Barts Health Integrated Performance Report

October-25

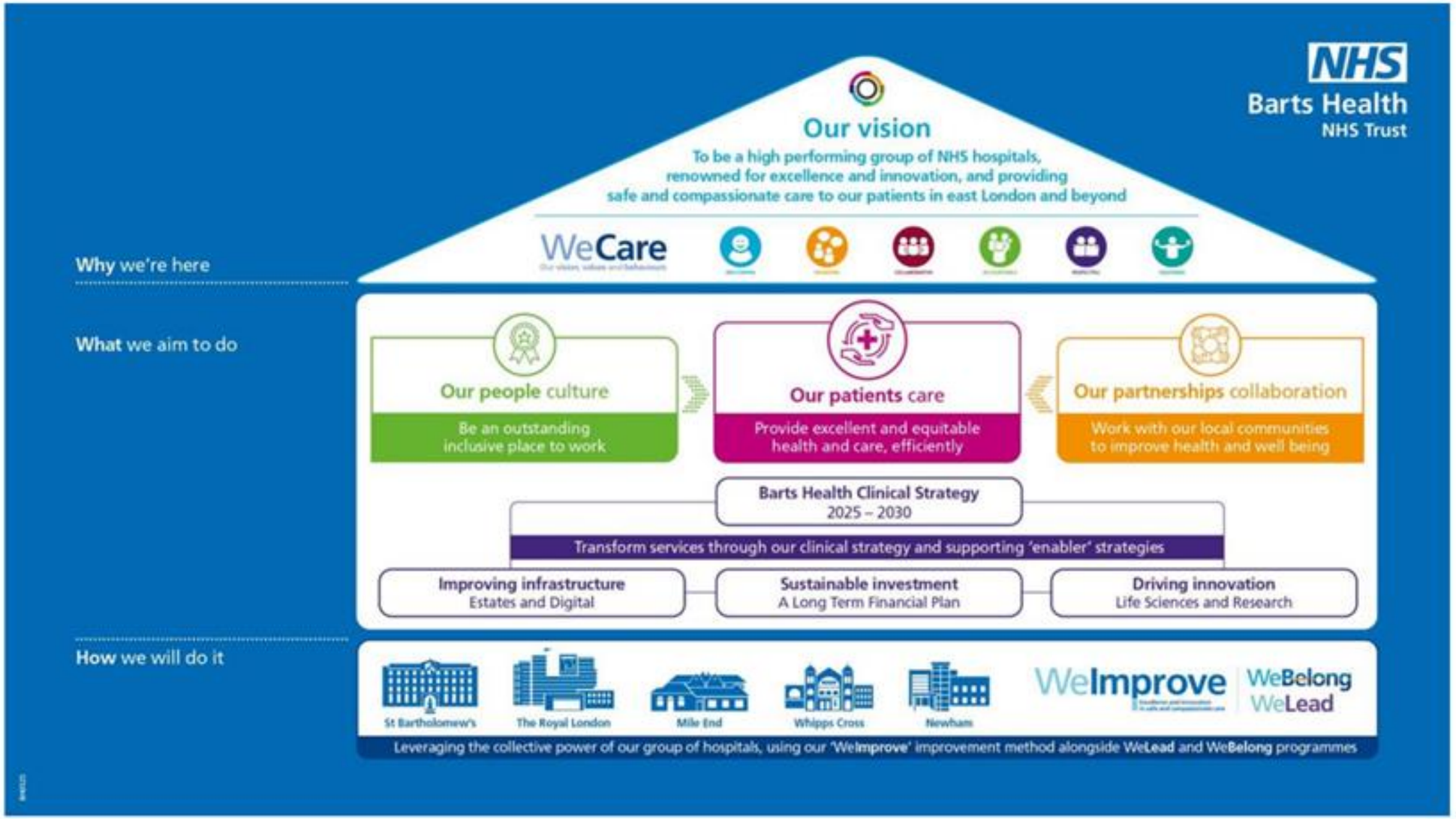
Performance for: **Aug-25**





Pack Contents

Barts Health Strategic Framework – sets out our vision, values and objectives as a Group, which we set our priorities and goals against.



Executive Summary

Executive Summary

Our Patients

Quality

Infection Prevention and Control: There has been increase in the number of MRSA cases reported. The Trust is undertaking a range of improvement initiatives, and each hospital has an improvement plan describing key actions. A thematic review has been completed which has enabled teams to understand systemic issues and ensure focus is in place on the high-risk areas which may need additional support or intervention. This remans a key focus for the Trust.

Duty of Candour: The Duty of Candour key performance indicator (KPI) has been extended from 10 working days (14 calendar days) to 20 working days (28 calendar days).This change allows for a more thorough and careful review of incidents, ensuring that all relevant information is accurately gathered and communicated. Extending the timeframe helps improve transparency, supports better decision-making, and ultimately enhances patient safety by fostering a more detailed and thoughtful response process, in line with the principle of compassionate engagement under PSIRF.

Incidents resulting in moderate Harm and Above: There remains a consistent level of reporting within obstetrics which is consistent with national reporting. However, in the most recent reporting month there has been a notable increase in moderate and severe harm incidents specifically at Newham Hospital and Whipps Cross Hospital. This rise has been predominantly linked to falls and pressure ulcers. In response, the hospitals have undertaken a detailed "deep dive" analysis into these incidents to understand the underlying causes and contributing factors. Based on the findings, targeted improvement plans have been implemented. A Trust wide focus continues on reducing falls and pressure ulcers through established networks at Trust level and fundamentals of care groups at hospital level.

Safety Alerts: The trust has two safety alerts that remain open and overdue. Both alerts are planned to be closed in October.

External Visits/Reports: The Draft report following the Environment Agency inspection in Nuclear Medicine at WCH (Radioactive Substances Activity Compliance Assessment Report (RASCAR1)) was received on the 29th of August. No major non-conformities reported; there were 6 recommendations made which will be actioned by the Hospital and monitored through the Trust Radiation Protection Committee (RPC) reporting into the Trust Safety Committee.
The draft report has been received following the CQC Diagnostic Imaging inspection at Whipps Cross Hospital in July. It is currently undergoing Factual Accuracy check.

Planned Care

Addressing the longest waiting patients and increasing productivity in non-admitted pathways remains a Trust priority. There is full engagement with the additional oversight support via the Tier 1 arrangements. The Trust achieved its objectives related to 18-week wait for first treatment. The 52w performance is 3.4% against the monthly trajectory of 2.5%

Diagnostics

The waiting time performance has been steadily improving across the Barts Health Group since December, however, capacity challenges in imaging modalities has led to a reduction in performance in July and August. For August 25, a performance of 71.2% was recorded, with a mean of 75.4%. This reduction was noted at the recent Tier 1 meeting with regional and national colleagues. A particular challenge was noted in Non Obstetric Ultrasound (NOUS) which is impacting most providers, along with some staffing and equipment challenges in CT and MRI.

Cancer

Strong performance in cancer has been maintained into July 25. The Trust delivered the Faster Diagnosis standard (81.1%), the Aggregate 31-day Decision to Treat standard (98.2%) and the 62-day standard (75.7%). These metrics have been delivered ahead of March 26.

Urgent and Emergency Care

Four hour performance in UEC for August was 72.0%, and the Trust's 12-hour position in August was 8%. Type 3 performance had improved to 93.20%, primarily driven by improved positions at RLH and NUH. Winter 1 planning with system partners continues and the NEL Mental Health Urgent and Emergency Care Programme Board is leading collaboration on improvements for this cohort of patients.

Executive Summary

Our People

The substantive fill rate has increased to 91.7% with the August rotations resulting in an expected increase of our medical and dental workforce.

Agency spend as a % paybill remained below target at 1.1% YTD, although bank spend continues to exceed target at 10.3% YTD.

Supporting Enablers

Finance

The Trust is reporting a (£30.3m) deficit for the year to date at Month 5, which is (£20.3m) adverse against plan. This overall position reported to NHS England is in line with the submitted Financial Recovery Plan with the exception of the £2.5m costs of resident doctors industrial action. This cost consists of the additional expenditure on staff cover net of payroll deductions for striking doctors.

