University Hospitals of Leicester NHS
NHS Trust

Trust Board Paper G

Meeting title:	Trust Board					
Date of the meeting:	12 November 2026					
Title:	**Integrated Performance Report and Executive Summary**					
Report presented by:	Helen Hendley Chief Operating Officer, Lee Bond Chief Financial Officer, Clare Teeney Chief People Officer, Julie Hogg Chief Nurse, Gang Xu Medical Director					
Report written by:	Helen Hendley Chief Operating Officer, Lee Bond Chief Financial Officer, Clare Teeney Chief People Officer, Julie Hogg Chief Nurse, Gang Xu Medical Director					
Action – this paper is for:	Decision/Approval		Assurance	X	Update	
Where this report has been discussed previously	Trust Leadership Team, Quality Committee, Operations and Performance Committee					

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

To note the performance for month 6.

Summary

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

Main report detail

Key headlines in performance are summarised below:

Summary of UHL Performance: September 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** 	September 2026 saw an increase of 1757 Emergency Department attendances to plan. Eye Casualty saw 215 more attendances than plan. In the first 6 months of this year, we have seen 8885 more patients than plan through our emergency department and eye casualty. 4-hour performance in September did not achieve the trajectory of 67.17% with a performance of 59.40% (UHL only). Type 2 activities achieved 91.54% against a trajectory of 90.93%. The key challenge in delivery was due to the volume of attendances and waits in ED for beds. An improvement plan is in place to address this going forward, but we see the volume impact as one of our key challenges and are therefore working with the Integrated Care Board on actions to reduce demand. At present the increase in community capacity, actions relating to neighbourhoods and changes in models of care relating to frailty are not having an impact. LRI monthly ambulance handover has been challenged during the Q1 and Q2, however, our performance has remained improved vs the same period last year and we met trajectory each month with average handover at 20.15 minutes in September vs a plan of 31.59 minutes. We had 0 extended delays on ambulances (over 8 hrs). The 12-hour performance (total time in dept) was 7.30% therefore achieving trajectory of <10%. Emergency admissions were over plan by 617 admissions against plan again driving challenges in flow from the Emergency Department for patients waiting for beds along with impacting the overall length of stay. Whilst not exhaustive some key improvement initiatives are: - · Work on LoS continues following challenges during the summer September has seen a slight improvement with a reduction to 3.50 days vs the above plan of 3.25 days but slightly better than August. · The Urgent Treatment Centre building work is progressing. · The Children's and Young People same day emergency care proposal has been completed, and funding has been confirmed. Mobilisation is now underway but there are space constraints that are a challenge to overcome, the working group continue to explore options. · Acute Virtual Ward funding has been approved, and the service will commence on the 14th October. · UEC Clinical Operating standards have been fully rolled out, and monitoring mechanisms have been agreed and implemented · System Single Point of Access is on track to go live from 1st October. · SDEC continues to perform well overachieving trajectory. · Improving discharge pathways action plan is in place along with the transfer of the Discharge Hub to UHL in November 2026 and the opening of the new discharge lounge at the LRI on the 30th November.
Elective Care **Referrals and Outpatient performance Elective activity Pathway**	Figures remain as forecast for September, due to a national extension on submission dates until later in the month. The total waiting list remains above plan and is a key priority. In September, it is forecast to be approximately 114,000 (an improvement from August of 114,889), with 18-week performance at 61.5% against a 62.5% plan. October also forecasts early risk to return to plan with the expectation that focused activity in November will improve the position. This

Improvements 	improvement will be delivered through additional activity, clock stops and targeted validation by services and the central team. External validation support has also been contracted until the end of March 2027, doubling validation capacity. The September position for 65-week waits is expected to be 52 patients (95% of the patients are Orthopaedics). Weekly calls are in place with CMGs led by the CEO and COO. The expectation is that all specialities with less than 100 patients in their cohort will be at zero 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. October forecast is ~50. Our risk currently sits at 78. This assumes all admitted dated in month patients go ahead. The risk sits in undated / dated and a 30% conversion from non-admitted dated in month to admitted. The current forecast for September 52-week wait position is circa 2,539 patients, equating to 2.2% of the total waiting list, remaining adverse to plan. 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 increased slightly from 82.7% in September from 81.6% in August and is 82.2% year to date, whilst below the 85% target it still puts the Trust in the upper quartile nationally for theatre productivity. Patient Initiated Follow Up continues to perform strongly at 6.3% in September, while follow-up appointments without a procedure increased slightly to 50.1% in September 49.1% year to date. **Outpatient performance and recovery:** The outpatient DNA rate reduced slightly to 6.5% in September and 6.4% year to date, above the 4.9% target. The increase is still impacted by digital issues relating to appointment reminders. The issues have been escalated to UHL digital teams. Other outpatient indicators continue to perform strongly.
Cancer **Referrals** **2 week wait** **Faster Diagnosis Standard** **62-day referral to treatment** 	Demand remains above last year, with rolling year-to-date (Sept 25 – Aug 26) referrals 2.3% higher and conversion rate of 6.5% broadly in line with the national average of 6.1%. Cancer performance in August remained ahead of the Trust's planned trajectory across all three standards, although performance varied between measures. The Faster Diagnosis Standard improved to 78.9%, continuing the recovery seen in recent months within breast and H&N specifically and moving closer to the national 80% standard. September is currently forecast to remain broadly stable at 79.0%. The 31-day treatment standard remained ahead of plan at 87.7% in August. Performance has improved significantly during 2026, although further improvement is required to achieve the national standard of 94%. September is currently forecast at 83%, with pressures particularly affecting surgical pathways. These pressures are emerging in breast who hold the largest backlog following pathway constrains earlier this year and Lung due to patients requiring specific procedures. The underlying improvement programme continues to focus on maintaining close oversight of patients awaiting treatment and addressing constraints in theatre and high-risk anaesthetic capacity. The 62-day referral-to-treatment standard remains the principal area of concern, with performance at 57.7% in August and forecast to reduce to 51.0% in September. Breast, Lower Gastrointestinal and Urology pathways account for much of the current pressure, with delays associated with diagnostic and pathology turnaround times, capacity and progression between stages of the pathway. Improvement work remains focused on the pathways experiencing the greatest pressure. This includes additional capacity, faster diagnostic reporting and action on results, greater use of

	parallel investigations where clinically appropriate, streamlining multidisciplinary decision-making and strengthened review of patients experiencing longer waits. The priority is increasingly to embed these improvements into sustainable pathways and capacity rather than relying on short-term measures.
Quality 	Quality performance remains mixed, with areas of improvement alongside a number of indicators requiring continued executive focus. Patient experience remains positive, with Friends and Family Test performance at 95% in September (94.7% YTD), and patients continuing to highlight the kindness and professionalism of staff despite concerns regarding waiting times, communication, discharge delays and responsiveness. Patient safety and flow remain key areas requiring executive oversight. No, Never Events were reported in September, with the year-to-date total remaining at seven. Investigation and organisational learning continue through the PSIRF framework, supported by strengthened safe surgery governance. C. difficile cases increased during the month and are subject to enhanced executive oversight, with targeted actions focused on antimicrobial stewardship and clinical areas with higher incidence. System flow pressures continue to impact performance, non-elective length of stay remains above plan, discharge delays remaining elevated but a slight decrease since August and a reduction of 1.1% in the general and acute bed occupancy accounted for by long-stay patients. These pressures continue to affect capacity and highlight the importance of the Trust's discharge improvement and length of stay reduction programmes. Clinical effectiveness indicators remain broadly stable, with mortality measures showing expected performance.
Finance 	The month 6 position for the Trust is a deficit of £10m which is £1m better than plan. This position includes £1.6m of costs related to industrial action incurred during M1. The CIP target in Q2 was £20.2m. For Q3, the target increases by 39% to £28m 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 Q3. 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 6 is £13.4m which is a reduction of £4.3m from Month 6. 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 position** At Month 6, the total workforce was 18,257 WTE - 229 WTE (1.27%) above plan. This variance was driven primarily by bank staffing, which remained above the submitted workforce plan. • **Agency staff:** Usage was 27 WTE, 1% above plan. Of this, 22 WTE related to allied health professionals (AHPs), where usage remains high. • **Bank staff:** Usage fell by 98 WTE from 942 WTE in the previous month to 844 WTE. However, it remained 339 WTE (67%) above the planned level of 505 WTE and has exceeded plan since Month 1 (April 2026). • **Contracted substantive staff:** The workforce was 17,386 WTE, 111 WTE (0.64%) below the planned position of 17,497 WTE. **Turnover, vacancies and agency controls** Workforce turnover reduced by a further 0.1 percentage points to 6.7%, remaining below the 10% target.

	• **Healthcare support workers:** Vacancies remain high and have been compounded by changes to visa and immigration requirements. The Band 2 HCSW development pathway has been introduced to attract talent from internal departments, including Estates and Facilities, and to reopen entry routes for school leavers who are new to care. • **Midwifery support workers:** Turnover is expected to rise as colleagues leave to begin university studies. External recruitment is under way. • **Registered nursing and midwifery:** Vacancies are below target. However, recruitment continues to reduce reliance on bank and agency staffing. One non-clinical agency worker remains assigned to the capital programme, with NHS England approval. The number of agency workers paid above the price cap has reduced from 18 to 16 and is expected to fall further. AHP agency workers are at or below the price cap, except in shortage specialties: specialist sonography, cardiac physiology and radiography. New medical agency appointments now follow the West Midlands medical rate card agreed through an NHS England workstream. This has reduced rates and generated savings. Further substantive recruitment is under way to support continued reductions in agency use and premium pay. **Mandatory training and appraisal** Mandatory training compliance has fallen to 91%, against a desirable target of 95%. Although rated red, this level compares favourably with many NHS organisations nationally and is not considered an immediate risk. This month, the priority is to improve compliance with Infection Prevention training as we head into winter and with the recently updated Conflict Resolution training. Appraisal compliance has declined further to 81.8%, against the 95% target. A revised process for all staff except doctors was launched in June, with an emphasis on high-quality, coaching-led conversations that include career aspirations. ESR is being trialled as the main appraisal data platform to improve administration and reporting. Services now need to review their performance, identify the causes of low compliance and target additional support where required. **Sickness absence and prevention** Sickness absence is reported one month in arrears and remained stable at 5% in August. Over the past 12 months, the highest absence rates were in Estates and Facilities (6.31%), Women and Children (5.69%) and ITAPS (5.06%). The NHS 10-Year Plan (2025) prioritises a shift from sickness to prevention, while the NHS Staff Standards identify health and wellbeing as a key focus. A UHL working group has reviewed the data and identified three workstreams to support achievement of the national 4.1% absence target: • Reduce absences recorded as unknown or other. • Address stress-related absence. • Reduce sickness absence in the nine areas with the highest rates. **Governance and overall rating** Workforce performance continues to be reviewed through CMG Performance Review meetings, CMG Boards, Senior Leadership Teams and Specialty Reviews. **Overall workforce rating: Amber.**
Tranformation &	**Theatres**

Productivity **Key Overview** **e.g Urgent and Emergency Care Elective, digital, Estates etc**	Theatre utilisation improved to 82.7% in September, up from 81.6% in August and above the YTD position of 82.2%. UHL remains ranked Green (Quartile 4) in Model Hospital for August (Sep data not yet available) achieving 83.7% utilisation and outperforming both peers (79.6%) and the national median (80.7%). EMPCC and GGH continue to perform strongly, delivering 89.5% and 88.2% utilisation respectively in September, both above the 85% target. LGH delivered 84.8%, just below target. LRI remains the key area of focus at 75.7%, with particularly low paediatric utilisation (67.7%). UHLiC utilisation 81.8%: review operating model, planned break recognition and the cost/benefit of additional workforce cover. **Key actions underway:** • Targeted improvement programmes are in place across Adult MSS, Gastro and Paediatrics. Paediatric Improvement Programme are meeting fortnightly, with targeted review of late starts and improving utilisation – work lead by the QI team. • UHLiC: Ongoing discussion with GIRFT to understand how other community surgical sites manage staff breaks. Review of the cost-benefit of additional workforce cover for breaks against the potential to deliver additional case(s) per list. • OTDC escalation policy to October TPAB for sign-off, strengthening escalation, ownership and review of avoidable cancellations. September OTDC increased in September by 2%, with notable pressures from non-clinical cancellations, including bed-related cancellations, emergency pressures, alongside patient-related cancellations, DNAs. • Exploring Automated Theatre Reminders to reduce avoidable patient-related cancellations, particularly DNAs (13% of all OTDC in September) BADS day-case performance remains below target at 81.3% (peers 83.7%; latest available data May). Work continues to strengthen existing pathways, such as Lap chole and develop new day-case pathways, including hemithyroidectomy. <u>Outpatients</u> PIFU performance remained broadly stable in September, with the conversion rate increasing slightly to 6.2%. This equates to 6,164 patients transferred to PIFU from 99,142 outpatient attendances. PIFU remains a key enabler of specialty plans to reduce routine follow-up demand. Specialty targets will be reviewed and reset using national benchmarking and opportunity data. The DNA rate has increased to 6.5%, with the year-to-date position at 6.6%. DNAs remain a significant area of focus due to their impact on patient access, clinic utilisation and waiting times. The rollout of Ambient Scribe has had an unintended impact on appointment reminders, as patient mobile numbers are now sourced from Nerve Centre rather than the Personal Demographics Service (PDS), highlighting data quality issues and resulting in some reminder messages not reaching their intended recipients and contributing to the increase in DNA rates over recent months. Work is ongoing to address the underlying data quality issues, resolve discrepancies in clinic lists and restore the reliability of appointment reminders.

