures, workforce challenges and delays in discharge processes are impacting patients' experience of care. • Environmental factors, including ward noise, heat and cleanliness, also feature consistently in patient feedback and remain areas of focus for improvement.	• Strengthen ward-level communication standards, including regular patient and family updates on care plans, delays and discharge arrangements. • Implement targeted support in areas with lower FFT performance, led by matrons and divisional leadership teams. • Increase executive and divisional walk-rounds to capture and respond to patient experience concerns in real time. • Reduce discharge delays through improved multidisciplinary discharge planning, pharmacy turnaround times and earlier discharge preparation. • Monitor responsiveness to call bells and patient requests through ward quality metrics and matron reviews. • Continue recruitment and workforce measures to mitigate staffing pressures in high-demand areas. • Deliver targeted environmental improvement plans focusing on ward noise, cleanliness and temperature management. • Review patient experience themes monthly through governance structures.	Expected Impact: • Improved FFT scores and patient-reported experience. • Increased patient confidence in communication and care planning. • Reduced dissatisfaction associated with discharge delays. • Improved responsiveness to patient needs. • Enhanced ward environment and patient comfort. • Sustained improvement in patient experience metrics and complaints relating to communication..

Caring – % Complaints Responded to in Agreed Timeframes



25 Working Days		
Jun 26	YTD	Target
77.8%	77.9%	90%

60 Working Days		
May 26	YTD	Target
88.0%	75.6%	90%

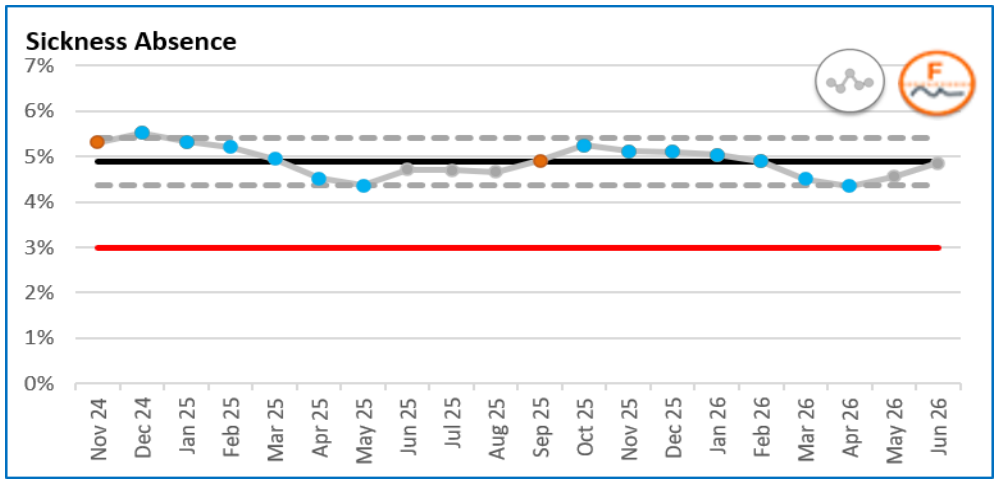
National Position & Overview

There is no single mandatory national timescale, but NHS organisations are expected to:

- Agree a response timeframe with the complainant.
- Respond as quickly as possible.
- Monitor compliance with agreed response times.

Root Cause	Actions	Impact/Timescale
• Ongoing improvement in % of complaints responded to within 25 working day timeframe • The target of 88% of complaints to be responded to within 60 working days was achieved in June	• New Complaints Manager has now commenced, filling the vacancy left by retirement • Ongoing oversight and monitoring of the complaint response times and working with the CMGs to support this	• Anticipated ongoing improvement in complaint response times to be monitored closely over the next few months

Well Led – Sickness Absence



Current Performance		
Jun 26	YTD	Target
4.9%	4.6%	3%

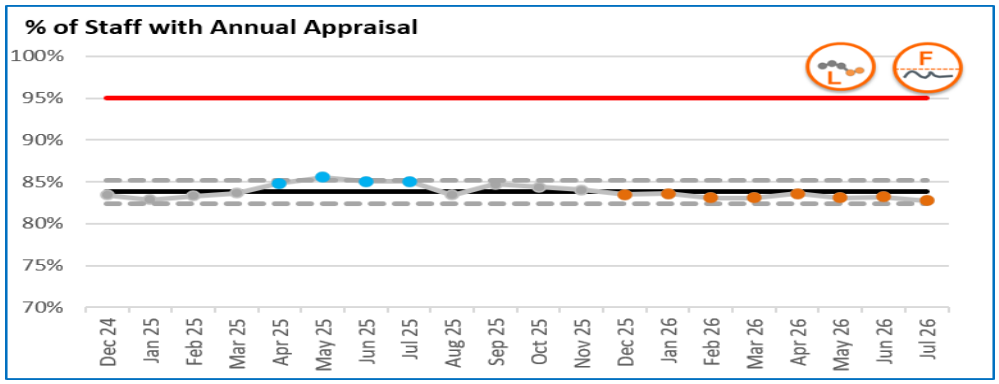
National Position & Overview

In June UHL has seen a 0.30% increase in sickness absence.

Root Cause	Actions	Impact/Timescale

• Clinical CMG's have seen a 0.32% increase and Corporate Directorates a 0.19% increase in June.
• Over the last 12 months, the highest levels of absence are in E&F (6.21%), W&C (5.67%) and ITAPS (5.02%).
• The areas achieving the 3% target are within the Corporate Directorates, and MSS has had three consecutive months below 4%.
• The top 3 reasons for sickness absence are anxiety/stress/depression (22.90%), Other known reasons (13.86%) and other musculoskeletal problems (10.06%).
	• One of the key priorities in the NHS 10-year plan is to shift from sickness to prevention. A UHL Supporting Attendance at Work is established to take this forward for our workforce, along with plans to achieve the national 4.1% target. Having reviewed the data there will be three workstreams:
	  • **Unknown/Other Reasons** - Reduce 'unknown/other' coding by improving sickness reason capture at first report / manager correction / and during RTW conversations.
	  • **Stress** - To be compliant with the stress risk assessment process and use primary and secondary interventions to reduce stress in the workplace
	  • **Reducing Sickness Absence in Services** - Reduce sickness absence in the top 9 areas with highest absence.
	• Alongside the Trustwide group, there is a staff group specific group with a focus on nursing sickness absence.
	• 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.
	• Plans are on track for the launch of the 2026/27 flu vaccination campaign launch on 1 October 2026. To date we have 255 Peer Vaccinators sign up and training is underway. The plan also includes Super Flu Days.
		• 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".

Well Led – % of Staff with Annual Appraisal



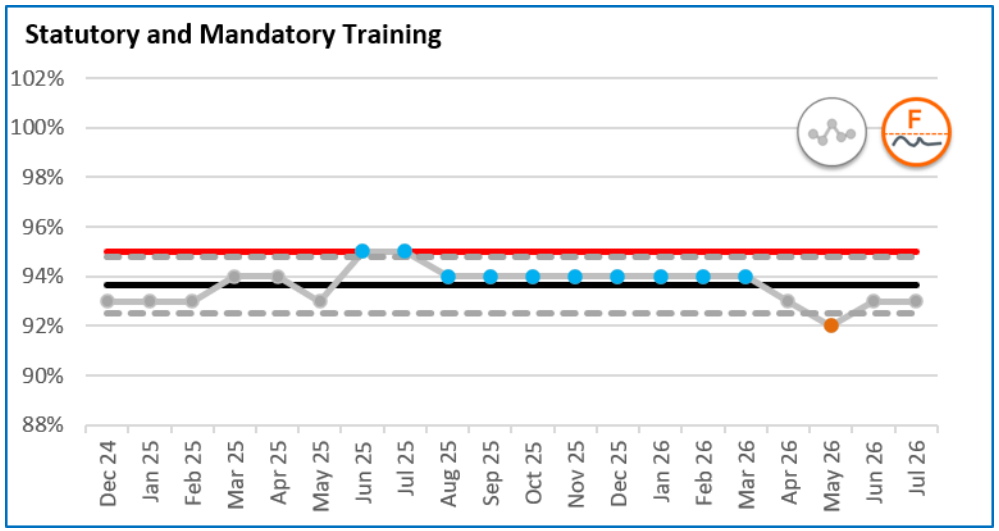
Current Performance		
Jul 26	YTD	Target
82.8%	-	95%

National Position & Overview

Peer data not available.
The July position has a 0.4 decrease in Appraisal compliance across the Trust in the last month, 12.2 away from the 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 seen a decrease in all Clinical areas with the exception of ITAPS and W&C and similarly with Corporate Teams - where positive gains are seen, compliance still remains below the expected 95% 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 appraisal process for all staff (excluding Doctors) has been reviewed and a revised process launched into UHL effective from 29 June. This will support greater focus on quality conversations including career aspirations. • ESR will be trialled to be the main data platform for appraisals which will create administrative efficiencies and improve reporting capabilities. • There now needs to be a greater focus on services reviewing their appraisal performance to identify any additional targeted support required	• In July 2025 Appraisal performance was at 85.1%, same as the previous month of June, and surpassing this month's compliance, in 2026. • 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 particularly given our key objectives this year. • 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