The key financial challenges for the Trust in achieving its plan for this financial year include:

- Delivering increased efficiency savings to meet the forecast outturn control totals for sites and group services aligned to the Financial Recovery Plan.
- Working with system partners to reduce delays in transfers of medically optimised and mental health patients out of acute hospitals to more appropriate care settings and to secure funding for the impact of delays for the year to date.
- Minimising additional costs of managing elective wating times particularly in relation to long waiter

NHSE Oversight Framework

	NOF SCORE			Trust Performance			NOF			
ACCESS TO SERVICES	**2.6**	**Metric**	**Latest data**	**Barts latest performance**	**Barts agreed trajectory**	**SPC Trend (monthly - 24 months)**	**Current NOF**	**NOF stretch**	**Objective**	**Variance to objective**
Elective Care		18 Week RTT Compliance (Incomplete)	Aug-25	56.2%	53.8%	No Significant Change	3.0	2	60.7%	-4.6%
		Difference between planned and actual 18 week performance	Aug-25	2.4%	-	-	1.0	-	-	-
		% RTT patients waiting 52 weeks or more	Aug-25	3.4%	2.5%	No Significant Change	3.5	2	2.4%	-1.0%
		Percentage of people waiting over 52 weeks for community services	Jul-25	10.9%	-	Improvement	3.5	2	1.0%	-9.9%
Cancer Care		Cancer 28 Day FDS Aggregate - 3 month rolling	Jul-25	80.8%	76.1%	Improvement	1.0	-	-	-
		Cancer 62 Days Aggregate - 3 month rolling	Jul-25	74.7%	69.5%	Improvement	2.1	2	75.7%	-1.0%
Urgent and emergency Care		A&E 12 Hours Journey Time	Aug-25	13.4%	-	Improvement	3.3	2	8.4%	-5.0%
		A&E 4 Hours Waiting Time - 3 month rolling	Aug-25	71.5%	74.1%	Improvement	3.4	2	76.0%	-4.5%

	NOF SCORE			Trust Performance			NOF			
NOF DOMAIN (EFFECTIVENESS AND EXPERIENCE OF CARE)	**1.9**	**Metric**	**Latest data**	**Barts latest performance**	**Barts agreed trajectory**	**SPC Trend (monthly - 24 months)**	**Current NOF**	**Stetch**	**Objective**	**Variance to objective**
Patient experience		CQC Inpatient survey satisfaction rate	Aug-25	TBC	-	-	2.0	N/A	-	-
		Summary Hospital-Level Mortality Indicator	Mar-25	101.5	-	Concern	2.0	N/A	-	-
Effective flow and discharge		Average number of days from discharge ready date to actual discharge date	Jun-25	0.5	-	-	1.7	-	-	-

*The 12-hour journey time methodology is different in the NOF framework compared to the IPR metric. NOF exclude type 3 attendances, whereas the IPR metric includes type 3 attendances
*Please note the 12-month rolling & 3 month rolling versions of the metrics, this is aligned to the NOF methodology.

NHSE Oversight Framework

	NOF SCORE			Trust Performance			NOF			
NOF DOMAIN (PATIENT SAFETY)	**2.8**	**Metric**	**Latest data**	**Barts latest performance**	**Barts agreed trajectory**	**SPC Trend (monthly - 24 months)**	**Current NOF**	**Stetch**	**Objective**	**Variance to objective**
Patient Safety		NHS Staff Survey - raising concerns sub-score score	Jul-05	6.31	-	-	3.1	2	6.42	0.11
		CQC safe inspection score (if awared within the preceding 2 years)	-	No Score	-	-	-	-	-	-
		12 month rolling count of MRSA cases	Aug-25	25	-	No Significant Change	4.0	3	3	-22
		12 month rolling count of C.difficile cases	Aug-25	113	-	Improvement	1.0	-	-	-
		12 month rolling count of E.coli cases	Aug-25	304	-	No Significant Change	2.5	2	TBC	TBC

	NOF SCORE			Trust Performance			NOF			
NOF DOMAIN (People and workforce)	**2.2**	**Metric**	**Latest data**	**Barts latest performance**	**Barts agreed trajectory**	**SPC Trend (monthly - 24 months)**	**Current NOF**	**Stetch**	**Objective**	**Variance to objective**
Retention and Culture		Sickness Absence Rate	Jun-25	4.4%	-	Concern	1.5	-	-	-
		NHS staff survey engagement theme	Dec-24	6.82	-	-	2.8	2	6.88	-

	NOF SCORE			Trust Performance			NOF			
NOF DOMAIN (Finance and Productivity	**2.5**	**Metric**	**Latest data**	**Barts latest performance**	**Barts agreed trajectory**	**SPC Trend (monthly - 24 months)**	**Current NOF**	**Stetch**	**Objective**	**Variance to objective**
Finance		Planned surplus/deficit	Jul-25	-10.0	-	-	1.0	-	-	-
		Actual surplus/deficit Vs. Plan	Aug-25	-20.3		-	4.0	-	-	-
Productivity		Implied productivity level	Jul-25	3.8%	-	-	2.1	2	-	-
		Relative difference in costs		-	-	-	-	-	-	-

Our Patients – Care

'Providing excellent and equitable healthcare'

Improving Equity, Quality and Standards – Improve equity of access to care for our population

Summary : Improving Equity, Quality & Standards

The data covered in this report covers the Quality dashboard metrics for July 2025 reporting period in line with the BH approach to reporting using Statistical Process Control (SPC) methodology. The report also provides updates from scheduled reports based on the established workplan in addition to other standing items.

Complaints: A deep dive has been completed by individual hospitals in which delays have occurred during the complaint process . This involves looking closely at individual cases to understand the root causes of delay. The reviews have shown that delays are often multifactorial, commonly linked to the complexity of the clinical issues raised, the need to involve multiple clinicians in the investigation, or delays in gathering the necessary information.

Infection Prevention and Control: There has been increase in the number of MRSA cases reported. The Trust is undertaking a range of improvement initiatives, and each hospital has an improvement plan describing key actions. A thematic review has been completed which has enabled teams to understand systemic issues and ensure focus is place on the high-risk areas which may need additional support or intervention. We remain firmly focused on reducing MRSA cases across our organisation. This continues to be a key priority in ensuring patient safety and delivering the highest standards of infection prevention and control. We are working closely with clinical teams, infection prevention specialists, and wider stakeholders to embed best practice, enhance awareness, and ensure consistent compliance with infection control standards.

Duty of Candour: A new audit tool and scoring system were implemented in Q1 2025-26. The audit results for Q1 2025-26 demonstrate strong overall performance across all four hospitals—particularly Whips Cross, which achieved an overall score of 99%.The Duty of Candour KPI has been extended from 10 working days (14 calendar days) to 20 working days (28 calendar days).
This change allows for a more thorough and careful review of incidents, ensuring that all relevant information is accurately gathered and communicated. Extending the timeframe helps improve transparency, supports better decision-making, and ultimately enhances patient safety by fostering a more detailed and thoughtful response process, in line with the principle of compassionate engagement under PSIRF.

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Safety Alerts: The trust has two safety alerts that remain open and overdue. Both alerts are planned to be closed in October.

External Visits/Reports :

- The Draft report following the EA inspection in Nuclear Medicine at WCH (Radioactive Substances Activity Compliance Assessment Report (RASCAR1)) was received on the 29th of August. No major non-conformities reported; there were 6 recommendations made which will be actioned by the Hospital and monitored through the Trust Radiation Protection Committee (RPC) reporting into the Trust Safety Committee.
- The draft report has been received following the CQC Diagnostic Imaging inspection at Whipps Cross Hospital in July. It is currently undergoing Factual Accuracy check.

Maternity: All hospitals have been reporting higher rates of Postpartum Hemorrhage (PPH) than previously. This could be due to recent change in recording all blood loss as measured rather than estimated. Services are reviewing their cases in line with PSIRF principles and have action plans to address them.