	A revised reminder schedule, comprising reminders 14, 7 and either 3 or 1 day before an appointment, is technically ready for implementation but remains on hold pending resolution of the data quality issues. Implementation will be prioritised once these dependencies have been addressed. The enhanced reminder schedule, alongside increased character limits, will support more personalised and informative patient communications, with the aim of improving attendance and reducing DNA rates. **UEC** • 6722 monthly SDEC attendances delivered in September (7% above monthly target) • 2547 calls received to Clinical Bed Bureau in September11% increase to 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 0.5% in September, an improvement from September 2025 where is was 1.5% • Average Ambulance Handover Time 18 minutes, a 2-minute improvement from previous month and a 15-minute improvement September 2025. • Interprofessional Standards/COS – E referrals - 66% closed within 15 minutes. A deterioration of 2% from same month previous year. • Interprofessional Standards/COS– E referrals 65% closed within 60 mins. A deterioration of 5% from same month previous year. • IPS/COS guidelines, SOP and Monitoring tool now in place per GIRFT. Monitoring tool still currently being underutilised. • Work ongoing to evaluate the financial and operational impact of the newly released National SDEC guidance regards to logging all SDEC activity in the admitted care dataset. • Works began on GH SDEC Extension • Urology SDEC Expansion plans underway, designs agreed with architects. Staffing Model plans going through CHUGGs governance. • GH SDEC process in place to now record Virtual or telephone follow ups. • T&O SDEC – Ambulance Trolly wait patients now going to wait in day ward discharge lounge to free up SDEC Capacity • GAU - Agreed implementation SDEC follow up clinics (20 slots per week) in gynecology outpatients 10.11.26
Perinatal	Perinatal performance improved across several measures in September, including reductions in stillbirths, neonatal unit admissions and significant postpartum haemorrhage, alongside improvements in maternity triage, assessment times and the induction of labour pathway. There remain areas requiring close oversight including severe perineal trauma and performance against the 15-minute maternity triage standard. Mortality cases are subject to the appropriate established multidisciplinary and PMRT review and governance processes, with ongoing monitoring to identify learning and any emerging themes. These perinatal measures are newly incorporated into the IPR and further work is required to strengthen data quality, establish meaningful trends and develop the assurance and variation methodology. Consequently, individual monthly movements should be interpreted with appropriate caution at this stage. The focus remains on sustaining improvements, addressing areas of variation and demonstrating measurable improvement in safer, more timely care for women, babies and families.

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

September 2026

Oversight Framework

Key Performance Indicator	Target	Jul-26	Aug-26	Sep-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	19.4	26.1	9.2	?			Mar-24	Local	Chief Nurse and Medical Director
Methicillin Resistant Staphylococcus Aureus	0	1	2	0	10	?			Mar-24	Local	Chief Nurse and Medical Director
E-Coli per 100,000 Bed Days		11.6	34.9		10.5				TBC	No Target	Chief Nurse and Medical Director
Hospital Acquired Pressure Ulcers - All categories per 1000 bed days	1.7	1.2	1.5	1.1	1.3	?			Sep-26	Local	Chief Nurse and Medical Director
Sickness Absence	3%	5.0%	5.0%		4.8%	F			Mar-25	Local	Chief People Officer
30 Day Readmission Rate		10.1%	10.0%		10.3%				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%	63.6%	64.1%	62.1%	63.8%	?			Mar-23	National	Chief Operating Officer
% of 12 hour waits in the Emergency Department	10.3%	10.6%	7.9%	7.3%	9.0%	?			Mar-23	National	Chief Operating Officer
Referral to Treatment (RTT) 18 wk performance *	69.3%	60.0%	60.3%			F	H		Sep-26	Local	Chief Operating Officer
Referral to Treatment (RTT) 52+ weeks as a % OF Total Incompletes *	0.9%	2.1%	2.1%			F			Sep-26	Local	Chief Operating Officer
6 Week Diagnostic Test Waiting Times *	5%	11.7%	12.9%	10.1%		F	L		Jul-23	National	Chief Operating Officer
28 Day Faster Diagnosis Standard *	80%	77.3%	78.9%		73.6%	?			May-24	National	Chief Operating Officer
Cancer 62 Day Combined *	70%	60.4%	57.7%		60.4%	F	H		May-24	Local	Chief Operating Officer
Trust level control level performance	-£10.6m	-£1.6m	-£1.0m	£0.0m	-£10m				Jun-22		Chief Financial Officer
Capital expenditure against plan	£17.7m	£3.6m	£7.1m	£5.9m	£26.8m				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).*

University Hospitals Leicester

Oversight Framework

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

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

Integrated Performance Report

September 2026

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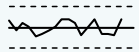
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- Exception Reports
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- Appendix - Data Quality Assessment

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Performance Overview (Safe)

Domain	Key Performance Indicator	Target	Jul-26	Aug-26	Sep-26	YTD	Assurance	Variation	Trend	Data Quality Assessment	Local or National Target?	Exec Lead
Safe	Never events	0	2	1	0	7	?			Aug-26	National	Chief Nurse and Medical Director
	Clostridium Difficile per 100,000 Bed Days	167 Cases	11.6	19.4	26.1	9.2	?			Mar-24	Local	Chief Nurse and Medical Director
	Methicillin Resistant Staphylococcus Aureus	0	1	2	0	10	?			Mar-24	Local	Chief Nurse and Medical Director
	Methicillin-susceptible Staphylococcus Aureus	40	9	6	7	41	?			Mar-24	Local	Chief Nurse and Medical Director
	All falls reported per 1000 bed days	4.0	3.9	3.4		3.5	?			Aug-26	Local	Chief Nurse and Medical Director
	Rate of Moderate harm and above Falls per 1,000 bed days	0.19	0.12	0.12		0.10	?			Sep-26	Local	Chief Nurse and Medical Director
	Hospital Acquired Pressure Ulcers - All categories per 1000 bed days	1.7	1.2	1.5	1.1	1.3	?	L		Sep-26	Local	Chief Nurse and Medical Director
	% of all adults Venous Thromboembolism Risk Assessment on Admission	95%	96.7%	97.5%		97.5%	P	L		Aug-26	National	Chief Nurse and Medical Director
	Number of Patient Safety Incident Investigations (PSIIs) commissioned		2	3	1	12	Awating more data for assurance and variance			Nov-24	No Target	Chief Nurse and Medical Director
	Number of reported Patient Safety Incidents		2422	2248	2321	14256				Nov-24	No Target	Chief Nurse and Medical Director
	Rate of reported Patient Safety Incidents (per 1000 inpatient, outpatient and ED attendances)		16.6	16.4	15.2	16.4		L		Nov-24	No Target	Chief Nurse and Medical Director

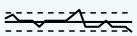
Performance Overview (Caring)

Domain	Key Performance Indicator	Target	Jul-26	Aug-26	Sep-26	YTD	Assurance	Variation	Trend	Data Quality Assessment	Local or National Target?	Exec Lead
Caring	Single Sex Breaches		71	38	31	224				Jul-22	No Target	Chief Nurse and Medical Director
	Inpatient and Day Case Friends & Family Test % Positive	95.5%	94.4%	94.4%	95.0%	94.7%				Jul-22	Local	Chief Nurse and Medical Director
	A&E Friends & Family Test % Positive	80.0%	87.3%	85.4%	84.1%	86.3%				Jul-22	Local	Chief Nurse and Medical Director
	% Complaints Responded to in Agreed Timeframe - 25 Working days	90.0%	59.3%	82.4%		60.5%				Jul-23	Local	Chief Nurse and Medical Director
	% Complaints Responded to in Agreed Timeframe - 60 Working days	90.0%	93.5%			67.3%				Jul-23	Local	Chief Nurse and Medical Director

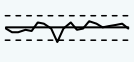
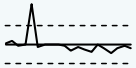
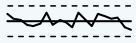
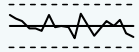
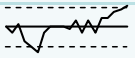
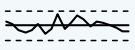
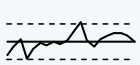
Performance Overview (Well Led)

Domain	Key Performance Indicator	Target	Jul-26	Aug-26	Sep-26	YTD	Assurance	Variation	Trend	Data Quality Assessment	Local or National Target?	Exec Lead
Well Led	Turnover Rate	10%	7.1%	6.8%	6.7%		P			Aug-26	Local	Chief People Officer
	Sickness Absence	3%	5.0%	5.0%		4.8%	F			Mar-25	Local	Chief People Officer
	% of Staff with Annual Appraisal	95%	82.8%	82.9%	81.8%		F	L		Mar-25	Local	Chief People Officer
	Statutory and Mandatory Training	95%	93%	93%	91%		F	L		Dec-22	Local	Chief People Officer
	Adult Nursing Vacancies	7%	6.5%	5.8%	6.0%		?			Dec-23	Local	Chief People Officer
	Paed Nursing Vacancies	10%	8.4%	8.1%	8.8%		?			Dec-23	Local	Chief People Officer
	Midwives Vacancies	7%	1.1%	1.0%	1.9%		?	L		Dec-23	Local	Chief People Officer
	Health Care Assistants and Support Workers Vacancies - excluding Maternity	5%	11.8%	11.7%	10.4%		F			Dec-23	Local	Chief People Officer
	Health Care Assistants and Support Workers Vacancies - Maternity	5%	5.2%	5.1%	5.3%		?	H		Dec-23	Local	Chief People Officer
	% Bank spend of Pay Bill	8%	5.8%	5.8%	5.7%		P			May-25	National	Chief People Officer
	% Agency spend of Pay Bill	3.2%	0.5%	0.5%	0.7%		P			May-25	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	26	18	16		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			May-25	National	Chief People Officer

Performance Overview (Effective)

Domain	Key Performance Indicator	Target	Jul-26	Aug-26	Sep-26	YTD	Assurance	Variation	Trend	Data Quality Assessment	Local or National Target?	Exec Lead
Effective	Published Summary Hospital-level Mortality Indicator (SHMI)	100				94 (Jan25 to Dec 25)	Assurance and variance not applicable			May-21	National	Chief Nurse and Medical Director
	12 months Hospital Standardised Mortality Ratio (HSMR)	100				96 (Feb 25 to Jan 26)	Assurance and variance not applicable			May-21	National	Chief Nurse and Medical Director
	Crude Mortality Rate		0.8%	0.8%	0.7%	0.8%				May-21	No Target	Chief Nurse and Medical Director
	DNA Rate - IMD Deciles 1 and 2	5%	9.8%	8.9%	9.1%	9.2%				Feb-24	Local	Director of Health Equality and Inclusion
	DNA Rate - IMD Deciles 3 - 10	5%	6.3%	5.7%	6.0%	5.9%				Feb-24	Local	Director of Health Equality and Inclusion

Performance Overview (Responsive Emergency Care)

Domain	Key Performance Indicator	Target	Jul-26	Aug-26	Sep-26	YTD	Assurance	Variation	Trend	Data Quality Assessment	Local or National Target?	Exec Lead
Responsive (Emergency Care)	Emergency Department 4 hour waits LLR	78%	78.1%	78.7%	76.8%	77.9%	?			Mar-23	National	Chief Operating Officer
	Emergency Department 4 hour waits UHL	61%	63.6%	64.1%	62.1%	63.8%	?			Mar-23	National	Chief Operating Officer
	Mean Time to Initial Assessment	15	7	7.7	7.0	7.1	P	L		Nov-24	National	Chief Operating Officer
	% 12 hour trolley waits in Emergency Department (DTA)	10.3%	3.8%	2.4%	2.1%	3.4%	P			Mar-23	National	Chief Operating Officer
	% of 12 hour waits in the Emergency Department	10.3%	10.6%	7.9%	7.3%	9.0%	?			Mar-23	National	Chief Operating Officer
	Average Clinical Handover time for ambulance handovers (Minutes)	30	29	20	18	27	?	L		Data sourced externally	Local	Chief Operating Officer
	Non Elective Average Length of Stay	7.2	7.8	7.4	7.4	7.5	?			Aug-25	Local	Chief Operating Officer
	% of Patients Discharged on Discharge Ready Date	88.1%	87.5%	89.0%	88.7%	88.3%	?			Aug-25	Local	Chief Operating Officer
	Average Delay (Post Discharge Ready Date)	3.8	4.9	5.0	5.1	4.8	?	H		Aug-25	Local	Chief Operating Officer
	Trust Bed Occupancy	92.0%	87.9%	85.9%	86.4%		?			Dec-23	National	Chief Operating Officer
	Long Stay Patients (21+ days) as a % of G&A Bed Occupancy	10%	17.4%	17.0%	15.9%		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	Jul-26	Aug-26	Sep-26	YTD	Assurance	Variation	Trend	Data Quality Assessment	Local or National Target?	Exec Lead
Responsive (Elective Care)	Referral to Treatment Incompletes	105,500	116,558	114,889			F	H		Jun-23	Local	Chief Operating Officer
	Referral to Treatment (RTT) 18 wk performance	62.3%	60.0%	60.3%			F	H		Sep-26	Local	Chief Operating Officer
	Referral to Treatment (RTT) – First Attendance - % waiting less than 18 weeks	68.1%	64.4%	0.0%			Awating more data for assurance and variance			Sep-26	Local	Chief Operating Officer
	Referral to Treatment (RTT) 52+ weeks as a % OF Total Incompletes	0.9%	2.1%	2.1%			F			Sep-26	Local	Chief Operating Officer
	6 Week Diagnostic Test Waiting Times	5%	11.7%	12.9%	10.1%		F	L		Jul-23	National	Chief Operating Officer
	Theatre Utilisation	85.0%	81.2%	81.7%	82.5%	82.2%	F			Dec-23	National	Chief Operating Officer
	Patient Initiated Follow Up	5.5%	6.2%	6.1%	6.2%	5.9%	?	H		Oct-23	Local	Chief Operating Officer
	% Outpatient Did Not Attend rate	4.9%	6.8%	6.2%	6.5%	6.4%	F			Apr-23	Local	Chief Operating Officer
	% Outpatient Non Face to Face	25%	27.6%	26.9%	25.5%	27.1%	?			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	Jul-26	Aug-26	Sep-26	YTD	Assurance	Variation	Trend	Data Quality Assessment	Local or National Target?	Exec Lead
Responsive (Cancer)	28 Day Faster Diagnosis Standard	80%	77.3%	78.9%		73.6%	?			May-24	National	Chief Operating Officer
	Cancer 31 Day Combined	96%	91.2%	87.7%		88.8%	F	H		May-24	National	Chief Operating Officer
	62 Day Backlog Combined	152	353	384	345		F	L		Dec-24	Local	Chief Operating Officer
	Cancer 62 Day Combined	70%	60.4%	57.7%		60.4%	F	H		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	Jul-26	Aug-26	Sep-26	YTD	Assurance	Variation	Trend	Data Quality Assessment	Exec Lead
Finance	Trust level control level performance	-£10.6m	-£1.6m	-£1.0m	£0.0m	-£10m				Jun-22	Chief Financial Officer
	Capital expenditure against plan	£17.7m	£3.6m	£7.1m	£5.9m	£26.8m				Jun-22	Chief Financial Officer
	Cost Improvement (Includes Productivity)	£21.3m	£4.7m	£5.5m	£7m	£30.8m				Dec-23	Chief Financial Officer
	Cashflow	No Target	£2m	-£11.5m	-£4.3m	£13.4m				Jun-22	Chief Financial Officer
	Aged Debt	No Target	£17.3m	£16.2m	£16.7m					Feb-24	Chief Financial Officer
	Invoices paid within 30 days (value)	95%	96%	96%	95%					Feb-24	Chief Financial Officer
	Invoices paid within 30 days (volume)	95%	91%	93%	88%					Feb-24	Chief Financial Officer