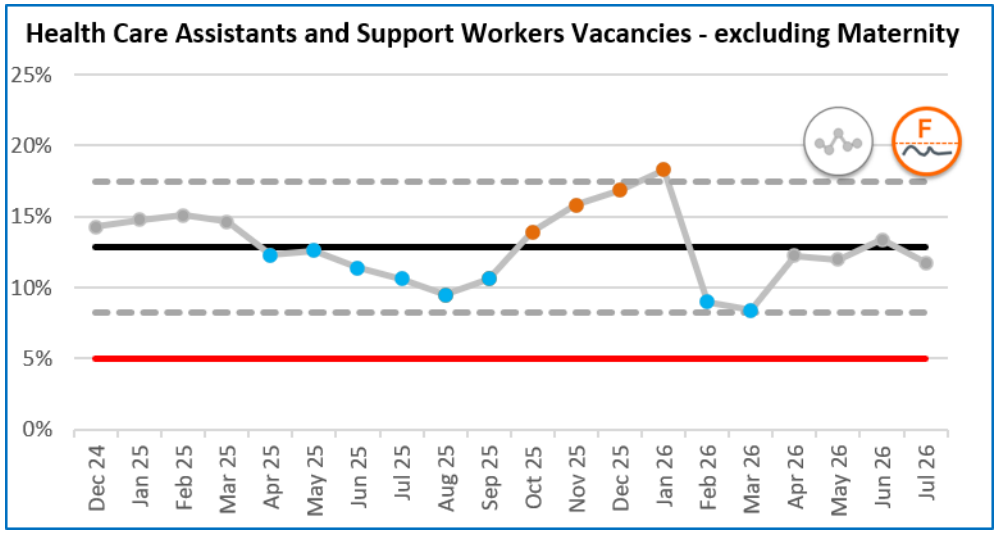
Current Performance		
Jul 26	YTD	Target
93%	-	95%

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.	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



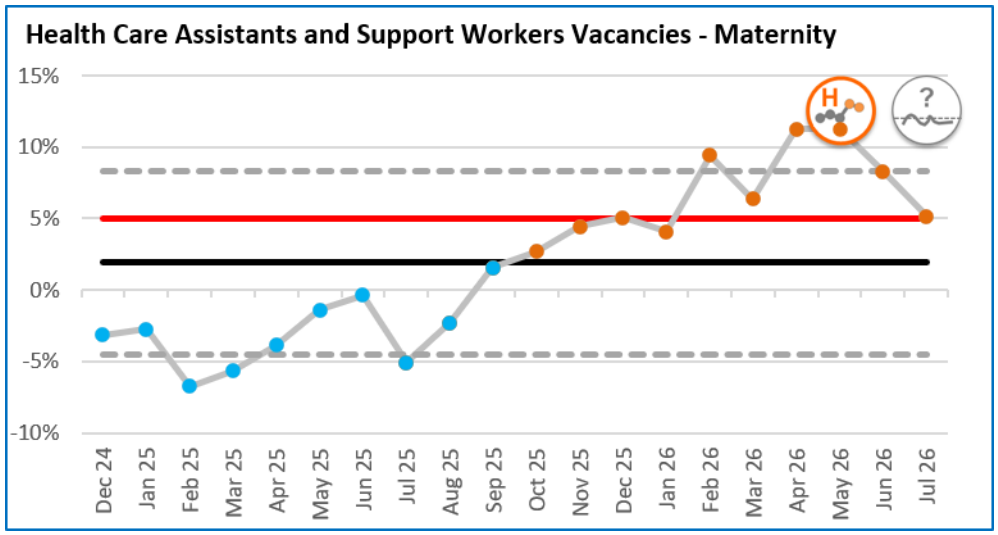
Current Performance		
Jul 26	YTD	Target
11.8%	-	5%

National Position & Overview

The role of a HCSW operates within the low-skill, high-supply labour market as it is an entry level role in healthcare with minimum educational requirements, where recruitment can generally be less challenging; high workforce mobility can result in increased turnover and ongoing retention challenges.
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
• Changes to visa and immigration requirements have restricted access to international candidates and increased compliance complexity, slowing recruitment pipelines. • To elevate this, we have developed a Band 2 HCSW development pathway to capture talent from internal departments, such as Estates and Facilities, and to reopen our *new to care* entry point for School Leavers or those looking for a new career.	• The Nursing Workforce Recruitment and Retention Plan for Financial Year 26-27 was approved at NMAHPCs (Apr-26). •This includes the aim to recruit HCAs 40WTE per quarter. • The most recent recruitment drive was approved for 50 wte Band 2 HCSW development pathway (6 months) and 50 wte for Band 3 HCSW (a total of 100 wte). • We are working with local colleges and provide industry placements for T-Level students, this includes: Leicester College, Gateway College, Loughborough College amongst others.	Recruitment drive progress: Band 3 HCA: • **Advert went live 14/08/2026 – 50 wte** • Capped at 200 applicants • Closed within 5 hours • Short-listing underway • Interviews scheduled for 4th September Band 2-3 development pathway: • **Advert went live 14/08/2026 – 50 wte** • Capped at 200 applicants • Closed within two days • Short-listing underway • Interviews scheduled for the 5th September

Well Led – Maternity vacancies are near target; sickness is the key risk



Current Performance		
Jul 26	YTD	Target
5.2%	-	5%

National Position & Overview

National publications (National Maternity and Neonatal Investigation / Ockenden) reinforce that safe staffing depends on the whole team's effectiveness; making support staff integral to workforce planning, not a standalone issue.

Position	Actions	Impact / next step
Projected MCA vacancies fall to 3.53 WTE in Aug-26 – 1.05 WTE lower than Jul-26. Short-term sickness is now the main pressure on actual staffing through summer.	Hold MCA vacancies at a minimum across maternity. Use the September Birthrate Plus report to confirm required staffing models. Actively manage short-term sickness and deployment.	Vacancy rate improved from 8.3% in Jun-26 to 5.2% in Jul-26 – just 0.2pp above the 5% target. Recruitment drive completed in Jun-26 Four MCAs (3.61 WTE) started on 17 Aug-26.

Well Led – Non Clinical Agency- No. of Staff

Current Performance		
Jul 26	YTD	Target
1	4	0

Awaiting more data for SPC chart

National Position & Overview

The service expects to require the remaining agency worker for the foreseeable future. Consider adding a review date or exit milestone to make the timescale measurable.

Root Cause	Actions	Impact/Timescale
The remaining agency worker supports delivery of the NHS England-approved capital programme, which is capital-funded rather than revenue-funded.	The service recognises the need to reduce its reliance on agency workers and has reduced the number from three to one. The remaining worker supports NHS England-funded projects, including Estate Safety and Our Future Hospitals (OFH) programme.	The service expects to require the remaining agency worker for the foreseeable future.

Well Led – Agency Staff above Price cap

Awaiting more data for SPC chart

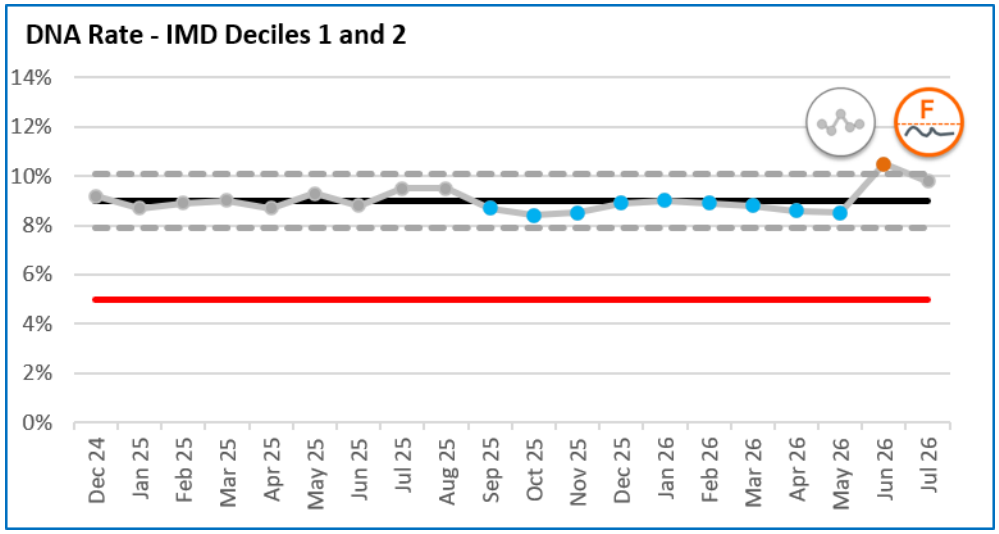
Current Performance		
Jul 26	YTD	Target
26	103	0

National Position & Overview

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
Medical agency rates remain above the price cap across all roles, reflecting a recognised national issue. AHP agency workers are at or below the price cap, except in nationally recognised shortage professions. Specialist sonography, cardiac physiology and radiography roles exceed the price cap because of limited workforce availability.	New medical agency appointments now follow the West Midlands medical rate card, agreed through an NHS England workstream. Three long-standing assignments have reduced hours, with exit plans in place. The regional AHP rate-reduction plan is currently paused. August rates remain in place for sonographers and July rates for cardiac physiologists. All other agency rates are controlled and approved, with assignments time-limited.	Medical agency demand is falling, and adoption of the West Midlands rate card has delivered significant savings. Further permanent recruits are expected to start in early autumn, supporting a continued reduction in agency reliance. Recruitment plans are also in place for AHP roles, although specialist agency support remains necessary. The number of agency workers increased by two in July 2026 following the appointment of a physiotherapist and a sonographer.