Domain Scorecard

Indicator	Exception Triggers: Month Target	Exception Triggers: Step Change	Exception Triggers: Contl. Limit	This Period	This Period Target	Performance: Last Period	Performance: This Period	Performance: YTD	Site Comparison: Royal London	Site Comparison: Whipps Cross	Site Comparison: Newham	Site Comparison: St Bart's	Data Quality
MSA Breaches	●			Jul-25 (m)	<= 0	20	**30**	***96***	5	15	6	4	
FFT % Positive - Inpatients	●			Jul-25 (m)	>= 91%	91.2%	**92.5%**	***91.7%***	88.5%	92.6%	94.4%	95.5%	
FFT % Positive - A&E	●			Jul-25 (m)	>= 60%	61.9%	**62.8%**	***62.0%***	61.8%	67.0%	57.1%	-	
FFT % Positive - Maternity	●			Jul-25 (m)	>= 93%	87.8%	**89.1%**	***86.2%***	82.4%	93.5%	88.9%	-	
FFT Response Rate - Inpatients	●			Jul-25 (m)	>= 23%	26.3%	**33.9%**	***28.6%***	23.2%	38.7%	42.3%	44.5%	
FFT Response Rate - A&E	●			Jul-25 (m)	>= 12%	7.1%	**7.6%**	***7.2%***	7.2%	9.6%	6.0%	-	
FFT Response Rate - Maternity	●			Jul-25 (m)	>= 17.5%	11.5%	**24.8%**	***14.7%***	18.9%	32.9%	23.6%	-	
Complaints Replied to in Agreed Time	●			Jul-25 (m)	>= 80%	79.2%	75.4%	*74.2%*	79.0%	73.2%	76.9%	70.0%	
Duty of Candour	●			Jul-25 (m)	>= 100%	89.3%	**94.2%**	-	100.0%	92.6%	90.6%	100.0%	

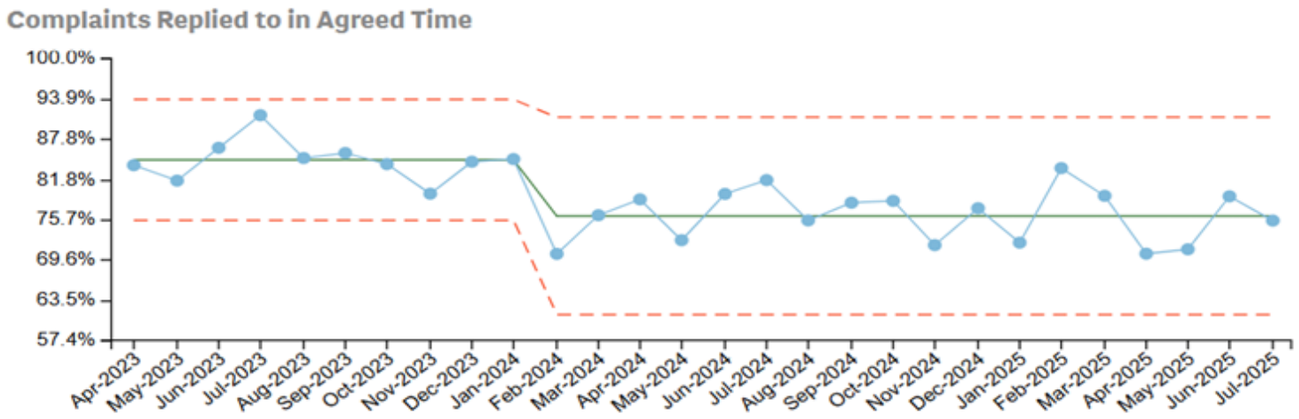
Domain Scorecard

Indicator	Exception Triggers: Month Target	Exception Triggers: Step Change	Exception Triggers: Contl. Limit	This Period	This Period Target	Performance: Last Period	Performance: This Period	Performance: YTD	Site Comparison: Royal London	Site Comparison: Whipps Cross	Site Comparison: Newham	Site Comparison: St Bart's	Data Quality
Clostridium difficile - Infection Rate	●			Jul-25 (m)	<= 16	9.1	**22.7**	***12.7***	9.4	37.4	27.7	41.8	
Clostridium difficile - Incidence	●			Jul-25 (m)	<= 13	6	**15**	***34***	3	6	3	3	
Assigned MRSA Bacteraemia Cases	●			Jul-25 (m)	<= 0	2	**2**	***9***	1	1	0	0	
MSSA Bacteraemias				Jul-25 (m)	SPC Breach	15	**8**	***39***	2	2	3	1	
E.coli Bacteraemia Bloodstream Infections	●			Jul-25 (m)	<= 28	29	**21**	***109***	5	8	3	5	
Never Events				Jul-25 (m)	-	0	**0**	***0***	0	0	0	0	
% Incidents Resulting in Harm (Moderate Harm or More)	●			Jul-25 (m)	<= 0.9%	4.1%	**3.0%**	***3.5%***	2.2%	2.7%	5.2%	1.8%	
Falls Per 1,000 Bed Days	●			Jul-25 (m)	<= 4.8	3.1	3.5	*3.2*	2.7	3.7	5.7	3.3	
Patient Safety Incidents Per 1,000 Bed Days				Jul-25 (m)	SPC Breach	46.4	**50.1**	***46.4***	34.4	66.2	63.7	61.3	
Pressure Ulcers Per 1,000 Bed Days	●			Jul-25 (m)	<= 0.6	1.2	**0.9**	***1.1***	0.6	1.3	1.2	0.9	
Pressure Ulcers (Device-Related) Per 1,000 Bed Days				Jul-25 (m)	SPC Breach	0.0	**0.0**	***0.1***	0.0	0.1	0.1	0.0	
Patient Safety Alerts Overdue				Jul-25 (m)	<= 0	2	**2**	***13***	-	-	-	-	
Summary Hospital-Level Mortality Indicator	●			Mar-25 (m)	<= 100	101	**101**	***101***	101	105	98	100	
Risk Adjusted Mortality Index	●			Jun-25 (m)	<= 100	92	**93**	-	97	88	83	114	
Cardiac Arrest 2222 Calls (Wards) Per 1,000 Admissions	●			Jul-25 (m)	<= 0.51	0.55	**0.53**	***0.55***	0.40	0.72	0.69	0.48	

- *Annual discharge data, ending in month indicated as 'This period', used for the generation of the indicator. Confirmed or suspected cass of Covid – 19 are excluded.*
- *The Trust is reviewing quality and safety data using statistical process control; this supports early identification of risk and enables proactive planning. A review of the metrics demonstrated common cause variation across the indicator metrics.*

Complaints Replied to in Agreed Time Trust

IMPROVING EQUITY, QUALITY AND STANDARDS - SAFE



Indicator Definition:

Complaints Replied to in Agreed Time
The number of initial reportable complaints replied to within the agreed number of working days (as agreed with the complainant). The time agreed for the reply might be 25 working days or might be another time such as 40 working days

Written Complaints per 1,000 Staff
The number of initial reportable complaints received by the trust per 1,000 whole time equivalent staff (WTEs), i.e. the number of initial reportable complaints divided by the number of WTEs which has been multiplied by 1,000

What is the Chart Telling us:

Complaints replied to in agreed time remains within control limits with normal variation .

Actions taken:

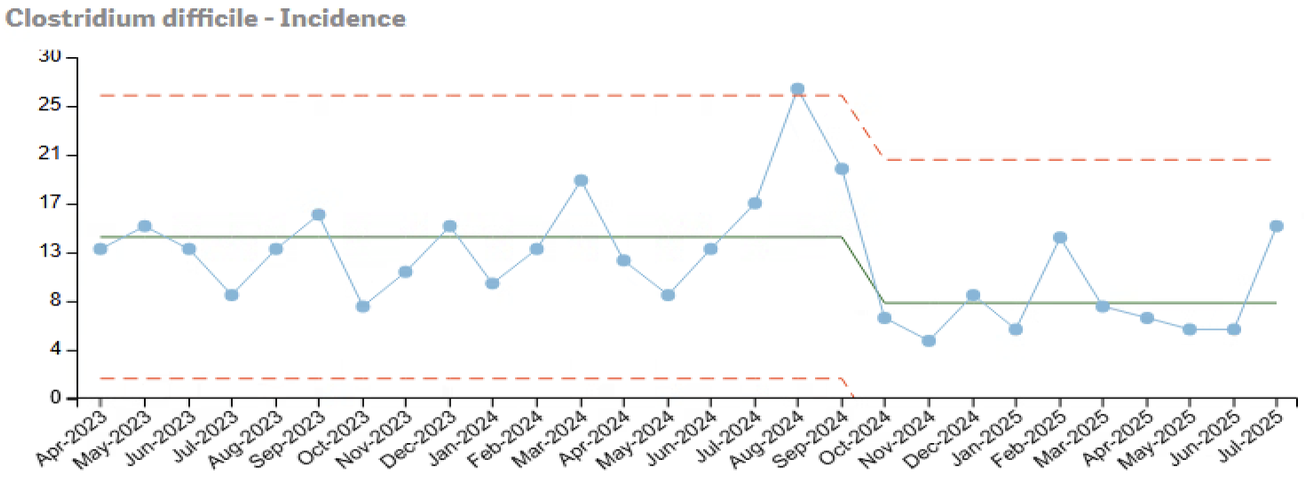
A deep dive has been completed by individual hospitals in which delays have occurred. This involves looking closely at individual cases to understand the root causes of delay. The reviews have shown that delays are often multifactorial, commonly linked to the complexity of the clinical issues raised, the need to involve multiple clinicians in the investigation, or delays in gathering the necessary information.
In response, all hospitals have been instructed to ensure that, where delays do occur, complainants are kept informed. Specifically, hospitals must contact individuals directly to explain the reason for the delay and provide an update on when they can expect a response.