Performance Overview (Activity)

Domain	Activity Type	Plan 26/27	Plan in Month (M6)	Activity In Month (M6)	Variance In Month (M6)	Plan YTD	Actual YTD	Variance YTD	YTD Variance to 19/20
Activity	New Outpatients (inc. NFTF)	271,664	23,423	26,169	2,746	136,000	144,450	8,450	9,450
	Follow Up Outpatients (inc. NFTF)	574,448	50,039	47,599	-2,441	286,940	256,739	-30,201	-41,146
	Outpatient Procedures	235,076	20,293	21,014	720	118,109	118,851	742	42,697
	Daycase	133,927	11,813	11,738	-76	66,731	66,052	-678	11,571
	Inpatient	23,088	2,021	1,976	-45	11,676	12,283	607	2,306
	Emergency	117,020	9,534	10,151	618	56,956	59,898	2,942	10,904
	Non Elective	23,094	1,896	2,029	134	11,580	12,173	593	1,215
	Emergency Department (inc. Eye Casualty)	289,426	23,986	25,959	1,973	142,407	151,291	8,884	20,941
	Diagnostic Imaging (inc. Direct Access)	418,297	35,137	33,767	-1,370	207,372	200,925	-6,447	118,254
	Other	12,855,542	1,119,222	1,092,787	-26,435	6,239,159	6,218,088	-21,071	1,781,599
	TOTAL	14,941,583	1,297,364	1,273,188	-24,176	7,276,930	7,240,751	-36,179	1,957,791

**Source Early Cut and Forecasting File*

The DM01 plan for imaging activity for M6 was 1,308 below plan in month (26,385 vs 27,693) and was -4,697 below plan YTD (160,534 vs 165,231)

Performance Overview (Workforce Performance Overview)

Activity Type	WTE	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sep 26
Performance against the workforce plan (Contracted Substantive)	Planned in Month	17,377	17,389	17,392	17,392	17,497	17,497
	Actuals in Month	17,294	17,293	17,284	17,296	17,396	17,386
	Variance (Actual vs Plan)	-83	-96	-108	-96	-45	-111
	% Variance (Actual vs Plan)	-0.47%	-0.55%	-0.62%	-0.55%	-0.26%	-0.64%

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	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	26/27 YTD	Variation	Assurance	Average	26/27 Target	19/20 Baseline
£	Finance: CpWAU	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)	2.96	3.01	3.21	3.01	2.93	3.10	3.20	3.57	3.11	3.25	3.16	3.32	3.27			3.10	-	3.37
	Ops: Avg LoS for emergency admissions	4.36	4.07	4.26	4.21	4.42	4.24	4.27	4.42	4.51	4.70	4.49	4.37	4.46			4.61	-	3.85
	Ops: Bed occupancy	92.8%	87.4%	88.9%	93.4%	91.5%	88.4%	90.3%	89.9%	88.7%	87.9%	85.9%	86.4%	88.2%			88.8%	-	~
	Ops: Do not meet Criteria to Reside (avg pts per day)	476	471	477	511	506	476	469	479	491	488	477	480	481			461	-	~
Theatres	Theatres: Capped Utilisation	80.7%	81.2%	80.9%	80.2%	82.0%	81.4%	81.8%	82.7%	83.4%	81.2%	81.6%	82.7%	82.2%			78.7%	85.0%	68.1%
	Theatres: ACPL	1.98	1.92	1.96	1.90	1.96	1.98	1.92	2.04	2.02	2.02	2.05	1.98	2.01			1.94	-	2.06
	% Theatre Sessions Utilised	93.6%	79.9%	83.9%	88.4%	81.9%	90.9%	81.3%	81.6%	91.2%	89.3%	83.3%	92.3%	86.5%			84.8%	-	
	Theatres: OTDC	8.4%	8.5%	8.7%	9.4%	8.9%	9.7%	8.4%	8.4%	8.4%	9.0%	8.3%	10.3%	8.8%			8.8%	5.0%	8.5%
	Diagnostics (Endoscopy): APPL	8.50	7.80	7.30	7.70	7.90	8.30	8.75	8.70	9.80	11.00	8.70	8.70	9.28			7.82	10.50	~
Outpatients	Outpatients: Clinic Utilisation	97%	99%	97%	98%	98%	98%	99%	97%	95%	94%	95%	95%	95.9%			93.1%	95.0%	90.9%
	Outpatients: DNA Rate	5.9%	6.1%	6.1%	6.1%	6.0%	6.0%	6.0%	6.1%	7.6%	7.1%	6.4%	6.5%	6.6%			6.7%	5.0%	6.6%
	Outpatients: % PIFU	5.2%	5.5%	5.5%	5.7%	5.3%	5.7%	5.7%	5.6%	6.0%	6.3%	6.2%	6.3%	6.0%			5.0%	6.5%	~
	Outpatient: % OPA Follow Up without procedure	52.1%	51.3%	51.1%	50.6%	49.5%	49.5%	49.0%	49.3%	49.1%	48.6%	48.5%	50.1%	49.1%			54.3%	-	~
	A&G: Specialist Advice Utilisation Rate	13.1	12.3	11.6	11.9	12.0	11.7	11.6	12.1	12.3	11.7			11.9			11.4	12.6	~
Diagnostics	Diagnostics: MRI Machine Productivity (Adjusted)	71.4%	68.9%	78.5%	72.2%	69.8%	72.7%	70.9%	77.5%	70.8%	69.2%	72.3%	69.5%	71.7%			71.7%	-	~
	Diagnostics: MRI scans per hour	1.30	1.30	1.30	1.40	1.30	1.30	1.30	1.40	1.30	1.30	1.40	1.30	1.33			1.34	1.80	~
	Diagnostics: MRI DNA rate	3.9%	3.7%	4.1%	2.9%	3.4%	3.6%	3.7%	2.7%	3.4%	3.8%	2.8%	2.3%	3.1%			3.8%	3.0%	~
	Diagnostics (Endoscopy): In session booked utilisation	95.6%	93.4%	86.4%	83.4%	83.3%	90.2%	91.8%	92.5%	94.0%	92.3%	92.9%	90.7%	92.4%			90.1%	95.0%	~
	Diagnostics (Endoscopy): In session actual utilisation	86.0%	85.3%	79.1%	76.6%	76.3%	82.6%	83.9%	83.0%	85.5%	85.0%	85.0%	85.0%	84.6%			81.5%	85.0%	~
	Diagnostics: CT Machine Productivity (Adjusted)	82.0%	72.2%	72.0%	79.1%	90.4%	80.8%	80.6%	87.3%	88.1%	86.5%	90.3%	84.7%	86.3%			76.8%	-	~
	Diagnostics: CT scans per hour	2.30	2.00	2.10	2.30	2.50	2.40	2.20	2.40	2.40	2.40	2.60	2.40	2.40			2.28	3.30	~
	Diagnostics: CT DNA rate	2.9%	2.6%	3.2%	1.8%	2.8%	2.9%	2.5%	2.3%	1.9%	2.0%	2.1%	2.4%	2.2%			3.0%	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	No new data available; March remains the latest position, showing continued year-on-year improvement.
Ops & Clinical Productivity	Elective length of stay remains broadly stable and below the 19/20 baseline. Emergency length of stay has reduced in August and September but remains higher than previous periods Bed occupancy remains stable with expected seasonal variation, while Criteria to Reside remains persistent but in a good position compared to the regional position
Theatres	Capped utilisation remains stable but below the 85% target. Session utilisation remains strong with highest delivery of 92.3% in September, although performance is variable between months. OTDC has deteriorated to 10.3% and remains well above the 5% target, continuing to constrain productivity.
Outpatients	Clinic utilisation remains strong. DNA remains above the 5% target. PIFU remains close to the 6.5% year-end target, with follow-ups without procedure continuing to reduce. A&G Utilisation rate latest published performance (July 26) remains below target.
Diagnostics	Endoscopy APPL remains variable, with achievement only once so far this year. It remains below the 2026/27 target. Endoscopy actual utilisation met target, but booked utilisation remained below target. Both MRI & CT productivity remain constrained and scans per hour remain below target, although DNA performance is strong. Cross sectional booking staff vacancies continue to affect delivery.

Performance Overview (Perinatal)

Key Performance Indicator	Target	Jul-26	Aug-26	Sep-26	YTD	Assurance	Variation	Trend	Data Quality Assessment	Local or National Target?	Exec Lead
Neonatal deaths		2	1	4		Awating more data for assurance and variance			TBC	Local	Chief Nurse and Medical Director
Stillbirths		2	8	3		Awating more data for assurance and variance			TBC	Local	Chief Nurse and Medical Director
No of MNSI Safety Recommendations and Safety Prompts	No Target	1	3	0	5				TBC	Local	Chief Nurse and Medical Director
Maternity Triage - % seen within 15 mins	90%	81.7%	82.6%	82.4%		Awating more data for assurance and variance			TBC	Local	Chief Nurse and Medical Director
Maternity Triage - % seen within 30 mins	95%	96.8%	96.1%	96.6%		Awating more data for assurance and variance			TBC	Local	Chief Nurse and Medical Director
Maternity Triage - Mean time to initial assessment (minutes)	15	9.0	8.9	8.6		Awating more data for assurance and variance			TBC	Local	Chief Nurse and Medical Director
Induction of Labour (Mean Time to Decision to Artifical Rupture of Membranes)		39.0	33.0	28.0		Awating more data for assurance and variance			TBC	No Target	Chief Nurse and Medical Director
Neonatal unit admissions		179	129	118	886				TBC	No Target	Chief Nurse and Medical Director
Total number of Postpartum Hemorrhage (PPH) >1500ml		19	38	19		Awating more data for assurance and variance			TBC	Local	Chief Nurse and Medical Director
Total number of 3rd & 4th Perineal Tears		45	27	45		Awating more data for assurance and variance			TBC	Local	Chief Nurse and Medical Director

Performance Overview (Perinatal Commentary)

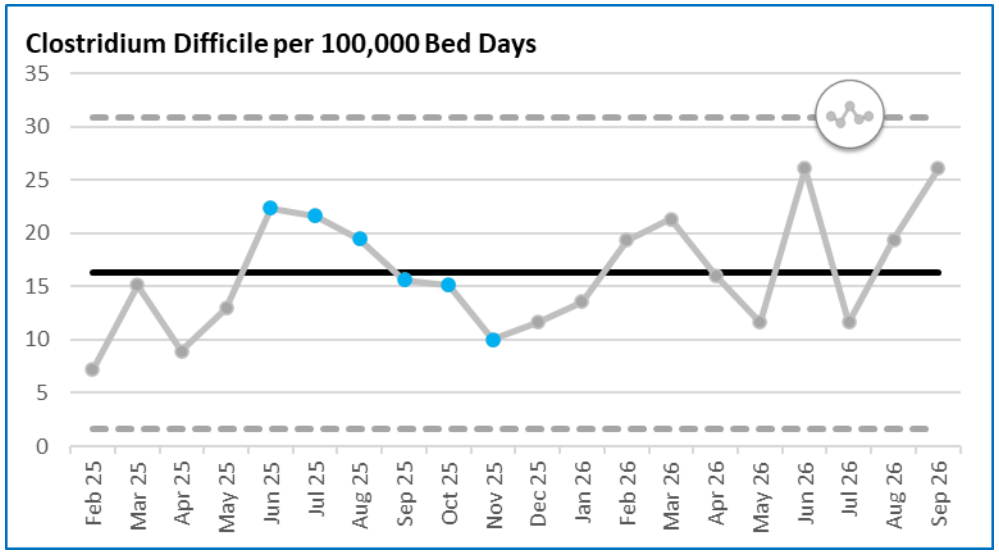
Section	Commentary
Overall Position	Patient flow and several outcomes improved in September. NNU admissions, PPH and stillbirths reduced, while 30-minute triage, assessment time and decision-to-ARM improved. However, neonatal deaths and severe perineal trauma increased. These exceptions require active review rather than interpretation from one month alone.
What is the data telling us?	There were 800 births in September. PPH >1,500ml halved from 38 to 19 cases, NNU admissions reduced from 129 to 118, and stillbirths fell from eight to three. Triage within 30 minutes rose to 96.6%, while 15-minute performance dropped slightly to 82.4%, remaining below the 90% target; mean assessment time improved to 8.6 minutes. Decision-to-ARM improved by a further five hours to 28 hours, although this remains a material patient-flow delay. The principal adverse movements were neonatal deaths, increasing from one to four, and third- and fourth-degree tears, rising from 27 to 45. Supporting surveillance indicates that mortality remains predominantly associated with prematurity and that perineal trauma remains within expected variation, although both require continued monitoring. Data validation following the BadgerNet transition remains ongoing.
Actions, recovery and assurance	**Stillbirths and neonatal deaths:** Multidisciplinary and PMRT review of the September losses continues through Perinatal Governance. Prematurity remains the predominant mortality theme; reviews have not identified widespread or systemic care-quality concerns, and no Q2 MOSS alert was issued. The Q2 Perinatal Safety Report and Perinatal Mortality report provides the next formal assurance checkpoint. **PPH:** Although the monthly number of PPH cases reduced, eight haemorrhage-related returns to theatre were recorded in September. The PPH Working Party will complete its thematic review, including compliance with risk assessment, the haemorrhage bundle, escalation, Blood Bank communication, TEG use and debriefing. Monthly evidence of fewer avoidable returns to theatre, not the lower monthly PPH count alone, will demonstrate recovery. **Triage and induction:** Daily and weekly oversight should continue across staffing, escalation, demand and 15/30-minute performance. The immediate priorities are to recover the 15-minute standard, sustain the improved 30-minute and assessment-time positions, and reduce decision-to-ARM through capacity and escalation actions. The end-October checkpoint should assess both 15-minute triage and decision-to-ARM, with formal reassessment in February 2027.