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



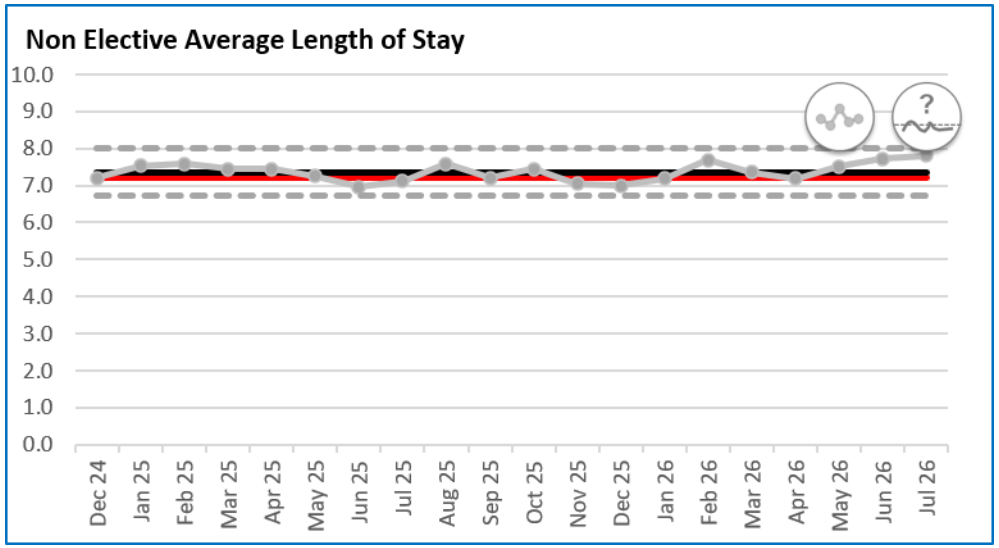
DNA Rate – IMD Deciles 1-2			DNA Rate – IMD Deciles 3-10		
Jul 26	YTD	Target	Jul 26	YTD	Target
9.8%	9.4%	5%	6.3%	6.0%	5%

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. • MSK physiotherapy community work	IMDs 1 & 2 have an average DNA rate of **9.6%** for June 26. Disaggregated by contact these rates are: **IMD1** • Patients contacted DNA rate 6.0% • Patients not contacted DNA rate 12.6% **IMD2:** • Patients contacted DNA rate 4.7% • Patients not contacted DNA rate 15.0% **Inclusion Healthcare:** • DNA rate for those contacted 25.0% • DNA rate for those not contacted 41.7% **Paediatric Outpatients** • WNB rate contacted 9.5% • WNB rate not contacted 25.8%

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

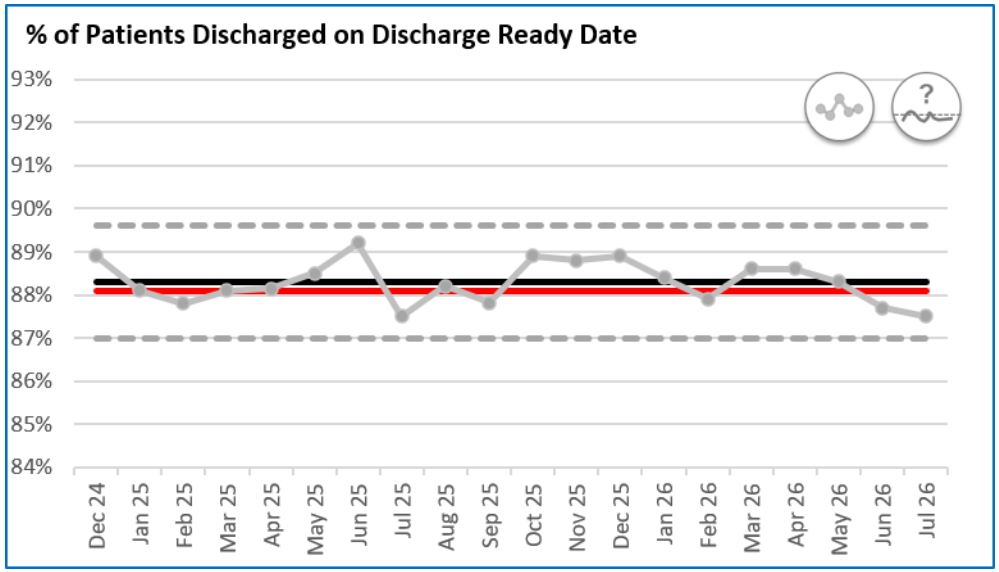


Current Performance			
Jun 26	YTD	Jun Plan	Target
7.7	7.5	6.7	7.2

National Position & Overview

Root Cause	Actions	Impact/Timescale
• Increase in admissions • Increase in NCTR 27th of 34th • Increase in Long Length of Stay	• Focus on internal efficiencies across ward process, diagnostics and support services • Work with partners to reduce long length of stay and • Temporarily open additional capacity at LGH (Ward 19) • Securing resourcing to support improvement programme to reduce LoS – programme running across 2025/26	• April 2026 – August 2026 • Weekly reviews in place • June 2026- closing August • April 2026 – December 2026

Responsive (Emergency Care) – % of Patients Discharged on Discharge Ready Date



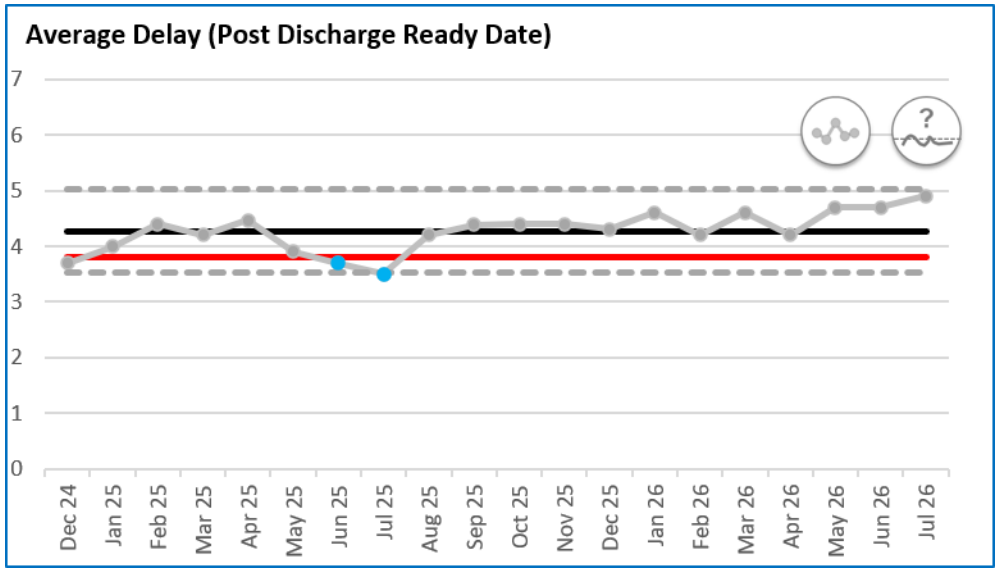
Current Performance		
Jul 26	YTD	Target
87.5%	88.0%	88.1%

National Position & Overview

In May, UHL ranked 62 out of 131 Acute Trusts that submitted acceptable data. The National average was 85.5%. 45 out of the 131 Acute Trusts achieved the target. UHL ranked 10 out of the 16 UHL Peer Trusts. The best value within our peer group was 94.3% and the worst value was 78.3%.

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) **334 complex patients stayed an additional night in hospital in July 2026, 50 more patients than June.** • **LLR system discharge hub interface and capacity delays** to provide timely plans for discharge**. >100 medically optimised complex patients awaiting a P1-P3 outcome. 152 Patients waiting at the end of July 2026 (155 in June, 149 May)** • **Deterioration in LOS from MOFD to discharge** for: o Pathway 1 : 0.17 day from June o Pathway 3: 6.93 days from June	• **Weekly escalation meetings** with Adult Social Care and CMG's. • Continue to **promote early referral** of patients (currently 33%) • Continue to work with SM on 3 wards over the next 3-6 months to understand processes and delays • Review LEAF QI projects relating to discharge for **shared learning of what works well.** • **Plan and Prepare** Target 'Future' allocated discharges, CLD and SHOP roll out. • **Nervecentre recording accuracy** – awareness training/ explore IT reconfiguration fix	•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) – Average Delay (Post Discharge Ready Date)



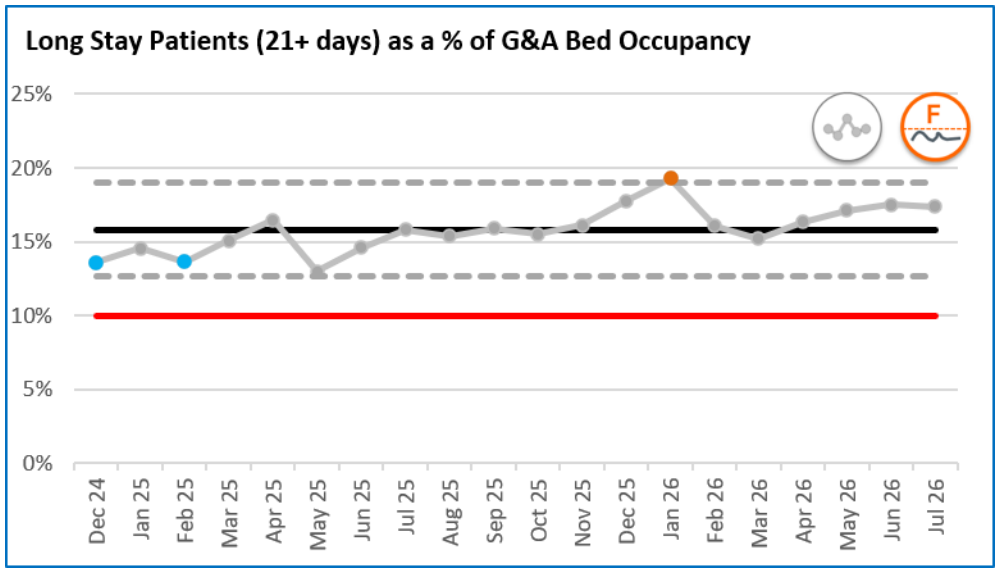
Current Performance		
Jul 26	YTD	Target
4.9	4.6	3.8

National Position & Overview

In May, UHL ranked 25 out of 122 Acute Trusts that submitted acceptable data. The National average was 6.2. 8 out of the 122 Acute Trusts achieved the target. UHL ranked 5 out of the 15 UHL Peer Trusts. The best value within our peer group was 2.5 and the worst value was 8.4