Issues and Risks:

Whilst complaints replied to within an agreed time has remained within control limits, the Trusts focus continues to ensure that complaints are handled fairly and promptly in line with the NHS constitution. Delays can damage and reduce patients confidence.

Clostridium difficile - Incidence

IMPROVING EQUITY, QUALITY AND STANDARDS - SAFE



Indicator Definition:

Clostridium difficile – Incidence

The number of Clostridium difficile (C.difficile) infections reported in people aged two and over and which were apportioned to the trust

What is the Chart Telling us:

Trust Ceiling 2025/26- 143 (YTD 59)

SBH: 7 cases reported Apr–Aug 2025 (peak of 3 in July; majority in Chemotherapy Day Care; no lapses in care or transmission).
WXH: 8 cases to July 2025 (6 in July; learning around delayed isolation/sampling, hand hygiene, PPE and equipment cleaning).
RLH: 20 cases YTD (4 Community Onset Healthcare Associated (COHA), 16 Hospital Oset Healthcare Associated (HOHA); below annual threshold of 45; no linked outbreaks; issues include delayed isolation/sampling, documentation, hand hygiene and environmental cleaning).
NUH: 3 HOHA cases, all associated with antimicrobial exposure; no outbreaks.

Actions taken:

Pharmacy stewardship reviews for antibiotic prescribing, Proton Pump Inhibitors (PPI) and laxatives

Targeted staff training and safety briefings (Ward isolation practice, stool sampling).

Patient placement and prompt isolation reviews monitored via side room usage reviews

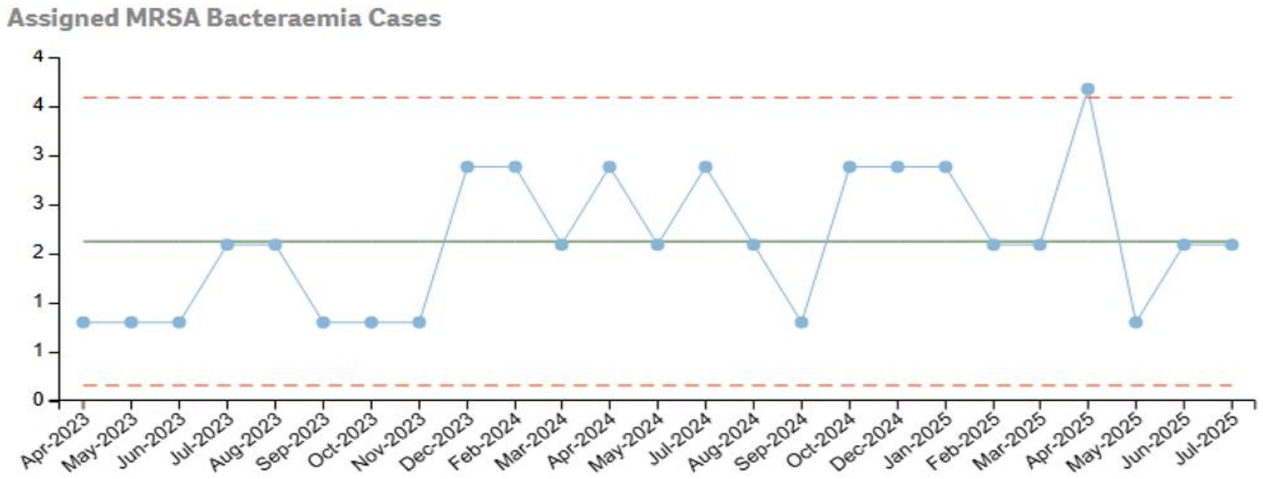
Reinforcing practices for equipment decontamination and environmental cleaning.

Issues and Risks:

C. difficile poses serious clinical, operational, and economic risks.Effective strategies include antibiotic stewardship, environmental hygiene, staff training, and careful medication management.

Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemias

IMPROVING EQUITY, QUALITY AND STANDARDS - SAFE



Indicator Definition:

Assigned MRSA Cases

The number of Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemias which can be directly associated to the trust.

What is the Chart Telling us:

Trust Ceiling- Set to Zero Tolerance YTD (12)

SBH: 1 case (Apr 2025; linked to skin condition reducing effectiveness of decolonisation).
WXH: 3 cases Apr–Jul 2025 (trajectory reached; July case due to missed admission screening opportunities).
RLH: 6 cases YTD (themes: missed admission screening, delays in decolonisation, IV line/wound care, low hand hygiene, poor equipment/environmental cleaning).

Actions taken:

Reinforcement of MRSA screening and decolonisation protocols, with escalation guidance and regular compliance audits

MRSA management- targeted training delivered across all hospital sites in key areas
Hand hygiene, Personal Protective Equipment (PPE) use, equipment and environmental cleaning reinforced as recurring improvement themes Trust-wide.
Hospital Infection Prevention Control (IPC) improvement plans monitored via monthly IPC Steering Group exception reports and Trust IPC Committee oversight.

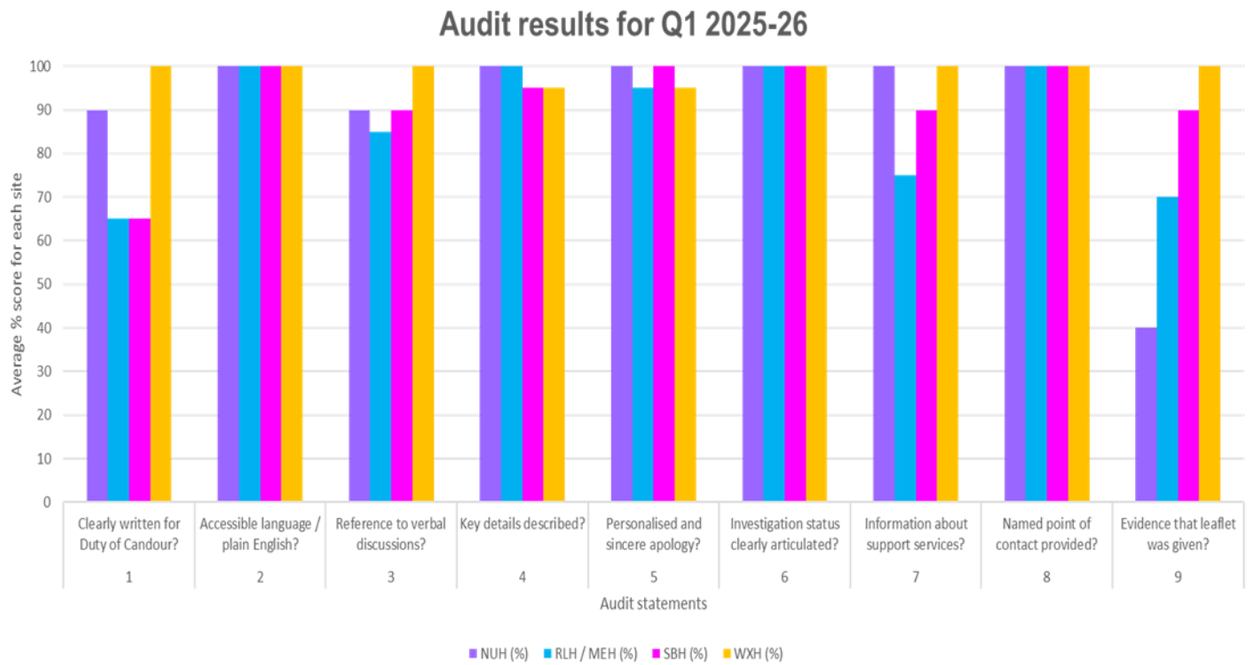
Trust Improvement Plan On a Page (IPOP) Actions overarching the Hospital IPC improvement
Exploring of alternative decolonisation options where standard protocols are deemed ineffective

Issues and Risks:

MRSA poses significant clinical, operational, and financial risks due to its resistance, potential for outbreaks, and impact on vulnerable patients. Effective management requires surveillance, infection control, antimicrobial stewardship, staff training, and environmental cleaning to protect patients, maintain safe healthcare environments, and meet regulatory requirements.