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%
% 12 hour trolley waits in Emergency Department (DTA)												
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%	80.9%	82.2%	78.4%	79.8%	82.0%	84.8%	83.7%	82.9%	83.9%	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 Clostridium Difficile per 100,000 Bed Days



Current Performance		
Sep 26	YTD	Target
17	77	131

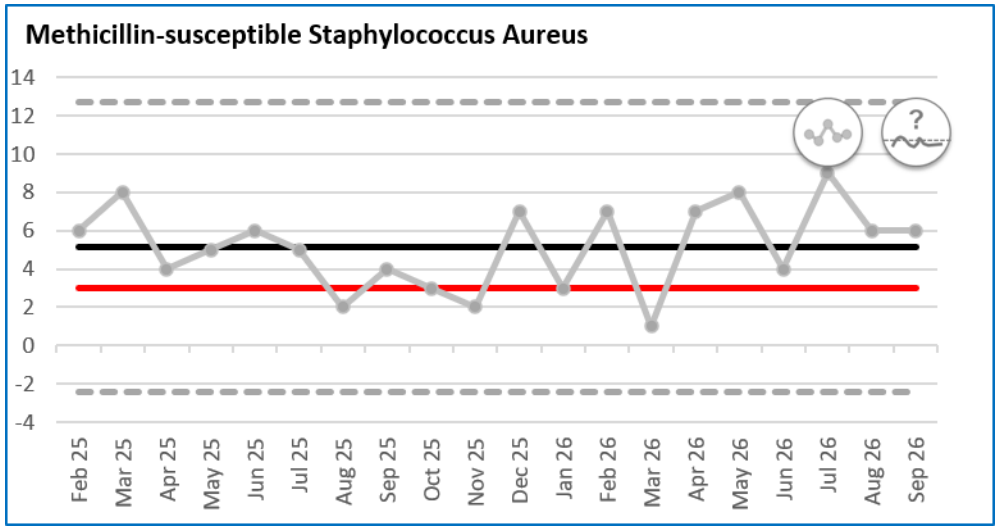
Number of Cases		
Sep 26	YTD	Target
17	9.22	131

National Position & Overview

	Sep 2026	Total	
CDIFF NHSE Threshold 26/27	11		
* Actual Infections (HOHA) 26/27	13		
* Actual Infections (COHA) 26/27	4		
* **Actual Infections Total (HOHA & COHA)** 26/27	17		
UHL 100,000 Bed Days (HOHA) 26/27	26.05	**9.22**	*YTD UKHSA Report
National Average	20.13		
National Highest	138.54		
National Lowest	0		

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

Safe – Methicillin-susceptible Staphylococcus Aureus

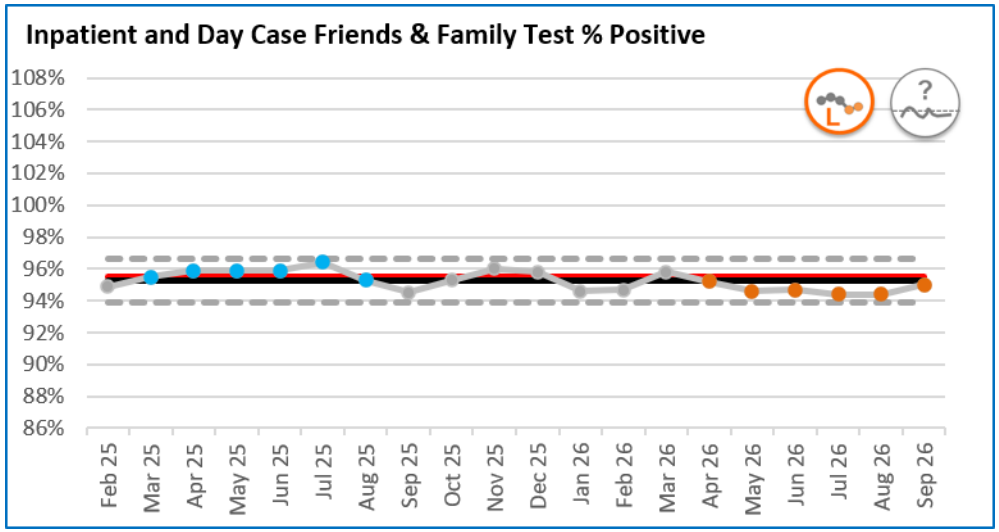


Current Performance		
Sep 26	YTD	Target
7	41	40

National Position & Overview			
	Sep 26	Total	
MSSA NHSE Threshold 26/27	3		
* Actual Infections (HOHA) 26/27	6		
* Actual Infections (COHA) 26/27	1		
*** Actual Infections Total (HOHA & COHA)** 26/27	7		
UHL 100,000 Bed Days (HOHA) 26/27	12.02	5.93	*YTD UKHSA Report
National Average	10.94		
National Highest	43.39		
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.	• Vascular Access Policy and Committee review required to support the delivery of the required actions identified in previous reports • UHL Vascular Access report completed in support of this. • The HON(DDIPAC) /DHON for Infection Prevention to attend each CMG Professional Nurse Forum to discuss the MRSA policy and its application within care environments • Discussion with the Medical Director how this can best be communicated to Medical colleagues will be undertaken by the DDIPAC for IP	Expected Impact: • Strengthened surveillance and assurance of vascular access practice. • Strengthened application of the MRSA policy

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



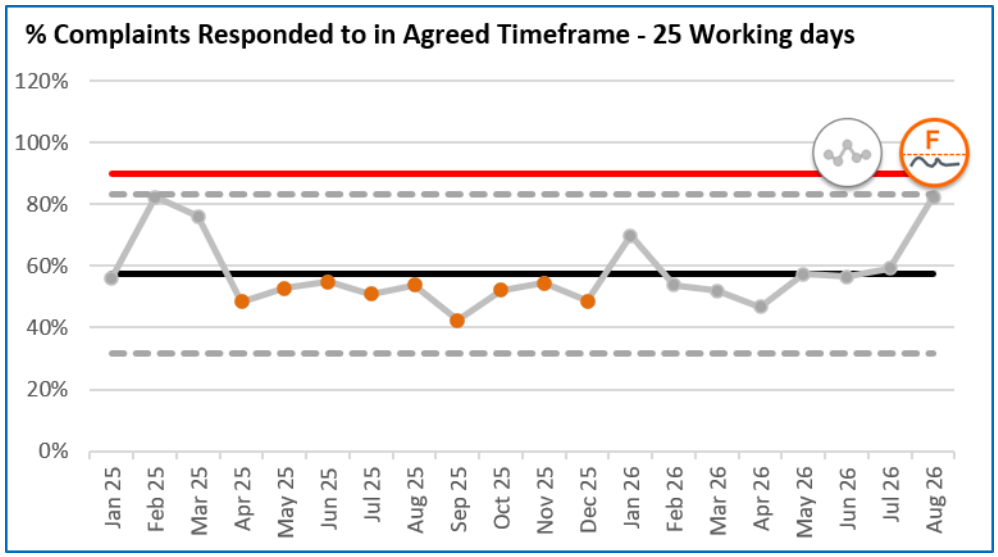
Current Performance		
Sep 26	YTD	Target
95.0%	94.7%	95.5%

National Position & Overview

National Inpatient % positive result in August 2026 (most recent available) was 94.2%. Trust Peer Group result for August 2026 was 94.4%.

Root Cause	Actions	Impact/Timescale
September feedback continued to highlight the impact of operational pressures on patient experience, particularly prolonged waits, communication and delivery of fundamental care. Delays were experienced most negatively where patients were not kept informed, reassured or supported with their basic needs.	September feedback will be shared with relevant CMGs and service leads, with targeted review of areas with recurring concerns. Actions will focus on communication during delays, timely fundamental care, medication and handover processes, and management of procedure delays. Safety, dignity, cleanliness and staff attitude concerns will be addressed through local governance and improvement processes.	Immediate concerns will be escalated during October, with initial actions completed within four weeks and impact reviewed at 8–12 weeks. Monthly monitoring against the 95.5% positive target will continue, with further escalation where improvement is not demonstrated.

Caring – % Complaints Responded to in Agreed Timeframes



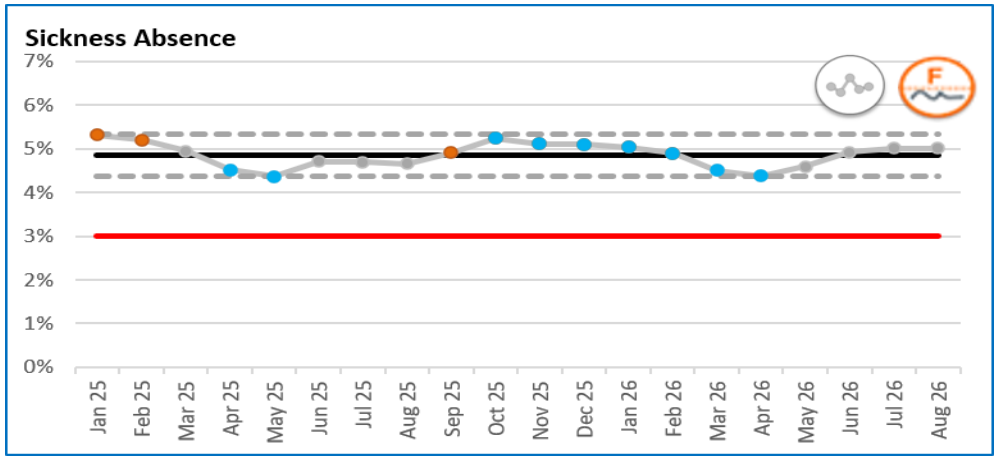
25 Working Days		
Aug 26	YTD	Target
82.4%	60.5%	90%

60 Working Days		
Jul 26	YTD	Target
93.5%	67.3%	90%

National Position & Overview

Root Cause	Actions	Impact/Timescale
• Quarter 2 saw a significant improvement in performance against the 25-working-day complaint response standard, reflecting the continued focus on timely resolution of concerns and strengthening the patient experience. • 94% complaints responded to within 60 working day standard in July 26	• Maintain focused oversight of overdue and approaching-due complaints • Escalate overdue complaint responses early to CMG triumvirates for support • Review delayed cases to identify recurring barriers • Continue targeted support for services with the largest outstanding caseloads	Expected impact: improved visibility of risk, earlier escalation and more consistent delivery against agreed response times Progress will be demonstrated through sustained monthly performance and improvement in the year-to-date position

Well Led – Sickness Absence



Current Performance		
Aug 26	YTD	Target
5.0%	4.8%	3%

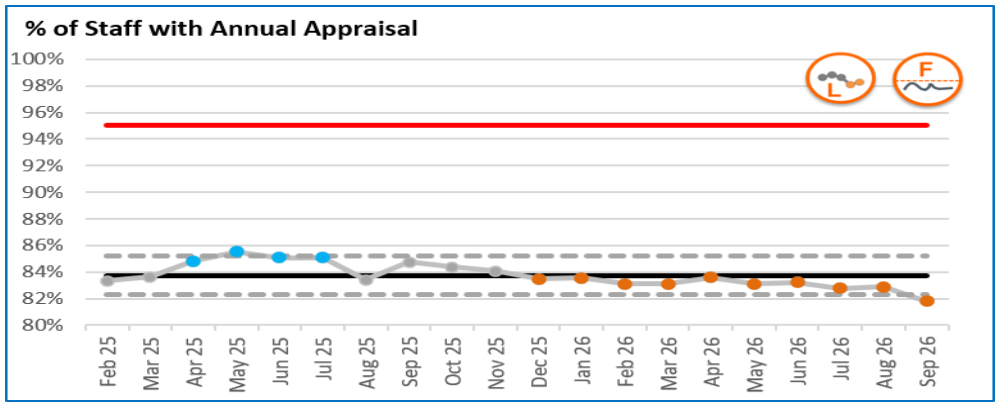
National Position & Overview

Sickness absence has remained stable at 5.01% in August (July 5.02%).

Root Cause	Actions	Impact/Timescale

• Clinical CMG's have seen a 0.07% reduction and Corporate Directorates a 0.23% increase.
• Over the last 12 months, the highest levels of absence are in E&F (6.31%), W&C (5.69%) and ITAPS (5.06%).
• The areas achieving the 3% target are within the Corporate Directorates.
• The top 3 reasons for sickness absence are anxiety/stress/depression (23.34%), Other known reasons (12.37%) and other musculoskeletal problems (11.12%).
	• 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 are three key 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.
	• There is particular focus on episodic absences to identify key areas for targeted support and interventions.
	• For longstanding and complex cases, case conferences with OH occur.
	• The flu vaccination campaign launch on 1 October 2026. The plans include an increased number of Peer Vaccinators along with Super Flu Days. As at 19 October the uptake is 22.8% against a target of 52% this year.
	• CMGs are taking local targeted actions to support the wellbeing of colleagues and management of 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.
		• 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



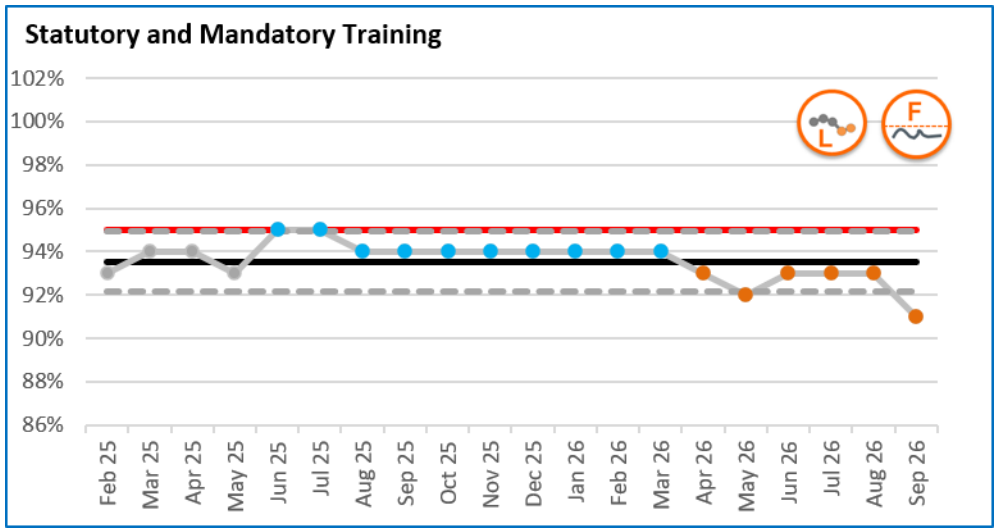
Current Performance		
Sep 26	YTD	Target
81.8%	-	95%

National Position & Overview

Peer data not available.
The September position sees a decrease in compliance of 1.1% on the previous month, Trust wide. Renewed focus and action is required by all Clinical and Corporate Directorates.