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) **334 complex patients stayed an additional night in hospital in July 50 more patients than June.** •**LLR system discharge hub interface and capacity delays** continue to impact the ability to provide timely P1-3 discharge plans . **152 Patients waiting at the end of July 2026 (155 June, 149 May)** •**Deterioration in LOS from MOFD to discharge** for: o Pathway 1 : 0. 17 day from June o Pathway 3: 6.93 day from June	**Continue weekly escalation meetings** with Adult Social Care and CMGs to address long waits, highlight recurring themes to inform transformation initiatives. • **Assess the underlying causes for discharge delays** and highlight recurring themes to inform transformation initiatives. • **Increase early patient referrals** currently at 33% through targeted engagement and process improvements. • **Share learning from LEAF and wider discharge QI projects** to inform approach to practice. • **Plan and Prepare** Target 'Future' allocated discharges, CLD and SHOP roll out. • **Nervecentre recording accuracy** – awareness training/explore IT reconfiguration fix	**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		
Jul 26	YTD	Target
17.4%	-	10%

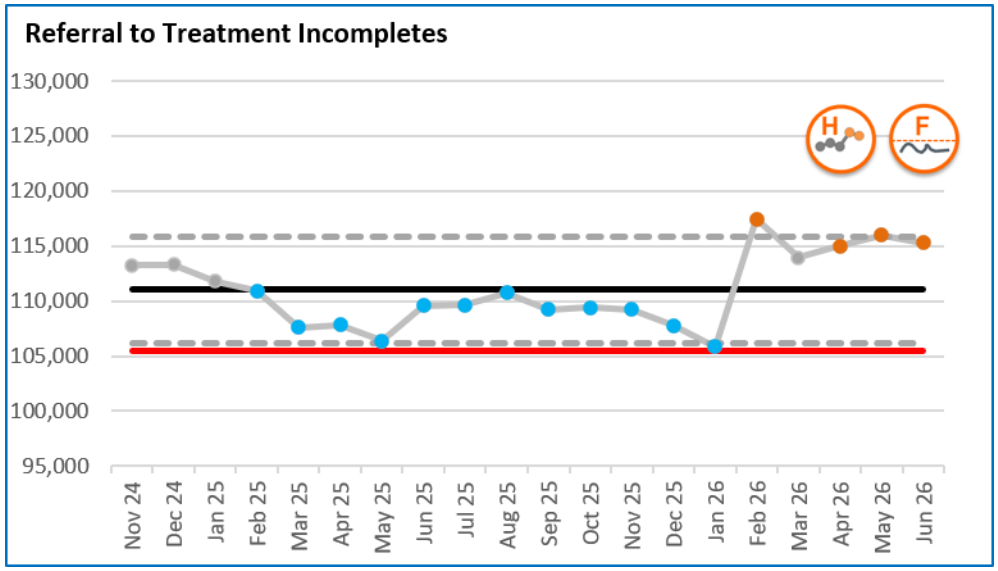
National Position & Overview

88 (304) Patients (29%) 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 (37 patients).

•93 Patients (31%) are medically optimised complex patients awaiting discharge with no reason to stay in an Acute Trust.

Root Cause	Actions	Impact/Timescale
• **LLR system discharge hub interface and capacity delays** As of the end of May there were circa 93 patients with a length of stay over 21 days awaiting a confirmed discharge outcome from LLR.	**Throughout August 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. **(33% July)** • Plan and prepare patients ahead of discharge (Focus on Future discharge) • Maintain Weekly CMG reviews of > 21 day patients and top 100 day patients • Improve occupancy of Virtual Wards and use of Criteria Led Discharge • Continue to work with 3 ward teams in medicine over the next 3-6 months to understand processes and delays • Deliver program of Discharge training • CMG Length of stay reduction programme	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



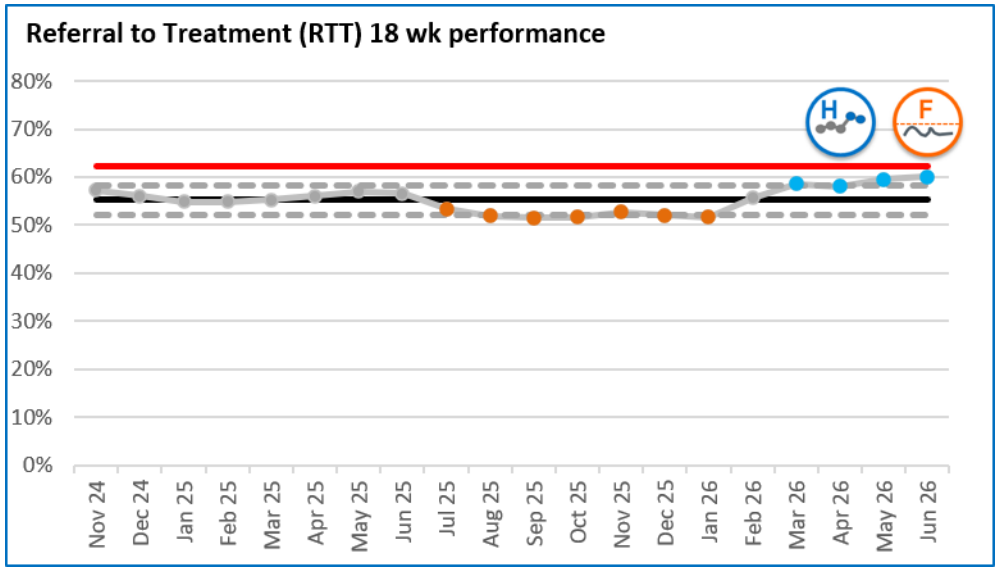
Current Performance		
Jun 26	Jun Plan	Target
115,279	110,485	105,500

National Position & Overview

At the end of June, UHL ranked 14 out of 17 trusts in its peer group with a total waiting list size of 115,259 patients. The best value within our peer group was 70,206, the worst value was 166,009 and the median value was 84,955. (Source: NHSE published monthly report)

Root Cause	Actions	Impact/Timescale
• Continued growth in demand against a significant number of specialties • Previous industrial action resulting in a 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. Further delays and issues with NC continue to contribute. • Workforce controls impacting on ability to maintain baseline and undertake additional activity through WLIs. • Inclusion of patients waiting e-Triage (previously excluded). There are c12,000 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 resource available to focus both on over 18 weeks to positively impact on performance and overall reduction on total wait list size.	• 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. • External validation resource to support required improvement plan for total waiting list reduction • Focused actions with the CMGs regarding meeting activity plans in the EMPCC, CDC and Endoscopy unit. • Continued learning and fix finding in new PAS • Specialties asked to provide recovery plans to reduce numbers of patients awaiting clinical triage. Figures are now being regularly reported to Senior Clinical Cabinet. • All CMGs have been asked to share developed 18-week trajectories during their monthly Performance Management Reviews in July.	• 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. • External validation support from mid August 2026.

Responsive (Elective Care) – RTT 18 Week Performance



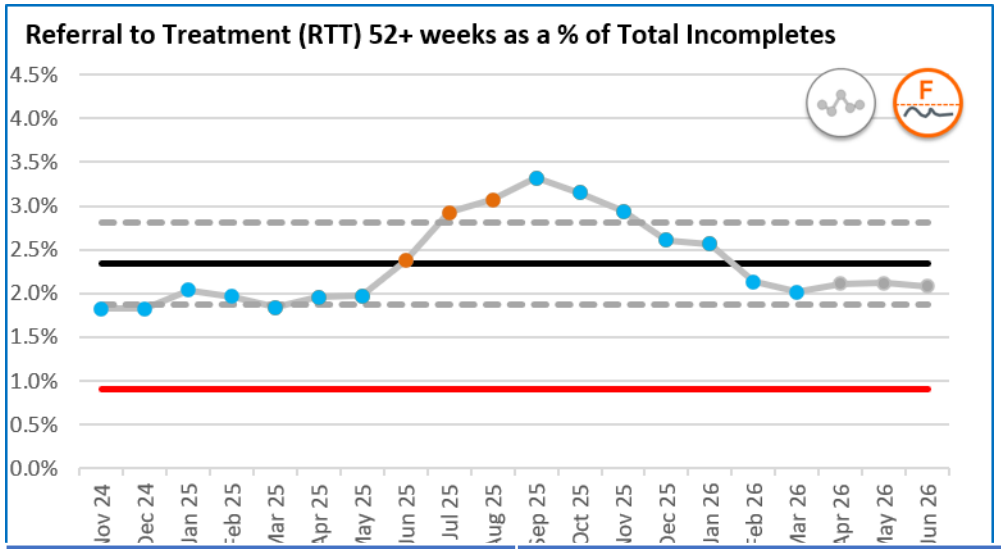
18 Week Performance			First Attendance - 18 Week Performance		
Jun 26	Jun Plan	Target	Jun 26	Jun Plan	Target
60.1%	59.0%	62.3%	63.8%	65.7%	68.1%

National Position & Overview

At the end of June, UHL ranked 14 out of 17 trusts in its peer group with RTT 18 Week Performance at 60.1%. The best value within our peer group was 74.6%, the worst value was 56.1% and the median value was 63.8%. (Source: NHSE published monthly report)

Root Cause	Actions	Impact/Timescale
• Continued growth in demand against a significant number of specialties • Previous industrial action resulting in a 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. Further delays and issues with NC continue to contribute. • Workforce controls impacting on ability to maintain baseline and undertake additional activity through WLIs. • Inclusion of patients waiting e-Triage (previously excluded). There are c12,000 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.	• 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 focused on over 18week waits, intent to over achieve performance against plan early in year. • External validation resource to support required improvement plan for total waiting list reduction • Focused actions with the CMGs regarding meeting activity plans in the EMPCC, CDC and Endoscopy unit. • Continued learning and fix finding in new PAS • CMGs have developed 18-week trajectories to deliver elective recovery targets. • Specialities being asked to produce plans to reduce the number of 'low value' clinical follow-ups to increase outpatient capacity • Actions in place with CMGs to recover and over-perform against activity plan.	• 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. • Reduced follow-ups, enabling capacity to be used for those on RTT waiting list and for an improvement in new to f/u ratio. • External validation support from mid August 2026.