Q1 Duty of Candour Letter audit results 2025/26

IMPROVING EQUITY, QUALITY AND STANDARDS - SAFE



A new audit tool and scoring system were implemented in Q1 2025-26. To maintain establish a baseline for future audits and maintain consistency, the audit was conducted by an individual member of the Group Patient Safety Team instead of hospital teams.

Methodology:
For each site, 10 letters were randomly selected from applicable cases for audit. Each letter was evaluated against a set of quality standards using a scoring system: 2 (Fully Met), 1 (Partially Met), or 0 (Not Met). The Datix ID and relevant comments were recorded for each case. With a maximum of 18 points per letter, the highest possible score per site was 180.

Observations and recommendations:

The audit results for Q1 2025-26 demonstrate strong overall performance across all four sites—particularly WXH, which achieved an overall score of 99%.

The hospitals teams focus will attention on ensuring compliance with the following two standards, which showed the lower average scores:
1.Is it explicitly clear that the letter has been written as part of the Duty of Candour process?

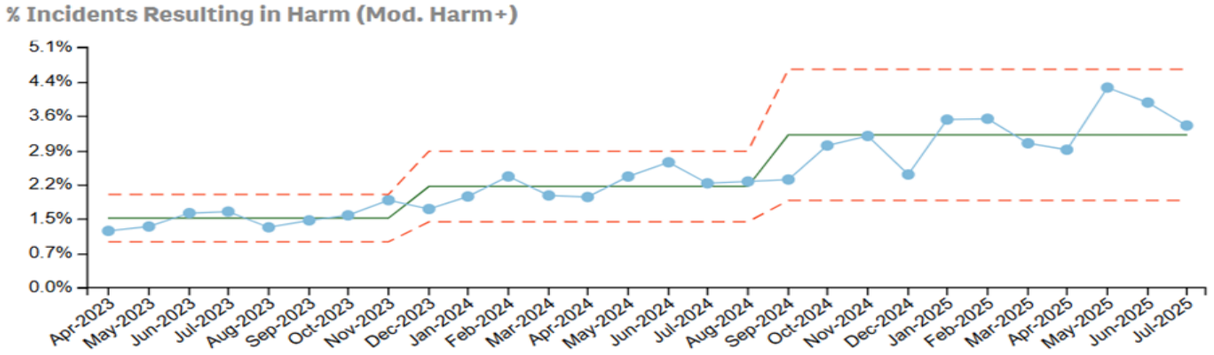
9. Is there evidence that a Duty of Candour information leaflet was enclosed with the letter, or that it was referenced as having been given during the verbal conversation within the letter***?***

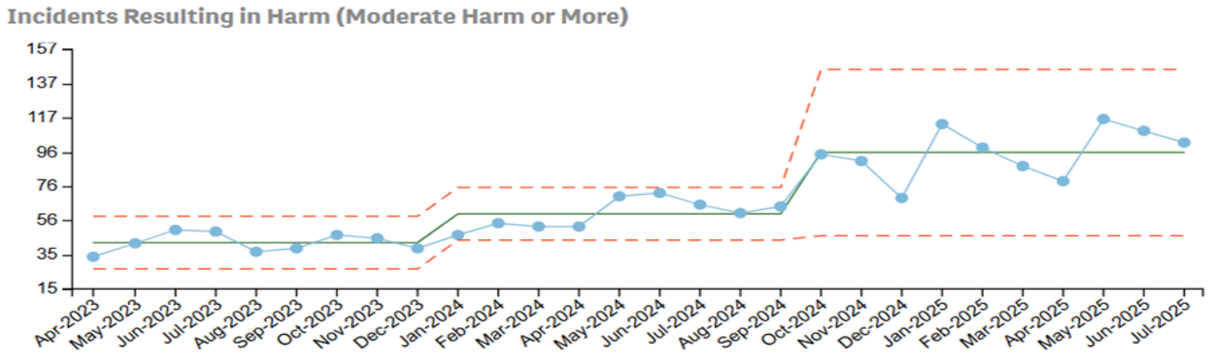
Next Steps:

Quarterly Peer Audit to continue.
Duty of Candour KPI extended from 10 working days (14 calendar days) to 20 working days (28 calendar days). This change allows for a more thorough and careful review of incidents, ensuring that all relevant information is accurately gathered and communicated. Extending the timeframe helps improve transparency, supports better decision-making, and ultimately enhances patient safety by fostering a more detailed and thoughtful response process, in line with the principle of compassionate engagement under Patient Safety Incident Response Framework (PSIRF).

Incidents Resulting in Harm (Moderate or More) - Trust

IMPROVING EQUITY, QUALITY AND STANDARDS - SAFE





Indicator Definition:

% Incidents Resulting in Harm (Moderate Harm or More)
The number of patient-related incidents occurring at the trust which caused harm (not including those which only caused low harm) divided by the total number of patient-related incidents occurring at the trust.

Incidents Resulting in Harm (Moderate Harm or More)
The number of patient-related incidents occurring at the trust which caused harm (not including those which only caused low harm)

What is the Chart Telling us:

Early indications of a downward trend in the number of reported incident graded as resulting in moderate or more harm at Trust level

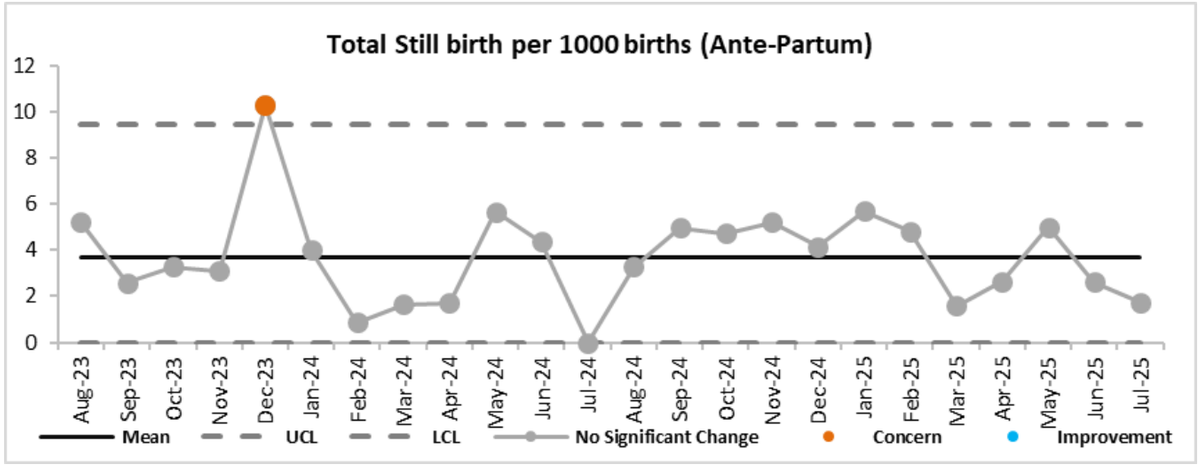
Actions taken:

- There are established processes for incident review at each hospital.
- A thematic review will be carried out for all non-maternal incident resulting in moderate harm and above, to identify if there are any themes or trends that would indicate increase in harm levels, or a change in the reporting in line with the Learning From Patient Safety Incident platform. (LFPSE)
- In July there has been an increase in the number of Pressure Ulcers driven by Whipps Cross Hospital.
- In July there has been an increase in the number of falls reported driven by Newham Hospital

Issues and Risks:

Under the Patient Safety Incident Reporting Framework (PSIRF), the emphasis is on systemic learning and proportional response, rather than simply counting and categorising incidents.
A full review has been completed by Whipps Cross Hospital and Newham Hospital in relation to the increase seen and reported in Month. There is an improvement plan that has been developed which includes increased focused on training, risk assessments and care planning.