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. Areas report work pressures as a contributing factor also. ••In month, the appraisal average for UHL has dropped due to a decline in all areas, bar a few minimal gains. Only ITAPS remains compliant Trustwide, with Corporate areas drifting further.	•It is acknowledged in previous exception reports that we would be unlikely to reach full compliance of 95% . •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 has been launched effective from the period of July. This aims to support greater focus on quality conversations including career aspirations. •ESR will be trialled to be the main data platform for appraisals and is being used in some areas. see 'root cause'. •There now needs to be a greater focus by both Clinical and Corporate areas reviewing their appraisal performance to be clear on the drivers for the low compliance and any actions to take.	•In September 2025 Appraisal performance was at 84.7%, an improvement on the previous month of August 2025. •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



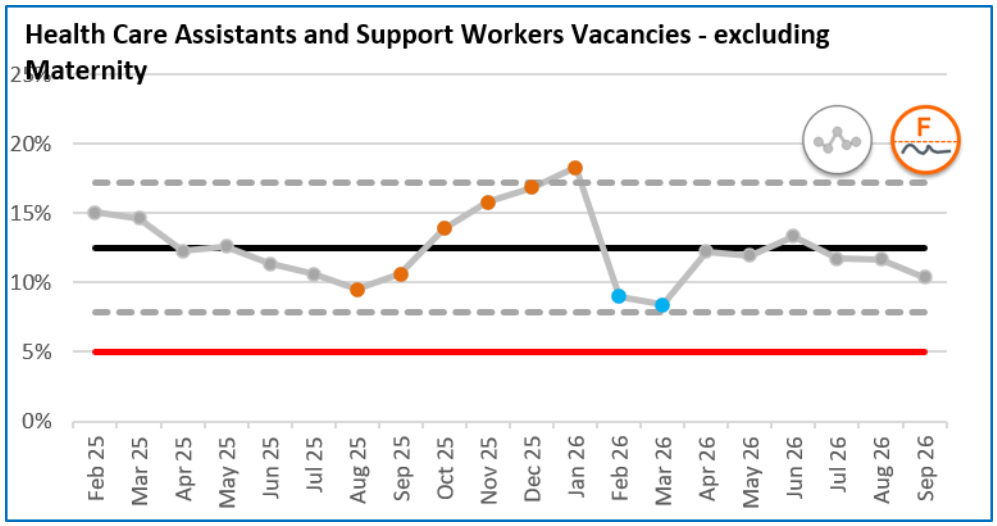
Current Performance		
Sep 26	YTD	Target
91%	-	95%

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. The drop in compliance is due to an update to the Conflict package that occurred at the start of September 2026, the compliance dropping to 40% from 92%. Compliance as of 14/10/2026 is 83%.	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		
Sep 26	YTD	Target
10.4%	-	5%

National Position & Overview

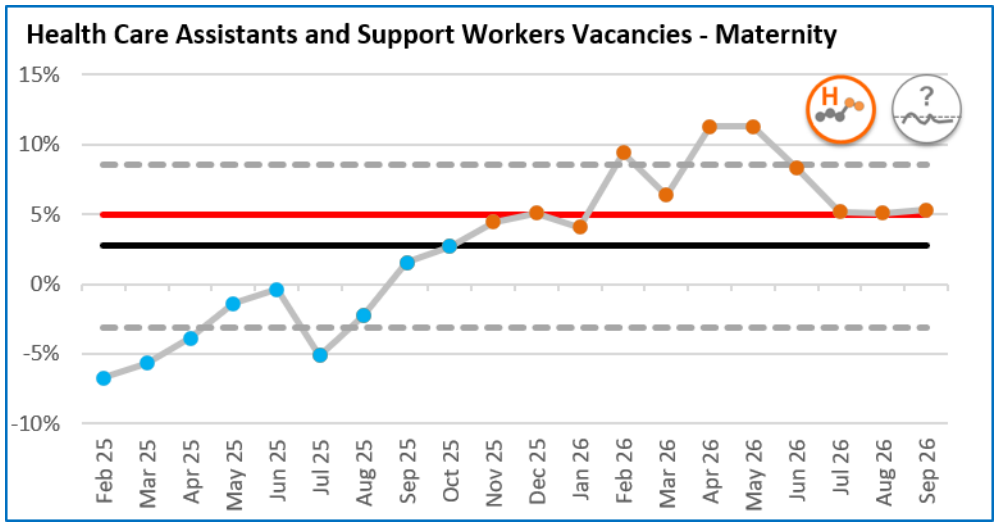
The role of a HCSW operates within the low-skill, high-supply labour market as it is an entry level role in healthcare with minimum educational requirements, where recruitment can generally be less challenging; high workforce mobility can result in increased turnover and ongoing retention challenges.

Ongoing evolvement/ upcoming visa rules, specifically the removal of visa eligibility for Healthcare Support Worker roles, 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 alleviate 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.
• A plan has been developed by Senior HR colleagues regarding the recruitment of applicants requiring sponsorship.
	• Going forward, bi-monthly recruitment drives for both Band 2 HCSW development pathway.
	• We are working with local colleges and provide industry placements for T-Level students, this includes: Leicester College, Gateway College, Loughborough College amongst others.
	• Future trial of Band 3 HCSW recruitment event to assess domestic pool.
		• Previous month performance: 11.7% (↓ 1.3%)
		• The following is the outcome from the Sept-26 recruitment drive:
		  • B3 HCSW – 39/50 successful, however, the true figure appears to be closer to 15/50 (due to visa status confirmation).
		  • B2 HCSW – 37/ 50 successful.
		• Due to post availability, stemming from the last recruitment drive, there was a Oct-26 event for another 50 B2 HCSW posts:
		  • B2 HCSW – 36/ 50 successful.
		• The B2 HCSW successful figures is due to candidates having the right permissions to work in the UK.

Well Led – HCA and Support Workers Vacancies –Maternity



Current Performance		
Sep 26	YTD	Target
5.3%	-	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.

Root Cause	Actions	Impact/Timescale
Staff departures increased in September, including several colleagues leaving to commence university studies. This is continuing impacting clinical areas whilst awaiting Short-term sickness continues to place significant pressure on available staffing capacity	Approval granted for external recruitment has through the Executive VCP. The anticipated Birthrate Plus report will inform the required staffing model; the full report is expected imminently Short-term sickness and workforce deployment continue to be actively managed.	The vacancy rate remains approximately 5% and is expected to rise following anticipated departures. 4.75 WTE – in short listing High workforce mobility continues to drive turnover and create ongoing retention challenges.

Well Led – Non Clinical Agency- No. of Staff

Awaiting more data for SPC chart

Current Performance		
Sept 26	YTD	Target
1	6	0

National Position & Overview

The service expects to require the remaining agency worker for the foreseeable future as they are supporting specialist projects.

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

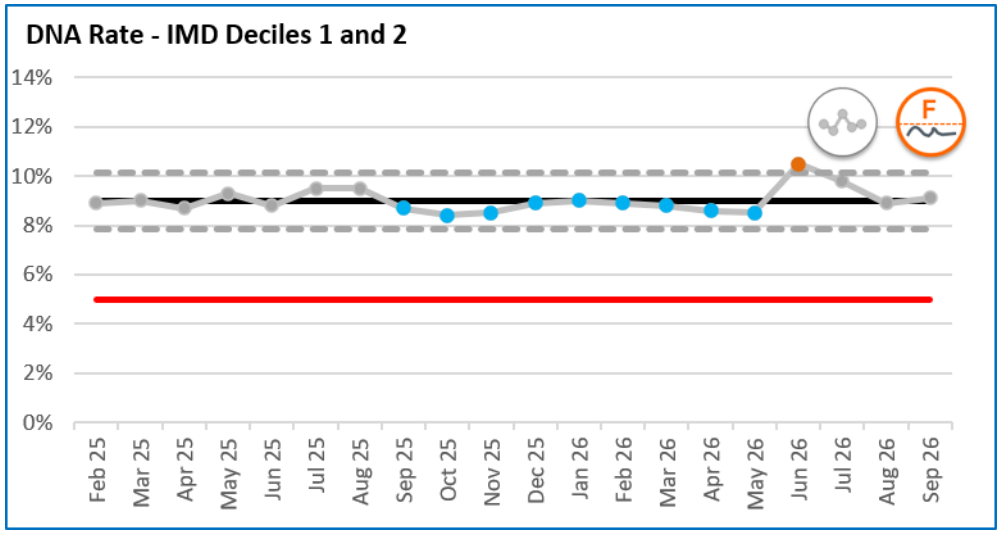
Current Performance		
Sept 26	YTD	Target
16	137	0

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.	All new medical agency appointments now follow the West Midlands medical rate card, agreed through an NHS England workstream. One of the three long-standing assignments have ended and the others 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 decreased by two in Sept 2026 and more agency workers are expected to end soon.

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



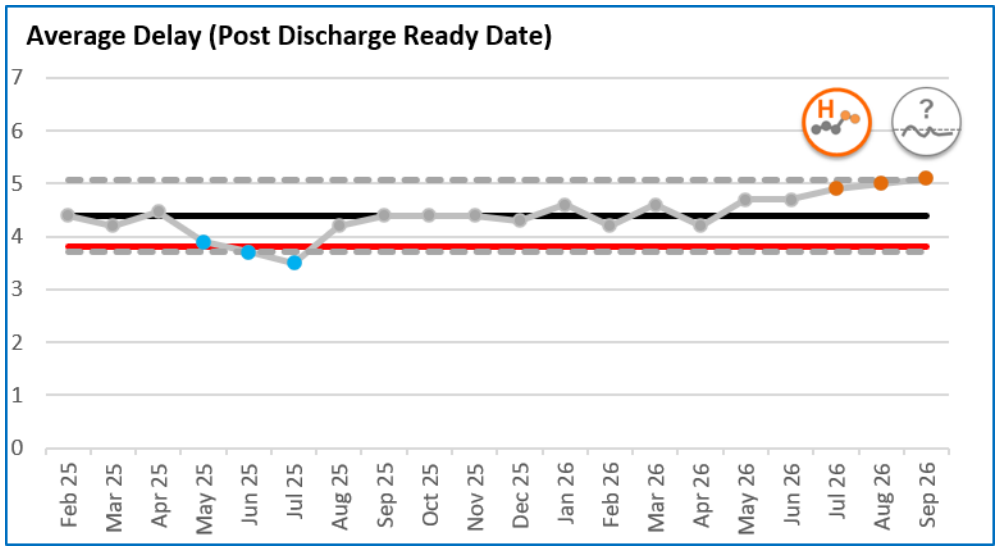
DNA Rate – IMD Deciles 1-2			DNA Rate – IMD Deciles 3-10		
Sep 26	YTD	Target	Sep 26	YTD	Target
9.1%	9.2%	5%	6.0%	5.9%	5%

National Position & Overview

here 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 **9.1%** for S**eptember 26.** Disaggregated by contact these rates are: • **IMD1** • Patients contacted DNA rate **5.28%** • Patients not contacted DNA rate **14.47%** • **IMD2:** • Patients contacted DNA rate **5.55%** • Patients not contacted DNA rate **13.94%** • **Inclusion Healthcare:** • DNA rate for those contacted **36.36%** • DNA rate for those not contacted 1**4.29%** • **Paediatric Outpatients** • WNB rate contacted **7.8%** • WNB rate not contacted **13.28%**

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



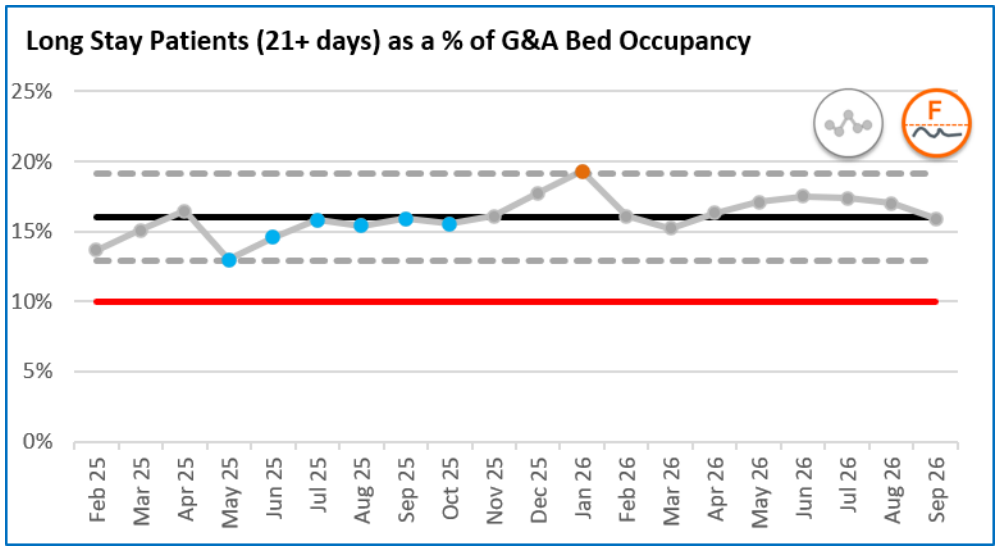
Current Performance		
Sep 26	YTD	Target
5.1	4.8	3.8

National Position & Overview

In July, UHL ranked 40 out of 128 Acute Trusts that submitted acceptable data. The National average was 6.4. 27 out of the 128 Acute Trusts achieved the target. UHL ranked 5 out of the 18 UHL Peer Trusts. The best value within our peer group was 2.4 and the worst value was 9.8.