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



Current Performance		
Jun 26	Jun Plan	Target
2.1%	1.8%	0.9%

National Position & Overview

At the end of June UHL ranked 12 out of the 17 Trusts in it's peer group with 2.1% of patients on the waiting list waiting over 52+ weeks. The best value within our peer group was 0.0%, the worst value was 3.8% and the median value was 1.9%. (Source: NHSE published monthly report)

Root Cause

- Challenged Cancer position and urgent priority patients requiring treatment
- Workforce challenges in anaesthetics leading to cancellations of theatre lists
- 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.

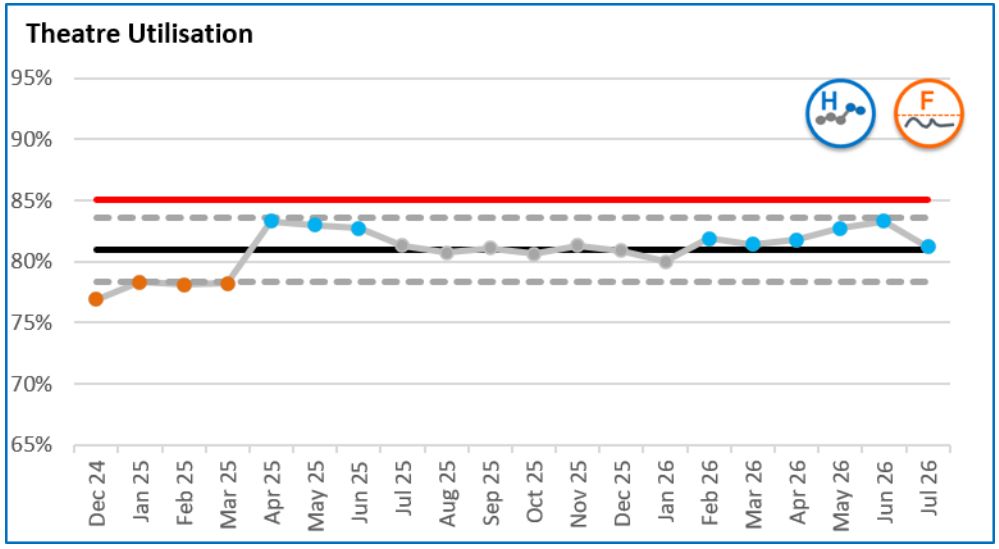
Actions

- 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.
- Escalation meetings chaired by COO/ Director for Planned Care with CMGs with the bulk of long waiters (52wws)
- Short term weekly CEO/COO-led escalation meeting to monitor delivery of specialty 65ww Route to Zero plans, track progress, remove barriers to delivery.
- Increased use of mutual aid and independent sector support, particularly within Orthopedics
- 52ww 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.
- GIRFT review in Orthopaedics and corresponding action plan to retunr to zero 52 week waits by end of December.
- Anaesthetic locum due to start in August; ongoing sickness absence continues to impact capacity.
- Additional insourced Maxfax clinics and theatre lists supporting long-wait reduction.
- UHN mutual aid for manometry diagnostics supporting Gastro

Impact/Timescale

- Zero 65+ week waiters not achieved. Expected July final position is 74. The majority of the continued capacity issue lies in Orthopaedic surgery, with very small numbers in a few other specialties which are complex cases or patient initiated delays in the pathways.
- Ensure elimination of 65-week waits by September for all specialties other than Orthopaedics whose route to zero in set for December.
- Additional activity with delivery favourable to plan.

Responsive (Elective Care) – Theatre Utilisation



Current Performance		
Jul 26	YTD	Target
81.2%	82.3%	85%

National Position & Overview

Overall theatre utilisation decreased to 81.2% in July, from 83.4% in June, primarily due to an increase in on-the-day cancellations (OTDCs), which rose from 8.3% to 8.9%. For the week ending 26th July, UHL ranked Green in Model Hospital (Quartile 3) with utilisation of 81.0%, performing slightly above both the national median (80.9%) and peer average (80.4%).
EMPCC continues to sustain the improvements achieved through super week, with monthly utilisation of 89.4%. Performance has been supported by continued reductions in late starts (2.3%) and OTDCs, which remain below 5% at 4.18%

Root Cause

- **LRI:** Utilisation was 75.2% (Adults 76.2%, Paediatrics 72.3%), impacted by high OTDC rates (11.7%). DNAs, list overruns and emergency admissions accounted for 39.3% of cancellations. Late starts increased to 40.3%, driven primarily by ward delays, prolonged surgical reviews and previous list overruns.
- **LGH/GGH:** Both sites fell below the 85% utilisation target in July (84.7% and 83.8% respectively). Performance was impacted by an isolated week commencing 20 July, when utilisation dropped to 81.2%. This variation was observed across multiple specialties, with utilisation otherwise averaging around 85% throughout the month
- **UHLiC:** Utilisation decreased to 77.1%, with continued variation between specialties (64%-91%), indicating inconsistent theatre productivity across services.

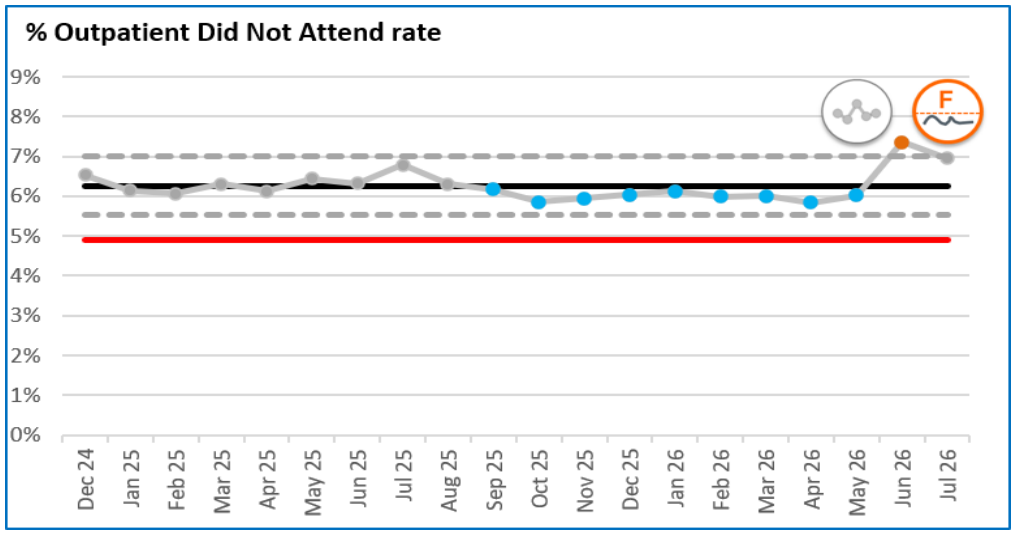
Actions

- **Adult MSS LRI Task & Finish Group** (OMF- Q1 Avg: 72%): Action plan in delivery to improve theatre readiness and reduce late starts on this site.
- **UHLiC Focus Meeting** (Q1 Avg: 74%): Parallel working trials underway in General Surgery and Plastics to reduce turnaround times and late starts.
- **Gastro Focus Group** (Q1 Avg: 59%): End-to-end pathway review undertaken with actions to improve scheduling, late starts and optimise delivery of GA endoscopy activity.
- **Paediatric Focus Group** (Q1 Avg. 73%): Observational work underway to identify and address the causes of late starts and turnaround delays.
- **POA Capacity:** Recruitment underway to 5 WTE ERF-funded posts, with implementation of the Orthopaedic nurse-led model progressing. Service at risk.

Impact/Timescale

- **MaxFax** improvements/actions underway; rollout across Adult MSS specialties during Q3 2026/27.
- **UHLiC -** Reduced turnaround times and non-operative time, creating capacity to add additional patients and maximise use of available theatre time. Trial underway at Melton.
- **GA Gastro:** Increased list utilisation, improved scheduling reliability and greater elective capacity through review of the most appropriate site and delivery model for GA endoscopy activity
- **Paediatrics:** Improved theatre flow, utilisation and seasonal resilience through targeted actions- Observation/QI project in-progress
- **Restore baseline POA activity** to reduce clinical avoidable cancellations and support elective throughput. Current capacity gap risks increased clinical avoidable OTDCs, delayed assessments + reduced patient pool availability.