Still Births



Indicator Background:

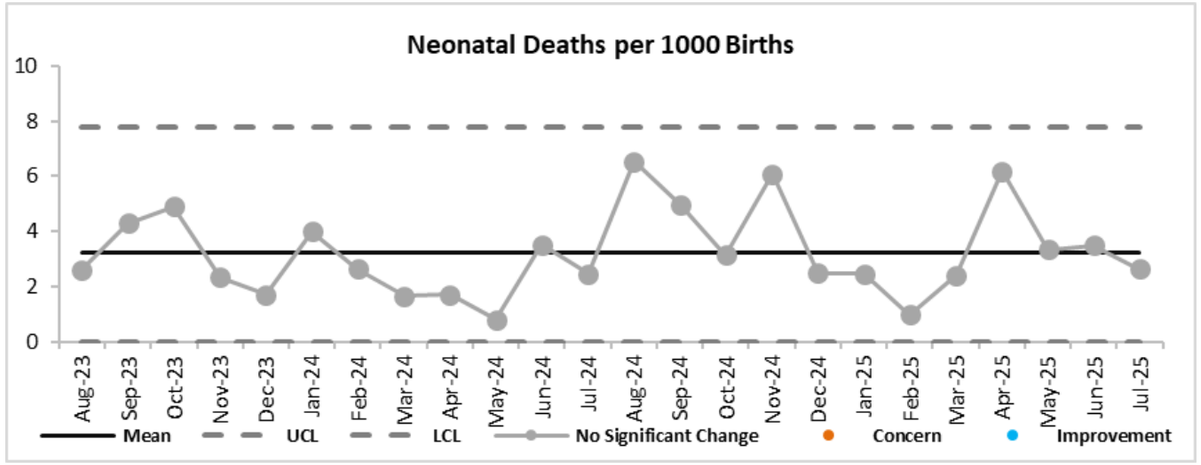
There is a national ambition to reduce stillbirth, neonatal death and brain injury by 50% by 2025. The stillbirth ambition is for the rate to decrease to 2.6 stillbirths per 1,000 births by 2025. The 2023 MBRRACE Group rate was 3.44 stillbirths per 1,000 births. When compared to comparable organisations with level 3 NICU and neonatal surgery, Barts Health has slightly higher stillbirth rates. Rates across the organisation have seen a small decrease over the last five years, with the exception of a small rise during the peak of the first two waves of the pandemic, as seen in national data (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRACE) last published in 2025 for 2023 data).

What is the Chart Telling us:

The chart is telling us that overall, for Barts Health there has been no significant change to the stillbirth rates.

Performance Overview	Responsible Director Update
There were two stillbirths in July, both to women who spoke English and were of South Asian ethnicity.	Both cases have had reviews with the perinatal mortality review tool. In one case the woman did not attend multiple appointments, was followed up appropriately, and declined some later appointments. Unknown case of deaths in both sad cases.

Neonatal Deaths



Indicator Background:

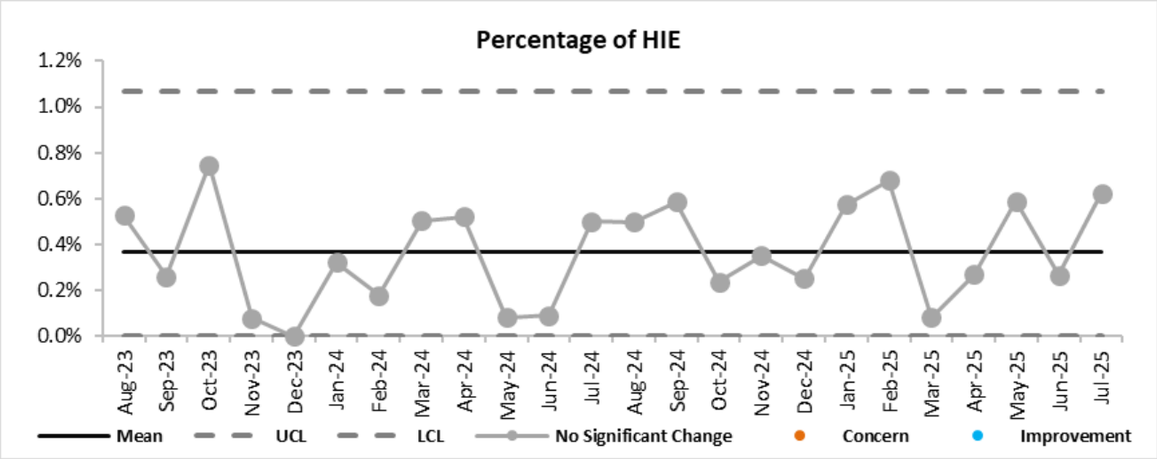
Prior to 2021, the national ambition covered all neonatal deaths and required the neonatal mortality rate to fall to 1.5 deaths per 1,000 live births by 2025. In 2021, the ambition was revised, as outlined in the Safer maternity care progress report 2021.The ambition was changed to 1.0 neonatal deaths per 1,000 live births for babies born at 24 weeks or over (1.3 for all gestations).
When compared to comparable organisations with level 3 NICU and neonatal surgery, Barts Health has lower Neonatal death rates. MBRACE 2022 (last available data published 2024)

What is the Chart Telling us:

The charts tell us that thankfully neonatal deaths are rare. Because of this, the data fluctuates from month to month. Work with the Making Data Count team at NHS Improvement will support the development of a rare events chart which will assist with visualisation of performance and outcomes.

Performance Overview	Responsible Director Update
There were two neonatal deaths. One was a case of lethal genetic abnormality and one case of extreme prematurity. Both women spoke English and were from South Asian ethnicities.	All cases have had initial reviews and will undergo an MDT review as part of the national Perinatal Mortality Review Tool. Both babies born at the tertiary service (RLH)

HIE (Hypoxic-Ischaemic Encephalopathy)



Indicator Background:

The rates for brain injury or HIE fluctuate monthly across the hospitals. Cases of severe brain injury are fortunately rare. Babies who are born in poor condition at birth are reviewed by our neonatal teams to review suitability for cooling therapy which is known to reduce the severity of injury to the brain following acute onset of hypoxia during birth. Cooling therapy is known to slow down the changes in the brain which can continue to have a detrimental effect even after the hypoxic insult has occurred. Babies are cooled for 72 hours, their body temperature is reduced and they are sedated and made comfortable during this process with various medications. Bart's Health provides this therapy at the Royal London site, and we also refer babies to The Homerton hospital where needed.
Brain injury can be as a result of changes that occur during the pregnancy as a result of reduced blood flow to the placenta, but can also occur during labour, which is why foetal monitoring is a vital component of safe care. Any cases where a baby is referred for cooling and has a brain injury is referred for external review by HSIB. The data captured through Barts Health only includes cases of severe damage (HIE grades 2 &3) and babies both born and treated at Barts Health. Improvement work at Barts health focuses on foetal well being in pregnancy and good foetal monitoring during labour to identify early signs of hypoxia and to help us deliver these babies in a timely way.