Root Cause	Actions	Impact/Timescale
Poor outflow from the inpatient wards through: •**Process delays** internally relating to ward processes, diagnostics, discharge delays (TTO's etc.) and externally (EMED ambulance, equipment) **279 complex patients stayed an additional night in hospital in September . 45 less patients than in August** •**LLR system discharge hub interface and capacity delays** continue to impact the ability to provide timely P1-3 discharge plans . **147 Patients waiting at the end of September 2026 (91 August 152 July, 155 June, 149 May)** •**Deterioration in LOS from MOFD to discharge** for: Pathway 1: 0.41 day deterioration Pathway 2: 0.35 day deterioration Pathway 3: 6.49 day deterioration from August 2026	**Continue weekly escalation meetings** with Adult Social Care/ ICB 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. •**Share learning from LEAF and wider discharge QI projects** to inform approach to practice. •**Plan and Prepare:** for future allocated discharges, including the rollout of CLD and SHOP, and increase early referrals to the hub, which are currently at 33%. •Commence NHS Discharge Sprint work stream	**Aim to:** •Reduce number of MOFD (Discharge Ready) patients waiting for discharge in UHL beds. •Reduce time to discharge from MOFD identification Improving Patient Discharge Project plan in place and reviewed within the discharge improvement meeting with CMG's

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



Current Performance		
Sep 26	YTD	Target
15.9%	-	10%

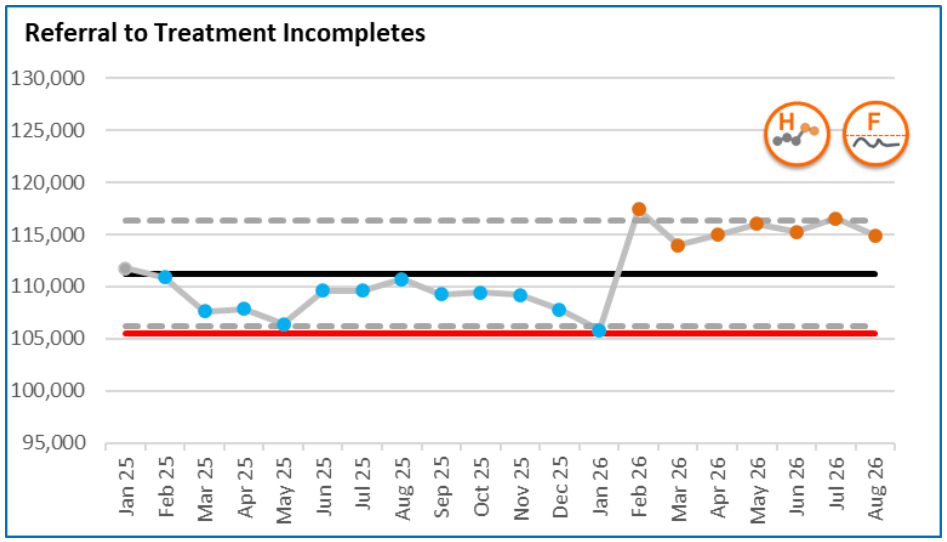
National Position & Overview

68 (266) Patients (26%) 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 (28 patients).

•94 Patients (35%) 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 September there were circa 94 patients with a length of stay over 21 days awaiting a confirmed discharge outcome from LLR.	**Throughout October 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. Continue to escalate delays to CHC/DST/FT Process **Work with CMG's to:** •Plan and prepare patients ahead of discharge: promote the early referral of patients to the discharge hub prior to being MOFD. **(33% Sept,32% August)** and readiness of 'Complex Future discharges' •Maintain Weekly CMG reviews of > 21 day patients and top 100 day patients •Improve occupancy of Virtual Wards and use of Criteria Led Discharge, SHOP model •Continue CMG Length of stay reduction program •Continue NHS Discharge Sprint work stream	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		
Aug 26	Aug Plan	Target
114,889	108,930	96,243

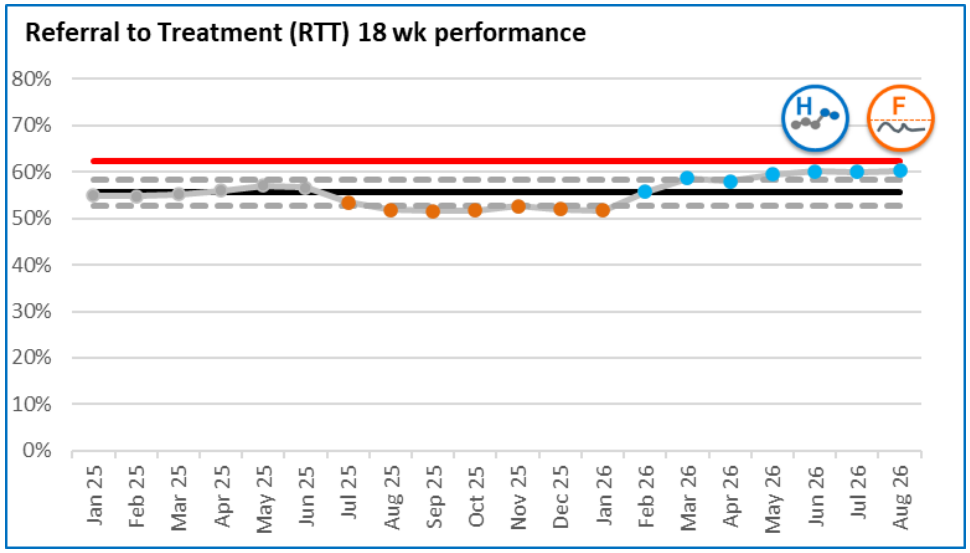
National Position & Overview

At the end of August, UHL ranked 13 out of 17 trusts in its peer group with RTT 18 Week Performance at 60.2%. The best value within our peer group was 72.6%, the worst value was 55.4% and the median value was 63.5%. (Source: NHSE published monthly report)

September forecast is c. 114,000 – adverse to plan (106,630).

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 and performance improvement. Focused actions with the CMGs regarding meeting activity plans in the EMPCC, CDC and Endoscopy unit. • Continued learning and fix finding in new PAS • Weekly oversight meetings in place with CMGs focused on long waiters (65+) woth fortnightly for 52+, 18wk performance, including wait to 1st OPA and Clinical triage and A&G performance. • All CMGs share progress and actions on 18-week trajectories during their monthly Performance Management Reviews.	• 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 to March 2027.

Responsive (Elective Care) – RTT 18 Week Performance



18 Week Performance			First Attendance - 18 Week Performance		
Aug 26	Aug Plan	Target	Aug 26	Aug Plan	Target
60.3%	61.0%	69.3%	64.2%	67.7%	75.1%

National Position & Overview

At the end of August, UHL ranked 14 out of 17 trusts in its peer group with a total waiting list size of 114,859 patients. The best value within our peer group was 66,055, the worst value was 167,070 and the median value was 87,366.5. (Source: NHSE published monthly report)

RTT: September forecast is 61.5% – adverse to plan (62.5%).
Wait to 1st: September forecast is 66.2% – adverse to plan (68.8%).

Root Cause

- 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 (35 theatre sessions lost this year due to maintenance).
- 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.

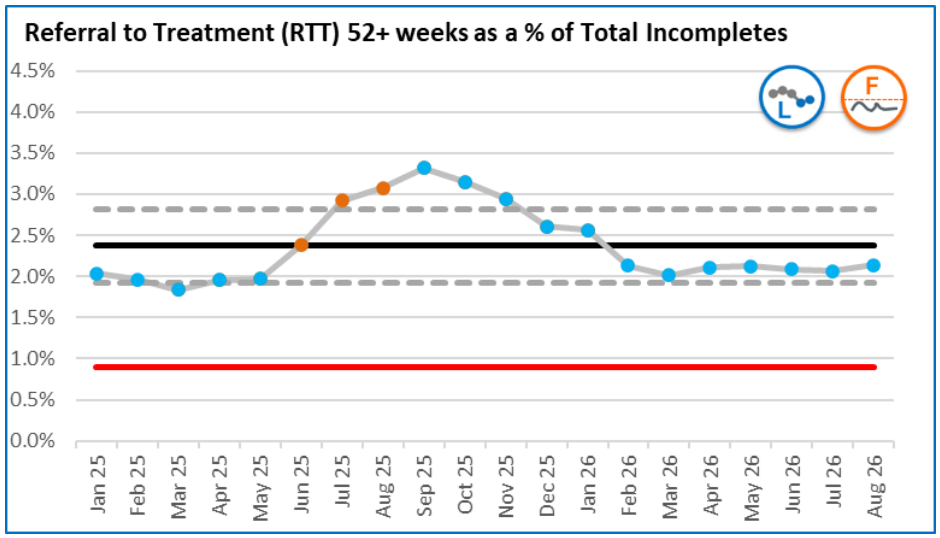
Actions

- Theatre productivity and outpatient transformation workstreams to improve productivity and increase capacity.
- Sharing session fill-rate for theatres with CMGs and active challenge on backfilling clinical activity
- Improvement plan to reduce total WL with 4 workstreams: Validation, Appointment Outcomes, Triage and Increased activity
- Planned additional data quality validation each month 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.
- Weekly oversight meetings in place with CMGs focused on long waiters (65+) woth fortnightly for 52+, 18wk performance, including wait to 1st OPA and Clinical triage and A&G performance.
- 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.

Impact/Timescale

- Increased ACPL on theatre lists- improving activity through existing resource- ongoing.
- Outpatient clinic template standardisation- to increase the number of new and follow-up appointments within clinic templates- ongoing.
- Increased number of theatre sessions delivered. Improving activity through existing resource.
- 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 to March 2027

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



Current Performance		
Aug 26	Aug Plan	Target
2.1%	1.5%	0.9%

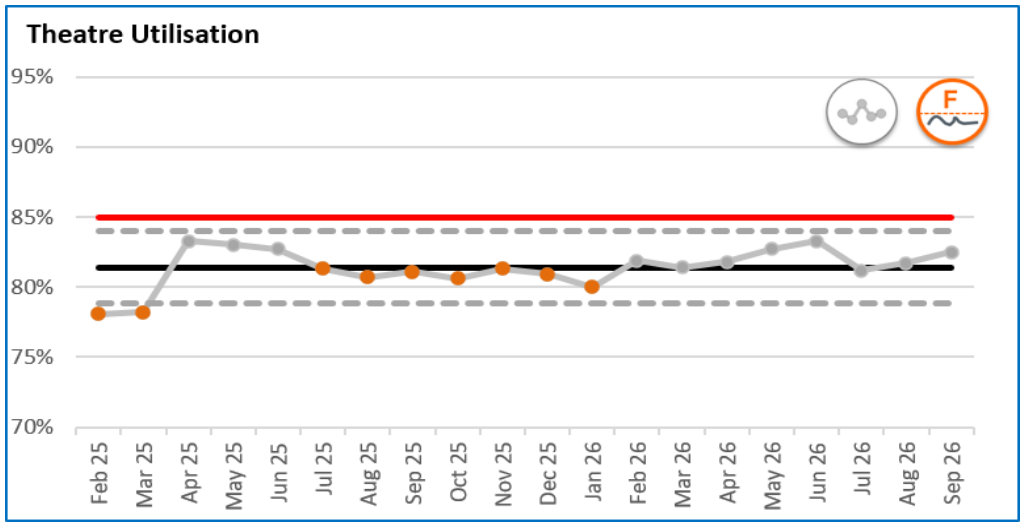
National Position & Overview

At the end of August UHL ranked 10 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 4.0% and the median value was 1.7%. (Source: NHSE published monthly report)

September forecast is c. 2.2% – adverse to plan (1.4%).

Root Cause	Actions	Impact/Timescale
• 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.	• 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. • Increased use of mutual aid and independent sector support, particularly within Orthopedics • Fortnightly oversight meetings in place with CMGs focused on long waiters (52+), 18wk performance, including wait to 1st OPA and Clinical triage and A&G performance. • CMG HoOps held accountable for 65 ww patient pathways in weekly meeting with COO & CEO until zero achieved and sustained. • Support CMGs/specialties to deliver as much activity as possible, utilising ERF funding where needed. • GIRFT review in Orthopaedics and corresponding action plan to return 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 and General Surgery long waiters.	• Zero 65+ week waiters not achieved. August 62 with September forecast 52. The vast majority of the continued capacity issue is in Orthopaedic surgery, small numbers continue in a few other specialties which are complex cases or patient initiated delays in pathways. • Of the 52 forecast end September, 45 are Orthopaedics. The remainder are 4 in Plastics, 1 Cardiology, 1 Gastroenterology and 1 General Surgery. • Orthopaedics route to zero is set for December. • Additional activity with delivery favourable to plan.

Responsive (Elective Care) – Theatre Utilisation



Current Performance		
Sep 26	YTD	Target
82.7%	82.2%	85%

National Position & Overview

Theatre utilisation improved to 82.7% in September, up from 81.6% in August and above the YTD position of 82.2%.
UHL remains ranked Green (Quartile 4) in Model Hospital for August (Sep data not yet available) achieving 83.7% utilisation and outperforming both peers (79.6%) and the national median (80.7%). **EMPCC** and **GGH** continue to perform strongly, delivering 89.5% and 88.2% utilisation respectively in September, both above the 85% target. **LGH** delivered 84.8%, just below target.

Root Cause

LRI utilisation remains below the 85% target at 75.7%, with adult utilisation at 78.7% and paediatrics notably lower at 67.7%. Performance continues to be impacted by high OTDC (12.5%) and late starts (37%). OTDC increased in September by 2%, with notable pressures from non-clinical cancellations, including 32 paediatric bed-related cancellations, alongside patient-related cancellations.
UHLiC: Utilisation remains below the 85% target at 81.8%, broadly in line with 81.4% last month, with continued variation between specialties (73%–92%). Of the 33 OTDCs, 7 (21%) were due to Urgent Theatre Maintenance. Utilisation continues to be impacted by the single-site, single-team and surgeon model, with planned downtime required during the day to accommodate staff breaks.