Responsive (Elective Care) – Outpatient DNA Rate

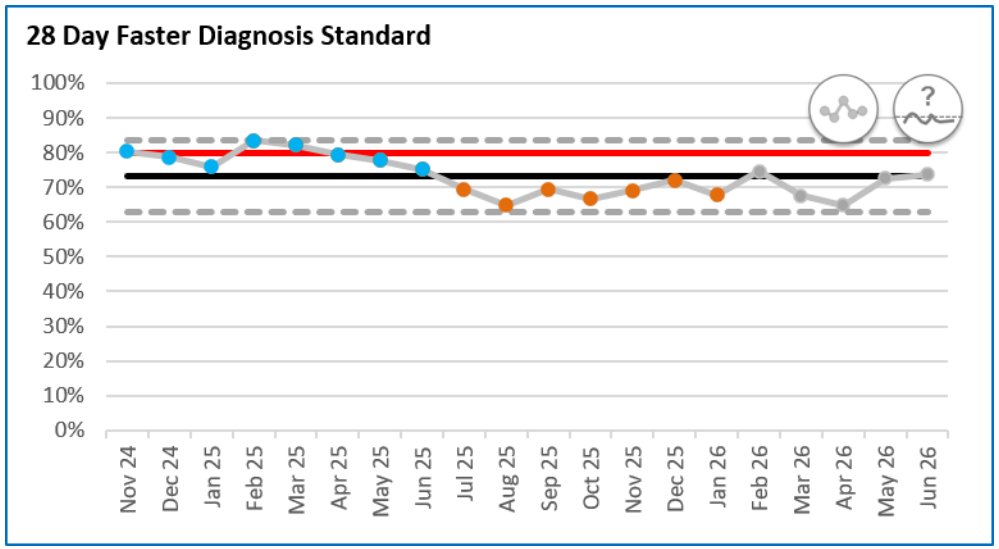


Current Performance		
Jul 26	YTD	Target
7.0%	6.5%	4.9%

National Position & Overview

Root Cause	Actions	Impact/Timescale
Following the rollout of Accurx Ambient Scribe, patient mobile numbers are now sourced from NerveCentre rather than the Personal Demographics Service (PDS). This has exposed longstanding data quality issues within NerveCentre, including mobile numbers being stored in incorrect fields or formats, resulting in appointment reminder messages failing to send. In addition, a longstanding NerveCentre issue means some patients do not appear on Accurx clinic lists, preventing them from receiving automated appointment reminders. These issues have contributed to an increase in the Trust DNA rate to **7.0%**.	The issues have been escalated as a priority with UHL IT, the Data Quality Team, EPR colleagues and Accurx. Work is underway to correct the underlying data quality issues, resolve the clinic list discrepancies and restore reliable appointment reminder functionality. DNA rates and reminder delivery performance continue to be monitored closely, with regular updates being provided.	The reduction in successful appointment reminders has significantly impacted patient attendance and is the primary driver for the increase in the Trust DNA rate. This has reversed improvements achieved over the last two years through digital transformation and enhanced patient communications. Resolution is dependent on completion of the NerveCentre data quality improvements and associated system fixes. The impact will continue to be monitored, with updates provided as actions progress.

Responsive Cancer – Cancer 28 Day Faster Diagnosis Standard



Current Performance			
Jun 26	YTD	Jun Internal Plan	National Target
73.7%	70.5%	74.0%	80%

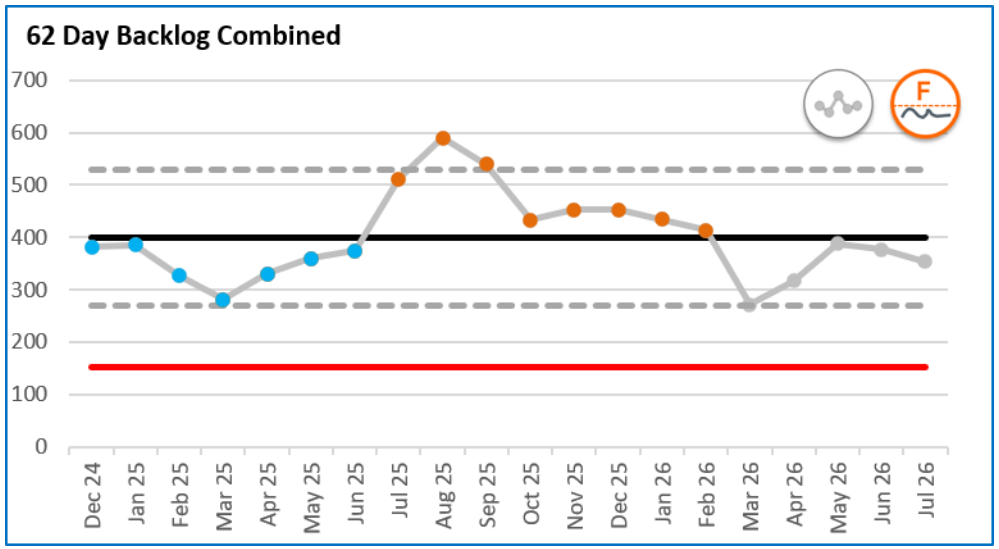
National Position & Overview

In June, UHL ranked 115 out of 137 Acute Trusts. The National average was 79.0%. 92 out of the 137 Acute Trusts achieved the target. UHL ranked 15 out of the 18 UHL Peer Trusts. The best value within our peer group was 87.3%, the worst value was 67.3% and the median value was 80.4%.

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 of 25/26. 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.	• Breast additional capacity continues through insourcing, bank and WLI, with wider recovery actions focused on symptomatic demand and screening assessment capacity. • Mutual aid and GP referral redirection support has been explored with neighbouring trusts, alongside escalation with NHSE. • Recruit to ENT locum, substantive & ACP • Triage ENT referrals to risk stratify demand • Colorectal (LOGI) audit and review of Straight to test pathways • Continued focus on 'Days Matter' 1st waits, imaging turnaround times & acting on results	• Breast 1st Appt improved to within 14 days for over 35s and 3 - 4 weeks for under 35s (lower clinical risk). Remains high risk and fragile – FDS improving from June • ENT 1st Appt improved to be within 14 days. Triage pilot continues successfully, up to 20% reduction in referrals noted – anticipate FDS improvement in Aug/Sept. • LOGI – Move from CTC to Endo, impact on pathology under review. Potential 3% FDS improvement. • Skin – sustaining delivery above 90% • Urology – sustaining delivery above 68% • Paper supporting clear documentation of diagnosis being considered for integration into AVT to support FDS turnaround times

Responsive Cancer – Cancer 62 Day Backlog



Current Performance		
Jul 26	YTD	Target
353	-	152

National Position & Overview

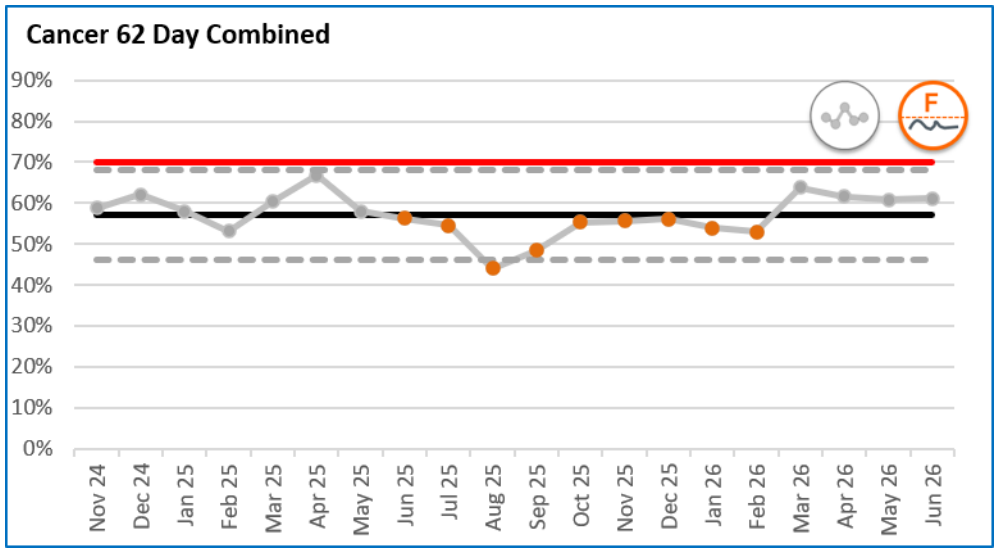
National and Midlands data is no longer available.

UHL end of July position:
>62 day 141 behind plan.
>104 day 38 behind plan.

Urology remains ahead of trajectory.

Root Cause	Actions	Impact/Timescale
• Breast, Colorectal and Urology drive the largest volume (62% in total), with Breast alone holding 30% of backlog. • Constraints include capacity, specifically outpatient, diagnostic (radiology & pathology) and workforce. • There has been an increase in diagnostic tests required per patient, patient complexity and patient choice which have impacted pathway length • There are some bottlenecks in capacity within Oncology OPD capacity and Plastics capacity for skin, which are causing longer waits for some patients.	• Clinical prioritisation and review of cancer patients over 42, 62 and 104 days, supported by senior Cancer Centre backlog escalation for TCIs, OPAs and reporting. • Breast recovery actions across screening and symptomatic pathways, with additional activity being put on to manage backlog and increased demand. • Focus on reducing delays from results available to clinical action and on supporting timely review outside MDT where possible. • Oncology improvement actions to reduce appointment waits progressing, with implementation from mid-July • Backlog clearance MDT focus – Sept/Oct	• Colorectal pathway actions commencing. Focus remains on CTC/Endoscopy flow, MDT roles and faster results-to-action. Impact from Q3. • Urology remains ahead of trajectory, supported by template biopsy histopathology outsourcing and increased collections. MRIp TAT fell in June and July, with improvement seen again in August. • Oncology improvement actions to be tracked once new data available. • Plastics - appointed 1 locum post, commencing later in the year, expect impact from Q4.

Responsive Cancer – Cancer 62 Day Combined



Current Performance			
Jun 26	YTD	Jun Plan	Target
61.2%	61.2%	62.4%	70%

National Position & Overview

In June, UHL ranked 120 out of 143 Acute Trusts. The National average was 69.9%. 82 out of the 143 Acute Trusts achieved the target. UHL ranked 15 out of the 18 UHL Peer Trusts. The best value within our peer group was 80.3%, the worst value was 49.1% and the median value was 67.5%.

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 (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 1 week of next step and 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. • Review of Oncology clinic schedules and virtual opportunities. ePROMs development for immunotherapy underway	• Breast MDT optimisation project launched with 30/60/90 day actions. Improvement plan to be in place by end Sept. • Pathology insource/outsourcing of Urology & Gynaecology supporting TAT. Plans for some digital reporting in Urology and Skin, expected ahead of Breast. • Imaging TAT plans to increase uptake of WLIs for reporting with impact seen from July • Breast, Colorectal, Upper GI and Urology show improved performance compared to May. Largest risk for 62 days held in Breast – not expected to improve until Q4 due to backlog clearance required.