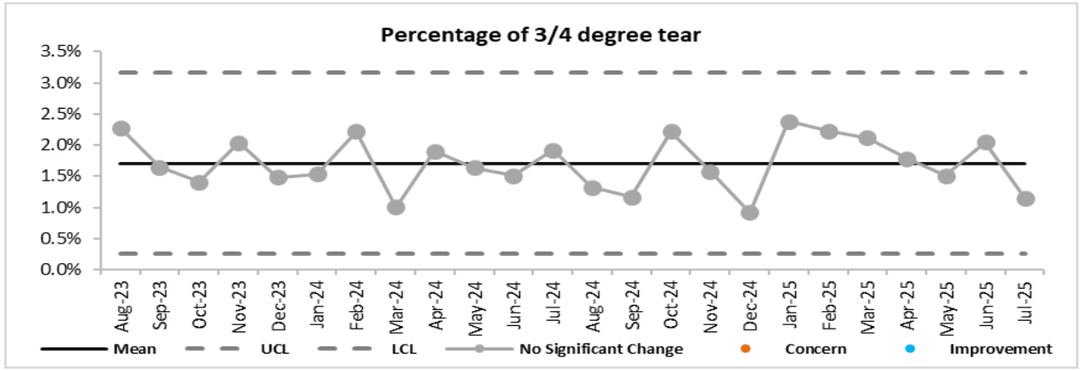
What is the Chart Telling us:

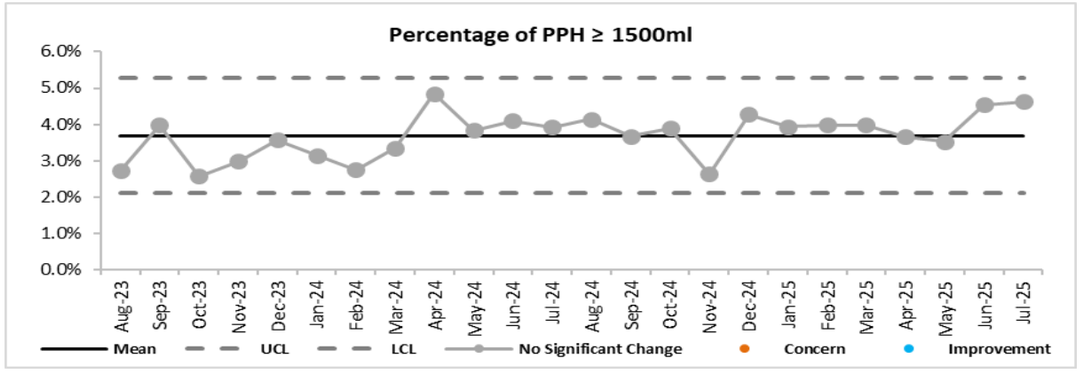
That there were 2 case of HIE grade 2/3 in babies born within and receiving treatment at Barts Health.

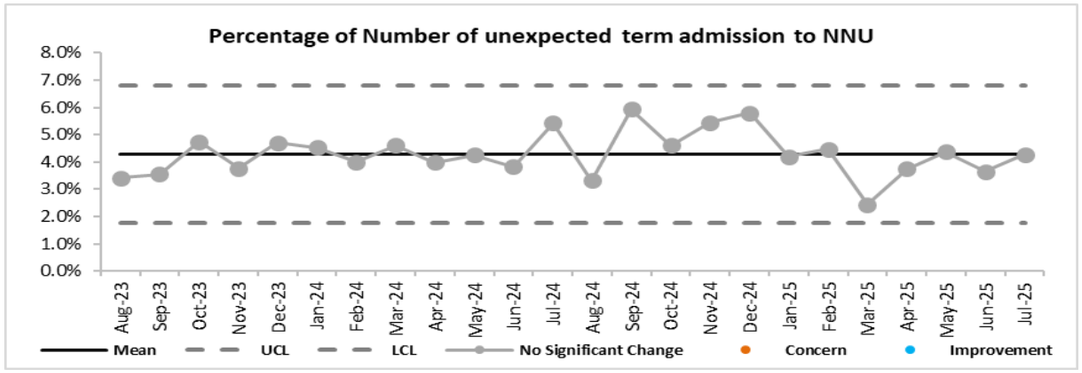
Performance Overview

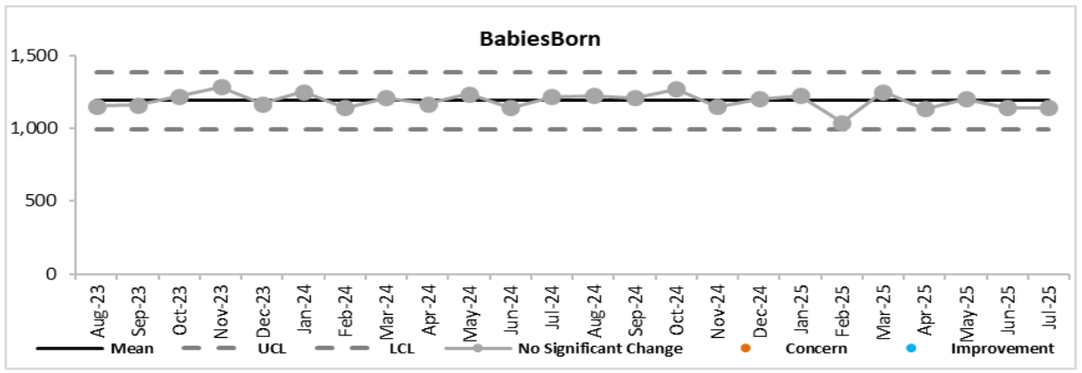
There were two cases of hypoxic brain injury in the month which have been referred to Maternity and Newborn Safety Investigations (MNSI) for investigation. Themes from cases include review of fetal monitoring and escalation of concerns, and capacity and acuity including staffing on the units.

Maternity Signals









Performance Overview	Responsible Director Update
All hospitals have been reporting higher rates of Post Partum Hemorrhage (PPH) than previously. This could be due to recent change in recording all blood loss as measured rather than estimated. Services are reviewing their cases in line with PSIRF principles and have action plans to address them.	Peer reviews of Major Obstetric Hemorrhage (MOH) cases, and to conduct these for losses >1500mls (previously conducted for >2000ml) will help share learning and help identify any themes that have been missed. In addition, Whipps Cross are reviewing blood transfusion practice from last year against this year to understand if this is an increase in accurate reporting or there has been a deterioration in clinical care and morbidity. Results will be shared when available. Themes from peer reviews have identified prolonged second stage of labour, poor compliance to risk assessments, and delays in administration of treatment uterotonics when blood loss is escalating. Loss of situational awareness and escalation have also been identified as problems

Operational Data Summary

Elective Care

- For 2025/26 the NHS has set all Trusts the objective of improving elective care performance, with three Referral to Treatment (RTT) targets, for Barts Health these are, (1) increasing the number and proportion of patients waiting less than 18-weeks for a first outpatient appointment to 68.8% by March 26, (2) increasing the number and proportion of patients waiting less than 18-weeks from referral to first treatment to 60.3% by March 26, and (3) reducing the number and proportion of patients waiting longer than 52-weeks for first treatment to less than 1% by March 26.
- The Trust set annual activity targets to drive improvements. In August, admitted activity exceeded trajectory. Total outpatient activity was marginally below trajectory by 998 appointments (0.7%) below plan, with the largest shortfalls at Royal London and St Bart's. Outpatient procedures showed the greatest variance, 1,153 (4.0%) below plan, mainly at Royal London, Newham and St Bart's.
- For July 25, the Trust had the fifth largest RTT patient tracking list in England and the second largest in London.
- For August 25, the list contained 133,989 total pathways, 392 less than reported in July.
- At the end of August 25, the Trust recorded 329 pathways waiting 65+ weeks, 95 fewer than reported in July. The volume of 52-weeks pathways was 4,508, 169 fewer than reported in July.
- For August 25:
  - The Trust just missed the monthly 18-weeks wait for first outpatient appointment objective, recording 66.0% against the monthlytrajectory of 66.3%
  - The Trust exceeded the monthly 18-weeks wait for first treatment objective, recording 56.2% against the monthly trajectory of 53.8%
  - The Trust did not achieve the monthly 52-weeks objective, recording 3.4% against the monthly trajectory of 2.5%

Operational Delivery Networks (ODN)

- Presentation to GEB on 16th September, phase 1 now business as usual in Gynaecology, Urology and Orthopaedics. Launch of phase two in ENT, Endoscopy and Vascular.
- Subgroups within each ODN presented Improvement plan on a page, which will improve patient access, patient information and awareness.
- ODN Away day planned for 6th October, reviewing achievements of phase 1, launching phase 2 aligning to ODN future strategy and overall ten-year plan ambitions.

Diagnostics

For July 25, Barts Health recorded the second largest Diagnostic Patient Tracking list in England and the largest in London.As a proportion of the Patient Tracking List, Barts Health had the 12th highest proportion of 6+ week waiters out of 17 acute Trusts in London and was ranked the third lowest out of the top 10 English acute Trusts (ranked by Patient Tracking List volume). For August 25, a performance of 71.2% was recorded, with a mean of 75.4%.