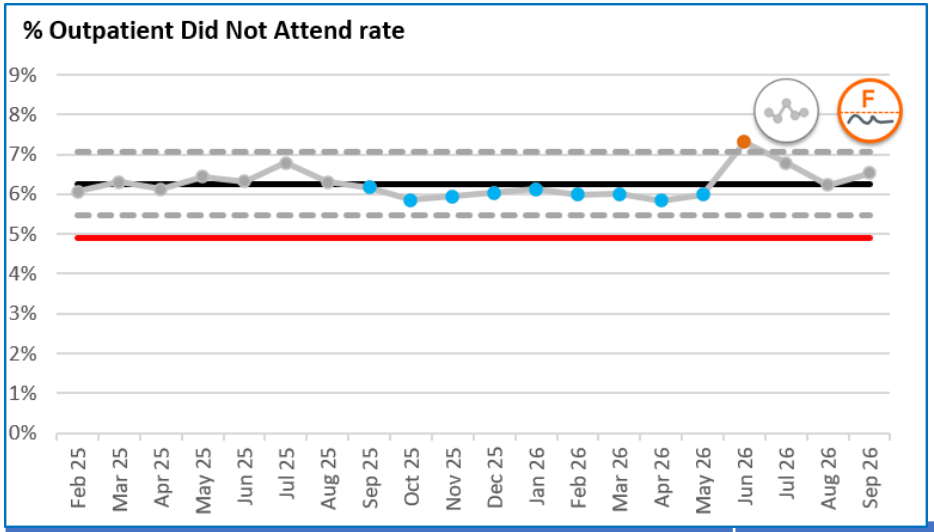
Actions

- Paediatric Improvement Programme, meeting fortnightly, with targeted review of late starts and improving utilisation.
- October TPAB focus on late starts, with targeted review of Golden Patient, First and Bedded Patient and list-order processes to improve first-case starts times.
- Progress automated theatre reminders to reduce avoidable patient-related cancellations, particularly DNAs.
- OTDC escalation policy to October TPAB for sign-off, strengthening escalation, ownership and review of avoidable cancellations
- Link in with GIRFT to understand how other community surgical sites manage staff breaks and assess the cost-benefit of additional workforce cover for breaks against the potential to deliver additional case(s) per list.

Impact/Timescale

- Paediatrics: Fortnightly specialty review, targeting improvement from the current 67.7% utilisation and addressing key late start drivers: Q3 26/27
- Reduce the current 37% late-start position, creating capacity for additional activity and reducing OTDC due to insufficient session time.
- Automated reminders expected to reduce avoidable patient-related OTDC, particularly DNAs. Delivery remains at risk due to provider dependency and has been escalated to the UHL Digital group.
- Reduce avoidable OTDC through earlier escalation and clearer accountability, supporting improved theatre utilisation.
- Identify the most cost-effective operating model. Recognising a 30-minute planned break could increase UHLiC General Surgery utilisation from 77.4% to c.82.6%, alongside assessing whether additional workforce offers sufficient activity benefit to justify the cost.

Responsive (Elective Care) – Outpatient DNA Rate

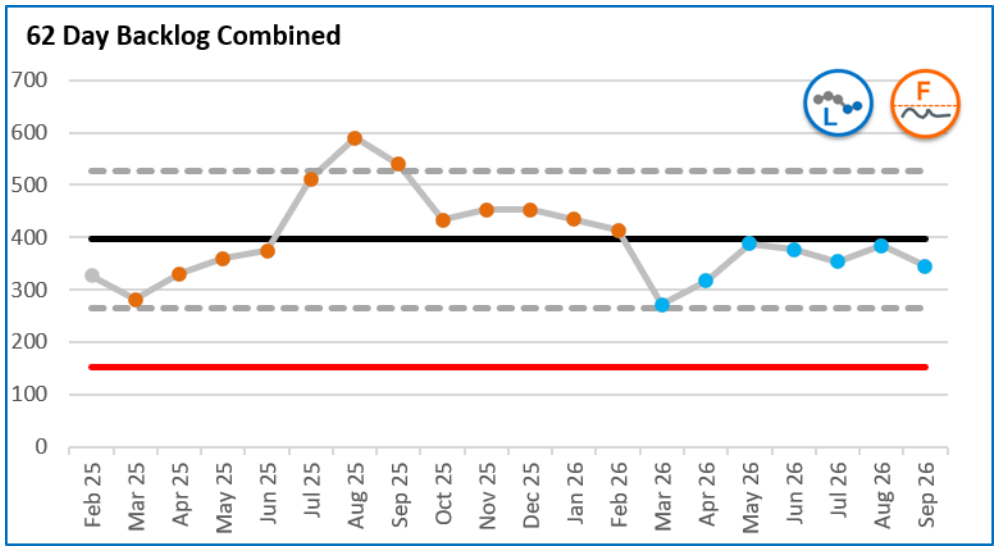


Current Performance		
Sep 26	YTD	Target
6.5%	6.4%	4.9%

National Position & Overview

Root Cause	Actions	Impact/Timescale
1. The launch of Nervecentre PAS has meant continuous issues with the data feed going to Accurx so patients aren't always receiving automated reminders or appearing in clinic lists 2. Late cancellations/rebooks often mean patients do not receive their appointment letters on time so unaware of appointment 3. Due to lack of admin staff, patients unable to get through to department to let them know they're unable to attend, or admin are not actioning cancel/rebook requests in Accurx. 4. Services are not always maintaining their appointment reminder house keeping in Accurx 5. For telephone appointments, clinicians not giving the patient enough time to answer or only calling the patient once 6. The NHS App currently allows patients to request to cancel/rebook upto midnight the day before their appointment.	1. Complete Neurons ticket when made aware of any issues with clinic lists in Accurx or feed going from UHL to Accurx. Remind services of the need to check the patients details are correct and up to date at every contact 2. Services to text patients appointment details if changes are made to appointments 3. Booking Centre are making additional calls to 'Health Inequalities' cohort now including Paediatrics. 4. Accurx automated clinic appointment reminders have gone live in the majority of services including Imaging and Therapies. Clinic lists are also available in Accurx for most services 5. Text fragments has increased to allow services to add bespoke messages to automated appointment reminders 6. Still awaiting a decision from IT on whether to increase cancellation window in NHS App as there's a cost	• All actions, plus many others, are happening imminently to help reduce the number of DNAs. • An improvement in the DNA rate should continue over the next 3 months providing the actions are carried out.

Responsive Cancer – Cancer 62 Day Backlog



Current Performance		
Sep 26	YTD	Target
345	-	152

National Position & Overview

National and Midlands data is no longer available.

UHL end of September position:
>62 day 155 behind plan (improvement of 17).
>104 day 42 behind plan (improvement of 15).
Backlog remains a concern, with Urology the only service favourable to recovery plans. All other services are working on plans to return to trajectory in Q3.

Root Cause	Actions	Impact/Timescale
• Breast, Colorectal and Urology represent 59% in total, with Breast alone holding 22% of backlog (improvement from last month of 5%) . • Constraints include capacity, specifically diagnostic (radiology & pathology), oncology and workforce. • Challenges in staffing additional pre-op & theatre lists above baseline are affecting the ability to recover at pace. • There has been an increase in diagnostic tests required per patient, patient complexity and patient choice which have impacted pathway length. • Bottlenecks in capacity within Oncology OPD capacity 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 requested 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 • Backlog clearance MDT focus – Oct	• Colorectal pre-MDT processes successfully implemented, EMCA MDT optimisation programme initiated in Sept with Breast completed with LOGI next. Focus remains on CTC/ Endoscopy flow, MDT roles and faster results-to-action. Impact due Q3. • Urology template bx histopath outsourced; with some improvements visible. • Oncology improvement actions in scope with triangulation to new data - Oct. • Working with CMGs for backlog recovery plans with focus in Breast, Colorectal & Lung – limitations in pre-op and Theatre workforce, teams are exploring options to increase above baseline to support inclusive of insourcing – expected in Q3.

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

Executive Summary

- The month 6 position for the Trust is a deficit of £10m which is £1m better than plan. This position includes £1.6m of costs related to industrial action incurred during M1.

- The CIP target in Q2 was £20.2m. For Q3, the target increases by 39% to £28m 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 Q3. 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 6 is £13.4m which is a reduction of £4.3m from Month 6. 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 M6

	I&E YTD		
	Plan	Actual	Variance to Plan
	£'000	£'000	£'000
NHS Patient-Rel Income	820,558	840,970	20,412
Other Operating Income	90,169	90,606	437
Total Income	**910,727**	**931,576**	**20,849**
Pay	(585,444)	(589,926)	(4,482)
Non Pay	(290,937)	(307,154)	(16,217)
Total Costs	**(876,381)**	**(897,080)**	**(20,699)**
EBITDA	**34,346**	**34,496**	**150**
Non Operating Costs	(45,058)	(44,844)	214
Retained Surplus/(Deficit)	**(10,712)**	**(10,348)**	**364**
Donated Assets	(311)	367	678
Control Total Surplus/(Deficit)	**(11,023)**	**(9,981)**	**1,042**

Comments – YTD Variance to Plan

Total Income: £20.8mF

- PCI income (£19.2mF) includes Elective Care £6.7mF and UEC £9.3mF (driven by NEL activity greater than one day over-performing) and various contract variations. Endoscopy activity remains a specific challenge.
- Other income (£0.4mF) includes Donated assets income (offset by donated assets adjustment further down the I&E)
- EDD (£1.2mF) matched by expenditure

Pay: £4.5mA:

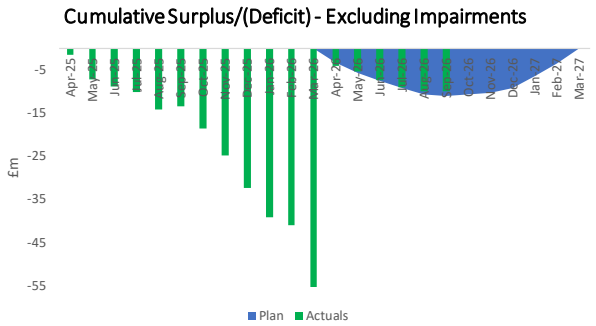
- Medical costs include £1.2m of additional costs due to industrial action, balance of variance driven by premium pay, partially linked to PCI overperformance.
- Nursing and Other Clinical and Non Clinical underspends are driven by vacancies

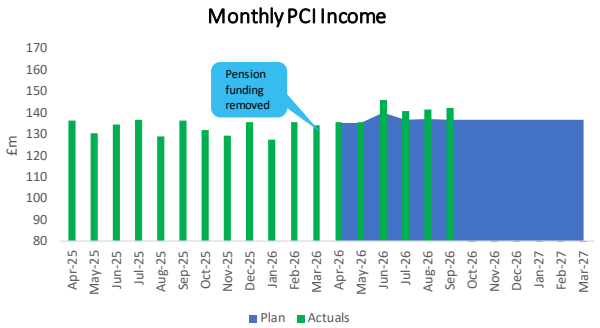
Bank (£36m) and Agency (£3.2m) spend YTD amounts to £39.2m which is 6.6% of total pay. The NHSE YTD cap for bank pay is £26m.

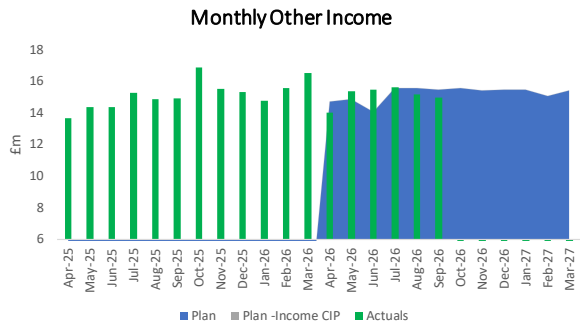
Non-Pay: £16.2mA:

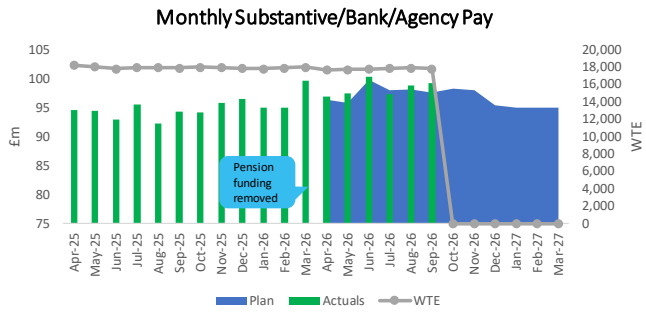
- Other is driven by
  - UEC blended income accrual £4mA (matched by income)
  - Write-off of bad debt £0.7mA
  - CIP (cash releasing only) underperformance £3m
- Clinical supplies largely is driven by additional activity delivered to date.
- EDD (£2mA) covered by income