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

Executive Summary

- The month 4 position for the Trust is a deficit of £8.9m which is £0.3m better than plan. This position includes £1.6m of costs related to industrial action incurred during M1.

- The CIP target in Q1 was £9.5m. For Q2, this doubles to £20.2m so delivering plan will become significantly more challenging each month. If the current run rate continues and does not improve then the Trust will be significantly adverse to plan over Q2. It is imperative that plans are formulated and progressed asap - particularly on bank and agency run rate reduction.

- The cash position at the end of Month 4 was £29.3m, which is an increase of £2m from June. If the Trust's financial position becomes adverse to plan then deficit support will be lost, which amounts to £4.7m per month. This will make the cash position even more challenged and creditor payments will need to be managed.

Summary Financial Position – YTD M4

	I&E YTD		
	Plan	Actual	Variance to Plan
	£'000	£'000	£'000
NHS Patient-Rel Income	546,687	557,375	10,688
Other Operating Income	59,161	60,501	1,340
Total Income	**605,847**	**617,876**	**12,028**
Pay	(389,747)	(391,918)	(2,172)
Non Pay	(195,070)	(205,426)	(10,356)
Total Costs	**(584,816)**	**(597,344)**	**(12,528)**
EBITDA	**21,031**	**20,532**	**(499)**
Non Operating Costs	(30,043)	(29,827)	216
Retained Surplus/(Deficit)	**(9,012)**	**(9,296)**	**(284)**
Donated Assets	(207)	334	541
Control Total Surplus/(Deficit)	**(9,219)**	**(8,962)**	**257**

Comments – YTD Variance to Plan

Total Income: £12mF

- PCI income (£9.2mF) includes Elective Care £3.8mF and UEC £4.7mF (driven by NEL activity greater than one day over-performing) and various contract variations
- Other income (£1.3mF) includes R&I pass through income and smaller variances across most CMGs along with technical phasing adjustments
- EDD (£1.4mF) matched by expenditure

Pay: £2.2mA:

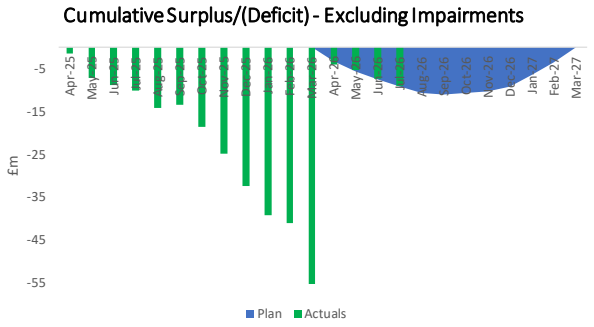
- Medical costs include £1.2m of additional costs due to industrial action, balance of variance driven by premium pay
- Nursing and Other Clinical underspends are driven by vacancies
- Non Clinical driven by phasing and allocation of CIP plans

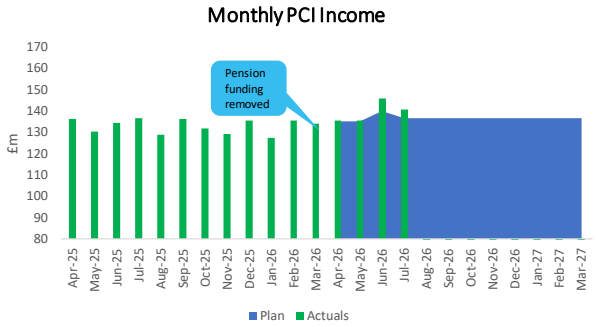
Bank (£24.7m) and Agency (£1.9m) spend YTD amounts to £26.6m which is 6.8% of total pay. The NHSE YTD cap for bank pay is £16.3m.

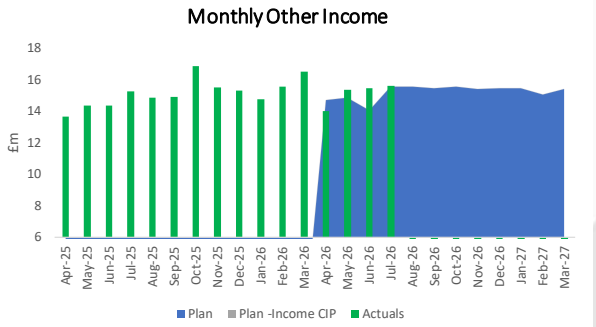
Non-Pay: £10.4mA:

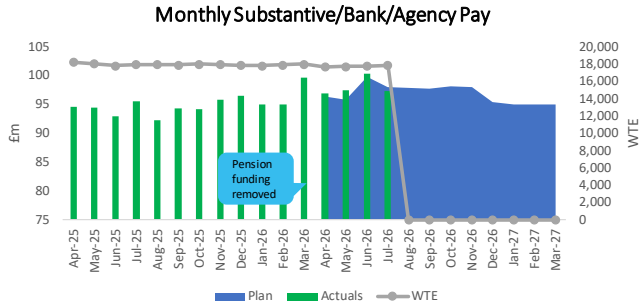
- Other is driven by UEC blended income accrual £3.2mA (matched by income), write-off of bad debt £0.9mA and R&I pass through costs (£0.8mA) matched by income and non delivery of CIP
- Clinical supplies is driven by additional activity delivered to date.
- EDD (£1.9mA) covered by income