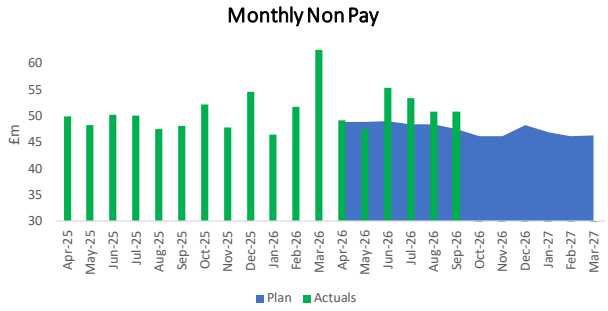
Month 6 I&E Dashboards

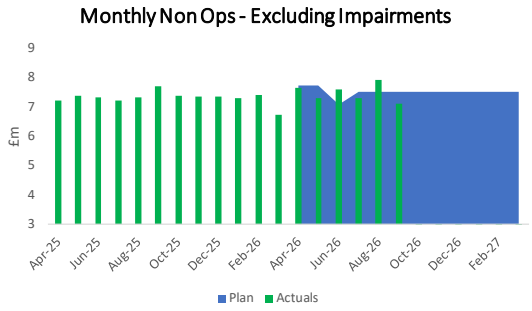




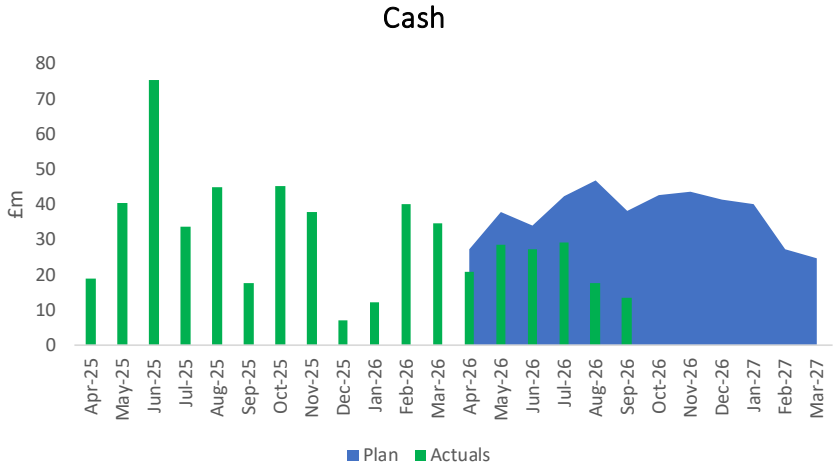


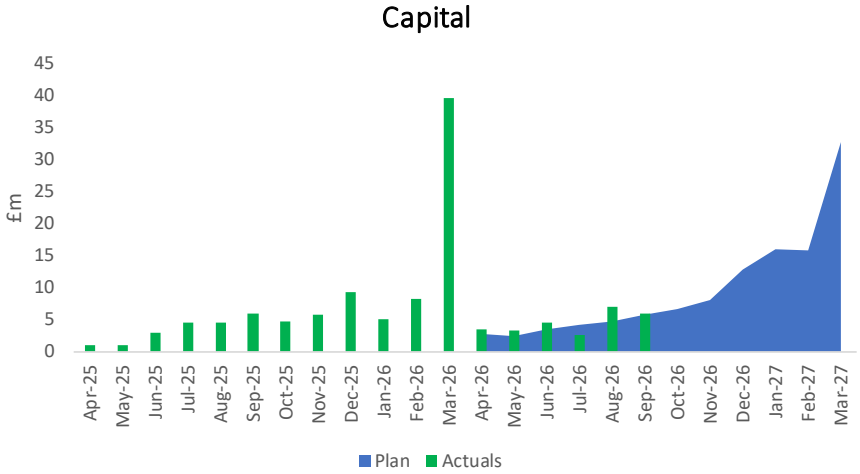


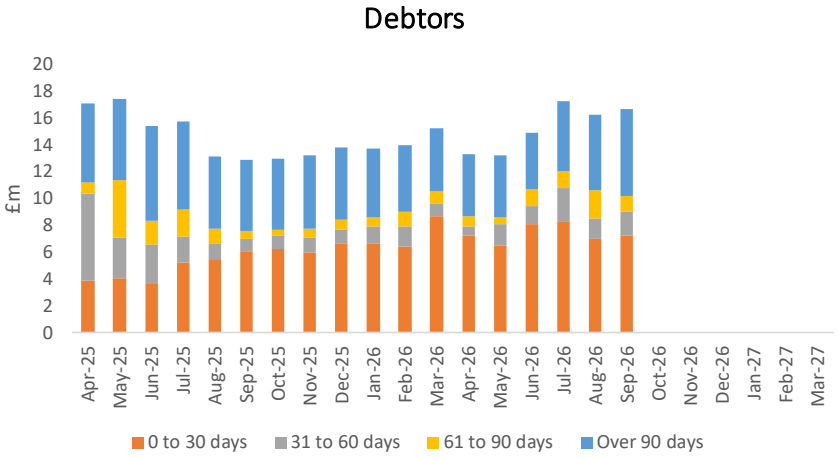


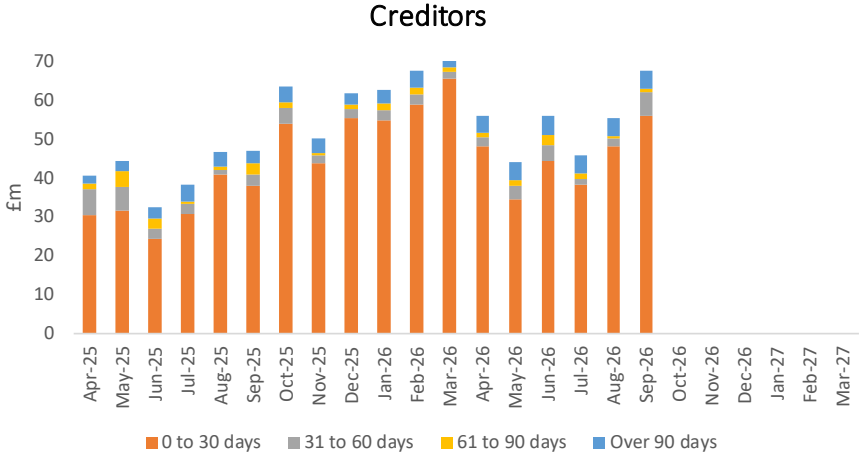


Month 6 Balance Sheet Dashboards









Statement of Financial Position

- **Non-Current Assets (£0.4m):** Additions of £6m in month were offset by depreciation of £5.6m.
- **Trade and other receivables(£6.2m)**: Increase in NHS Debtors (£0.8m), Non NHS Debtors (+£1.2m). VAT debtors(+£1.6m). Prepayment increase (£1.7m) of which (£0.9m) relates to prepayments on EDD cost to align with income; (£0.7m) CNST prepayments
- **Cash (-£4.3m) –** Refer to liquidity and cash slide.
- **Trade and other payables and accruals (£11.4m):** Increase in Trade Creditors (£7m) combined with increase in capital creditors (£3m); (£1.4m) due to other non pay expenditure accruals.
- **Deferred Income (-£6.5m):** Reduced due to the patient care income(+£7m).
- **Dividend Payable (-£4.4m**): Reduction due to the M6 payment of Dividend (£6m) offset by the in month accrual (£1.4m).
- **Income and Expenditure Reserve (+£0m):** movement reflects the in month reported adverse income and expenditure position.

Statement of Financial Position

£m	31-Mar-26	Aug-26	Sep-26	In Month Movement	YTD Movement
Non Current Assets					
Intangible assets	33.9	30.7	30.1	(0.7)	(3.9)
Property, plant and equipment	663.9	660.0	661.1	1.1	(2.8)
Other non-current assets	4.6	4.7	4.7	0.0	0.1
Total non-current assets	**702.4**	**695.4**	**695.9**	**0.4**	**(6.6)**
Current Assets					
Inventories	27.8	28.3	28.7	0.5	1.0
Trade and other receivables	44.6	88.2	94.4	6.2	49.8
Cash and cash equivalents	34.7	17.8	13.4	(4.3)	(21.3)
Total Current Assets	**107.0**	**134.2**	**136.5**	**2.3**	**29.5**
Current Liabilities					
Trade and other payables	(168.7)	(142.5)	(153.9)	(11.4)	14.8
Leases < 1 Year	(12.3)	(13.0)	(12.2)	0.8	0.1
Accruals	(23.1)	(30.9)	(32.3)	(1.4)	(9.2)
Deferred income	(4.9)	(42.5)	(36.0)	6.5	(31.1)
Dividend payable	0.0	(8.9)	(4.5)	4.4	(4.5)
Provisions < 1 year	(9.1)	(8.6)	(8.6)	0.0	0.5
Total Current Liabilities	**(218.1)**	**(246.4)**	**(247.6)**	**(1.2)**	**(29.5)**
Net Current Assets / (Liabilities)	**(111.1)**	**(112.2)**	**(111.1)**	**1.1**	**0.0**
Leases > 1 Year	(35.8)	(35.3)	(34.8)	0.5	1.0
Provisions for liabilities & charges	(3.0)	(3.0)	(3.0)	0.0	(0.0)
Total non-current liabilities	**(38.8)**	**(38.4)**	**(37.8)**	**0.5**	**1.0**
Total Assets/(Liabilities)	**552.5**	**544.9**	**547.0**	**2.1**	**(5.5)**
Public dividend capital	(984.6)	(987.4)	(989.5)	(2.1)	(4.8)
Revaluation reserve	(178.0)	(178.0)	(178.0)	0.0	0.0
Income and expenditure reserve	610.1	620.4	620.4	0.0	10.3
Total Capital & Reserves	**(552.5)**	**(544.9)**	**(547.0)**	**(2.1)**	**5.5**

Liquidity and Cash Position – Month 6

- Cash balance at end of September: £13.4m (£12.5m for the Trust) compared with a plan of £38.2m. Year End Forecast of £24.8m.
- Net in-month reduction of £4.3m.
- M6 BPPC of 95% by value, 88% by volume.

Receivables & Payables

- Payables increased by £12.2m.
- Total debt: £16.7m, of which >90 days £6.5m (£5.6m at M5 and £4.7m at 31 March)
- The £1m increase in over 90 days debt is driven by overseas (£0.2m), LPT (0.3m) caused by delayed approval of invoices, cash issues at Northampton (£0.2m) and Kettering (£0.2m)
- The table shows a breakdown by category of debt over 90 days

Total Debt Over 90 Days		M5	M6	Var
		£'000	£'000	£'000
Non NHS Debtors	Overseas Visitors	2,249	2,425	176
	Other	805	687	(118)
	Salary overpayment	351	314	(37)
	Private Patients	323	462	139
	Other NHS	32	15	(17)
	Universities	745	879	134
	Accomodation Charges	1	0	(1)
	Local Authority	77	101	24
	Total Non NHS	**4,583**	**4,884**	**301**
NHS Debtors	Leicestershire Partnership Nhs Trust	120	437	317
	Northampton General Hospital Nhs Trust	86	273	187
	Department Of Health	220	220	0
	Nottingham University Hospitals Nhs Trust	141	195	54
	Kettering Gen Hosp Nhs Foundation Trust	23	194	171
	North West Anglia Nhs Foundation Trust	143	157	14
	Cambridge University Hosp Nhs Ft	163	59	(104)
	Care Quality Commission	57	55	(2)
	United Lincolnshire Hospitals Nhs Trust	4	45	41
	Other NHS	21	24	3
	Total NHS	**978**	**1,659**	**681**
	Total Debtors over 90 Days	**5,561**	**6,543**	**982**

	Month 6						Month 5					
	Total	0 to 30 days	31 to 60 days	61 to 90 days	Over 90 days	Percentage over 90	Total	0 to 30 days	31 to 60 days	61 to 90 days	Over 90 days	Percentage over 90
	£000	£000	£000	£000	£000	%	£000	£000	£000	£000	£000	%
Non-NHS receivables	**10,333**	3,873	1,210	366	4,884	47%	**10,577**	4,296	580	1,120	4,582	43%
NHS receivables	**6,366**	3,344	587	776	1,659	26%	**5,624**	2,678	983	986	978	17%
Total receivables	**16,699**	**7,217**	**1,797**	**1,142**	**6,543**	**39%**	**16,201**	**6,974**	**1,563**	**2,105**	**5,559**	**34%**
Non-NHS payables	**57,697**	49,481	3,895	384	3,936	7%	**47,213**	42,043	812	999	3,360	7%
NHS payables	**10,048**	6,643	2,068	629	707	7%	**8,288**	6,149	1,108	(337)	1,368	17%
Total payables	**67,744**	**56,125**	**5,963**	**1,013**	**4,643**	**7%**	**55,501**	**48,192**	**1,920**	**662**	**4,727**	**9%**

Capital Programme - 26/27 M6 Position

The Trust committed gross expenditure of £27.1m year to date (£21.0m at M5) against a plan of £23.7m which netted down to £26.8m, after deducting charitable donations/capital grants and disposals of £47k year to date. The overall programme is therefore ahead of the year-to-date plan by £4.1m at month 6 (£3.2m ahead at M5). 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 £2.6m overspend on Medical Equipment and MES, offset by £6.6m slippage on LRI enabling works (the phasing to be reprofiled) and £2.1m slippage on NHP Incoming Power. The balance is made up of other smaller variances.

	M6 YTD Plan £'000	M6 YTD Actual £'000	Variance to M6 Plan £'000
Gross capital expenditure including IFRS impact:	23,689	27,080	(3,391)
Less: Book value of asset disposals including IFRS16 Disposals	0	(47)	47
Less: Capital grants/donations received	(960)	(239)	(721)
Charge against the Capital Resource Limit (CRL) incl IFRS impact	**22,729**	**26,794**	**(4,065)**

Scheme	Revised Plan £'000	M6 YTD Plan £'000	M6 YTD Actual £'000	Variance YTD Plan v Actual £'000
Digital infrastructure obsolescence	4,113	1,438	3,992	(2,554)
EPR	7,178	3,153	3,955	(802)
Medical Equipment	3,341	217	1,946	(1,729)
MES Equipment	3,800	63	126	(63)
MES Enabling	6,135	1,595	1,226	369
Estates Backlog Maintenance	3,763	551	3,795	(3,244)
Bede Island		0	244	(244)
Ward Improvement	2,000	0	161	(161)
Other Operational Schemes	28,404	0	497	(497)
Total 26/27 Operational Funded Schemes	**58,734**	**7,017**	**15,942**	**(8,925)**
Leases: IFRS16 (including re-measurement)	6,725	547	1,334	(787)
Total System Funded Schemes incl. IFRS16	**65,459**	**7,564**	**17,276**	**(9,712)**
Other Estates Schemes	9,339	0	1,544	(1,544)
Diagnostics (RtCS)	8,285	0	59	(59)
UEC (RtCS)	2,000	0	1,210	(1,210)
NHP	17,705	15,877	6,754	9,123
Charity Funded Schemes	2,500	248	239	9
Total Capital Programme	**105,288**	**23,689**	**27,082**	**(3,393)**
Donated Income/Grant rec'd and Disposals	(2,500)	-960	-286	(674)
NET CDEL	**102,788**	**22,729**	**26,796**	**(4,065)**

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.