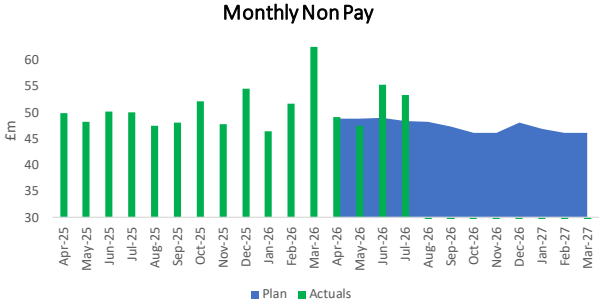
Month 4 I&E Dashboards

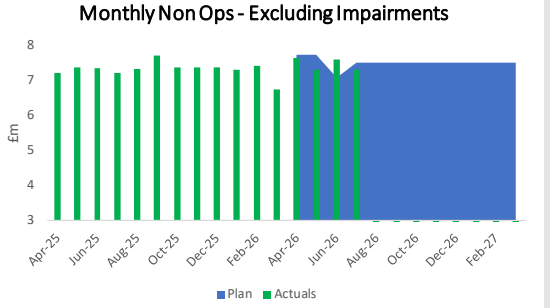




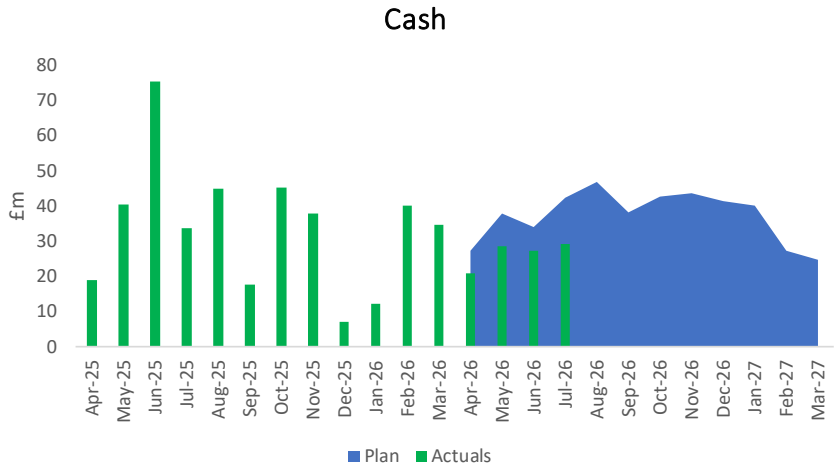


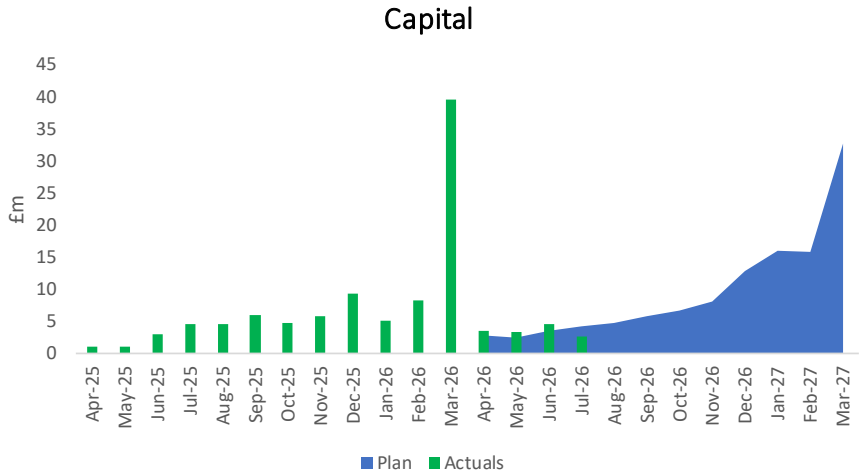


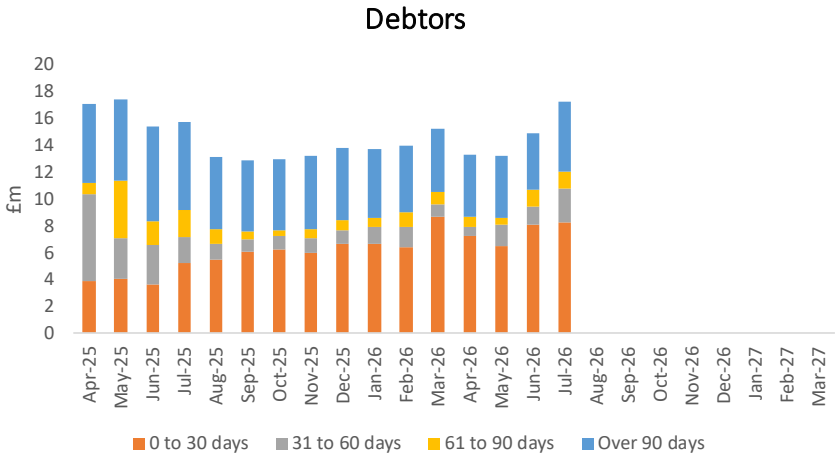


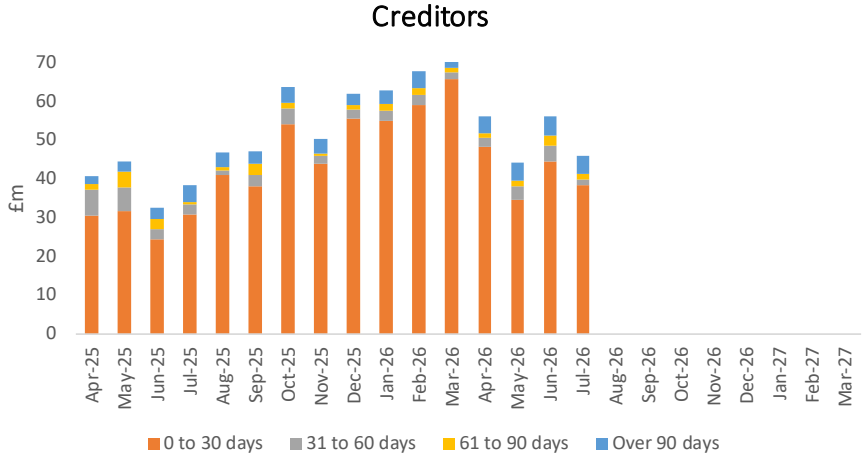


Month 4 Balance Sheet Dashboards









Statement of Financial Position

- **Non-Current Assets (-£1.9m):** Depreciation of £5.6m in M4 offset by asset additions of £3.7m.
- **Trade and other receivables (+£15.4m**): £9.2m increase in NHS income accruals, VAT receivables (£1.0m) and Prepayments (£2.8m).
- **Cash (£2.0m) –** Refer liquidity and cash slide.
- **Trade and other payables and accruals (-£12.5m):** Reduction in Trade Creditors (-£9.0m) resulting from larger payment runs processed for payment and a drop in CMG accruals (+£2.3m).
- **Deferred Income (+26.3m):** increased due to the deferral of patient care income(+£13.0m) which will be released to match future period activity performance (ie effectively it's a payment in advance) and an increase in HEE income (£13.0m) which has been paid quarterly in advance.
- **Dividend Payable (+£1.6m**): In line with plan and represents the accrual of PDC dividend payable at M4.
- **Income and Expenditure Reserve (+£1.7m):** movement reflects the in year reported adverse income and expenditure position.

Statement of Financial Position

£m	31-Mar-26	Jun-26	Jul-26	In Month Movement	YTD Movement
Non Current Assets					
Intangible assets	33.9	32.2	31.4	(0.8)	(2.6)
Property, plant and equipment	663.9	659.1	657.9	(1.2)	(6.0)
Other non-current assets	4.6	4.6	4.6	0.1	0.1
Total non-current assets	**702.4**	**695.8**	**693.9**	**(1.9)**	**(8.5)**
Current Assets					
Inventories	27.8	27.5	28.1	0.6	0.3
Trade and other receivables	44.6	77.3	92.7	15.4	48.2
Cash and cash equivalents	34.7	27.3	29.3	2.0	(5.4)
Total Current Assets	**107.0**	**132.1**	**150.1**	**18.0**	**43.1**
Current Liabilities					
Trade and other payables	(168.7)	(146.9)	(136.7)	10.2	32.0
Leases < 1 Year	(12.3)	(13.3)	(13.0)	0.3	(0.8)
Accruals	(23.1)	(31.6)	(29.4)	2.3	(6.3)
Deferred income	(4.9)	(38.6)	(64.9)	(26.3)	(60.0)
Dividend payable	0.0	(5.5)	(7.1)	(1.6)	(7.1)
Provisions < 1 year	(9.1)	(8.7)	(8.6)	0.1	0.5
Total Current Liabilities	**(218.1)**	**(244.7)**	**(259.8)**	**(15.1)**	**(41.7)**
Net Current Assets / (Liabilities)	**(111.1)**	**(112.5)**	**(109.7)**	**2.9**	**1.4**
Leases > 1 Year	(35.8)	(35.4)	(35.3)	0.1	0.6
Provisions for liabilities & charges	(3.0)	(3.0)	(3.0)	0.0	(0.0)
Total non-current liabilities	**(38.8)**	**(38.4)**	**(38.3)**	**0.1**	**0.6**
Total Assets/(Liabilities)	**552.5**	**544.9**	**546.0**	**1.1**	**(6.5)**
Public dividend capital	(984.6)	(984.6)	(987.4)	(2.8)	(2.8)
Revaluation reserve	(178.0)	(178.0)	(178.0)	0.0	0.0
Income and expenditure reserve	610.1	617.7	619.4	1.7	9.3
Total Capital & Reserves	**(552.5)**	**(544.9)**	**(546.0)**	**(1.1)**	**6.5**

Liquidity and Cash Position – Month 4

- Cash balance at end of June: £29.3m (£26.6m for the Trust) compared with a plan of £42.4m. Year End Forecast of £24.8m.
- Net in-month reduction of £2.0m
- M4 BPPC of 96% by value, 91% by volume.

Receivables & Payables

- Total debt: £17.3m, of which >90 days £5.2m (£4.2m at M3)
  - Overseas Debt > 90 days £1.9m with 174k put forward for write off Q2 Action plan being finalised to strengthen identification and improved recovery. Billing and Debt Recovery Processes.

- Payables reduced by £10m, however there remains a significant backlog of invoices waiting to be registered due to P2P process blocks and delays in approval and authorization process and staff resourcing issues in Accounts Payable.

	Month 4						Month 3					
	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	**12,490**	6,032	1,427	858	4,172	33%	**10,599**	5,197	987	941	3,474	33%
NHS receivables	**4,770**	2,194	1,143	420	1,013	21%	**4,366**	2,932	299	402	733	17%
Total receivables	**17,260**	**8,226**	**2,570**	**1,278**	**5,186**	**30%**	**14,965**	**8,130**	**1,285**	**1,343**	**4,207**	**28%**
Non-NHS payables	**39,431**	33,741	1,117	1,236	3,337	8%	**49,080**	39,663	3,323	2,016	4,078	8%
NHS payables	**6,291**	4,680	146	194	1,271	20%	**7,054**	4,817	774	425	1,039	15%
Total payables	**45,722**	**38,421**	**1,263**	**1,430**	**4,608**	**10%**	**56,134**	**44,480**	**4,097**	**2,441**	**5,116**	**9%**

Capital Programme - 26/27 M4 Position

The Trust committed gross expenditure of £13.9m year to date (£10.3m at M3) against a plan of £13.1m which netted down to £13.8m, after deducting charitable donations/capital grants and disposals of £117k in the month. The overall programme is therefore ahead of the year-to-date plan by £0.8m at month 4 (also £1.4m ahead at M3). This is mainly driven by £2.1m of VM licences coming through for Digital Infrastructure Obsolescence, £2.0m under-commitment on Estates Backlog Maintenance in 25/26 (costs coming through in 26/27), and £1.1m overspend on Medical Equipment and MES, offset by £5.8m slippage on LRI enabling works (the phasing to be reprofiled) and £1.1m slippage on NHP Incoming Power. The balance is made up of other smaller variances

	M4 YTD Plan £'000	M4 YTD Actual £'000	Variance to M4 Plan £'000
Gross capital expenditure including IFRS impact:	13,148	13,924	(776)
Less: Book value of asset disposals including IFRS16 Disposals	0	(43)	43
Less: Capital grants/donations received	(164)	(75)	(89)
Charge against the Capital Resource Limit (CRL) incl IFRS impact	**12,984**	**13,806**	**(822)**

Scheme	Revised Plan £'000	M4 YTD Plan £'000	M4 YTD Actual £'000	Variance YTD Plan v Actual £'000
Digital infrastructure obsolescence	4,113	457	2,824	(2,367)
EPR	7,178	1,764	2,181	(417)
Medical Equipment	3,341	148	884	(736)
MES Equipment	3,800	63	124	(61)
MES Enabling	6,135	443	861	(418)
Estates Backlog Maintenance	3,763	426	2,488	(2,062)
Ward Improvement	2,000	0	58	(58)
Other Operational Schemes	15,033	0	11	(11)
Total 26/27 Operational Funded Schemes	**45,364**	**3,301**	**9,432**	**(6,131)**
Total 25/26 Capital Slippage	1	0	1	(1)
Leases: IFRS16 (including re-measurement)	6,725	0	593	(593)
Total System Funded Schemes incl. IFRS16	**52,090**	**3,301**	**10,026**	**(6,725)**
Other Estates Schemes	9,339	0	502	(502)
Diagnostics (RtCS)	15,250	0	198	(198)
UEC (RtCS)	2,000	0	221	(221)
NHP	29,646	9,683	2,905	6,778
Charity Funded Schemes	2,500	164	74	90
Total Capital Programme	**110,824**	**13,148**	**13,924**	(776)
Donated Income/Grant rec'd and Disposals	(2,500)	(164)	(117)	(47)
NET CDEL	**108,324**	**12,984**	**13,806**	**(822)**

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.