Cancer

For 2025/26 the NHS has set two headline cancer standards for all Trusts, (1) improving performance against the 28-day Faster Diagnosis Standard to 80% by March 26, and (2) improving performance against the 62-day standard to 75% by March 26.

- In July 25, the Trust achieved both the monthly Aggregate Faster Diagnosis objective, as well as the March 26 target, recording a performance of 81.1% against the monthly trajectory of 76.1% and the year-end target of 80%.
- While no longer a national objective, during July 25, the Trust achieved the Aggregate 31-day Decision to Treat standard, recording a performance of 98.2% against the previous 96% standard, this is the tenth consecutive month the standard has been achieved.
- For July 25, the Trust achieved the monthly Aggregate 62-day objective, recording a performance of 75.7% against the monthly trajectory of 69.5%.

Urgent & Emergency Care

- For 2025/26 the NHS has set all Trusts the objective of delivering an A&E 4-hour performance standard of 78% by March 26.
- For August 25, Barts Health recorded the highest volume of A&E attendances of any Trust in England as well as the highest volume in London. In terms of performance against the 4-hour standard, the Trust was ranked 15th out of 17 acute Trusts in London and was ranked 8th out of the top 10 English acute Trusts (ranked by volume of attendances).
- In August 25 the Trust did not achieve the monthly 4-hour objective, recording a performance of 72.0% against a monthly trajectory of 74.1%.
- In August, 42,424 attendances were recorded, 3,069 less than the 45,493 recorded in July 25 (-6.7%).
- The proportion of patients with an A&E 12-hour journey time was 8.0% in August against a mean of 8.9%, with the national expectation that this should be a reducing trend.

Domain Scorecard

Performance							Site Comparison				
Metric	This Period	Standards	Latest Value	Mean	This Period Assurance	Variation	Royal London	Whipps Cross	Newham	St Bart's	Data Quality
% RTT patients waiting 52 weeks or more	Aug-25 (m)	<=2.5%	3.4%	3.7%	Hit & miss Standard	No Significant Change	4.0%	4.4%	2.7%	0.1%	
% RTT patients waiting < 18 Weeks for first attendance	Aug-25 (m)	>=66.3%	66.0%	62.4%	Achieving standard	Improvement	65.8%	60.2%	71.3%	73.8%	
% RTT patients waiting no longer than 18 weeks for treatment	Aug-25 (m)	>=53.8%	56.2%	55.4%	Achieving standard	No Significant Change	56.1%	51.7%	58.4%	62.7%	
65+ Week RTT Breaches	Aug-25 (m)	0	329	386	Not achieving standard	No Significant Change	271	44	13	1	
Diagnostic Waits Over 6 Weeks	Aug-25 (m)	>=78.3%	71.2%	75.4%	Hit & miss Standard	No Significant Change	66.3%	89.5%	62.3%	94.4%	
Cancer 28 Day FDS Aggregate	Jul-25 (m)	>= 76.1%	81.1%	75.8%	Achieving standard	Improvement	75.5%	78.3%	88.5%	96.7%	
Cancer 31 Day Aggregate	Jul-25 (m)	>= 96.9%	98.2%	95.9%	Achieving standard	Improvement	96.2%	97.0%	100.0%	98.6%	
Cancer 62 Days Aggregate	Jul-25 (m)	>= 69.5%	75.7%	63.1%	Achieving standard	No Significant Change	71.4%	81.9%	80.3%	71.8%	
A&E 4 Hours Waiting Time	Aug-25 (m)	>= 74.1%	72.0%	70.1%	Hit & miss Standard	No Significant Change	76.8%	66.5%	70.1%	-	
A&E 12 Hours Journey Time	Aug-25 (m)	-	8.0%	8.9%	-	Improvement	6.5%	11.5%	7.0%	-	
Ambulance Handover - Over 60 mins	Aug-25 (m)	-	73	105	-	No Significant Change	22	27	24	-	
Ambulance Handover - Over 30 mins	Aug-25 (m)	-	2,119	2,197	-	No Significant Change	640	651	828	-	

* Mean represents the average value for the latest stable SPC period"

Performance Matrix

Variation	Assurance: Achieving standard	Assurance: Hit and Miss	Assurance: Not Achieving standard
Improving	Cancer 28 Day FDS Aggregate Cancer 31 Day Aggregate % RTT patients waiting < 18 Weeks for first attendance		
No Change	Cancer 62 Days Aggregate % RTT patients waiting no longer than 18 weeks for treatment	A&E 4 Hours Waiting Time % RTT patients waiting 52 weeks or more	Diagnostic Waits Over 6 Weeks 65+ Week RTT Breaches
Deteriorating	-		

Summary Narrative:

Five measures are consistently achieving their target:

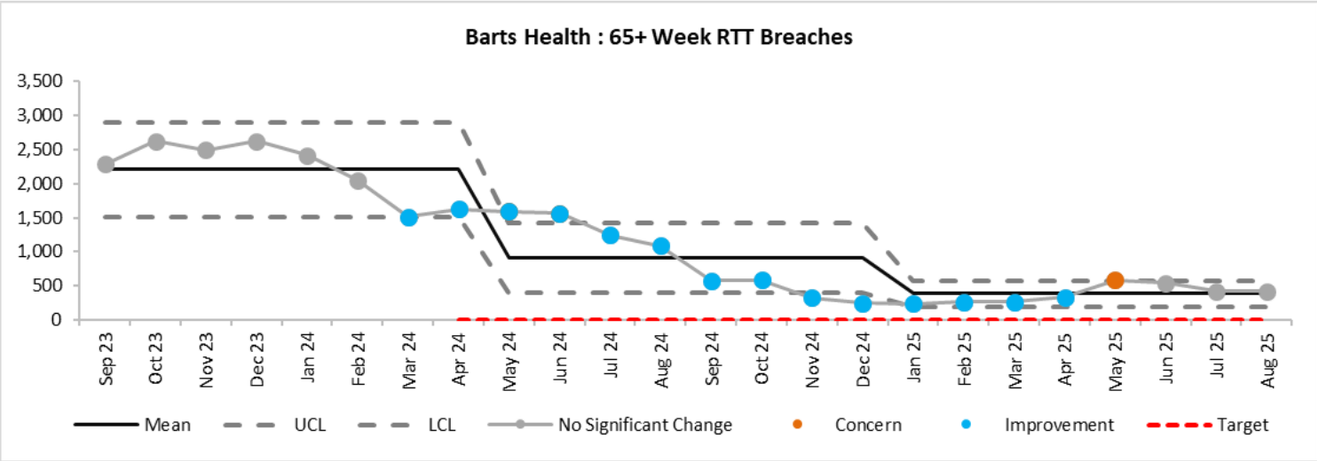
% RTT patients waiting < 18 weeks for first attendance (Improving)
% RTT patients waiting no longer than 18 weeks for treatment (No Change)
Cancer 31-Day Aggregate (Improving)
Cancer 28-Day FDS Aggregate (Improving)
Cancer 62-Day Aggregate (no change)

Three measures are not consistently achieving their targets (Hit and Miss):

% RTT patients waiting 52 weeks or more (No change)
A&E 4-Hour Waiting Time (No change)

Two measures are consistently missing their targets:
65+ Week RTT Breaches (No Change)
Diagnostic Waits Over 6 Weeks (No Change)

65+ Week RTT Performance



Indicator Background:

Since 2022/23 the NHS has set a number of targeted objectives to drive down the number of long-waiting patients, for 2024/25 the national objective was to clear all 65 weeks waiters by September 2024. Due to the persistent nature of the Barts Health backlog a reduction trajectory is current being managed in partnership with NHS England, supported by a two-weekly meeting.

What are the Charts Telling us:

The SPC chart presents a period of no significant change in the volume of 65+ week waiters from September 23 to February 24. However, decreases in the volume of 65+ week wait patients and therefore an improving trend is consistently recorded across the period March 24 to April 25. There is then one data point (May 25) recording a concern (increasing volume). This increase relates solely to the implementation of the new LUNA patient tracking list technology, thereby resolving several data quality issues. Data then stabilises across the period June to August 25.

Trust Performance Overview

At the end of August 25, the Trust recorded 329 pathways waiting 65+ weeks, 95 fewer than reported in July.

Trust Responsible Director Update

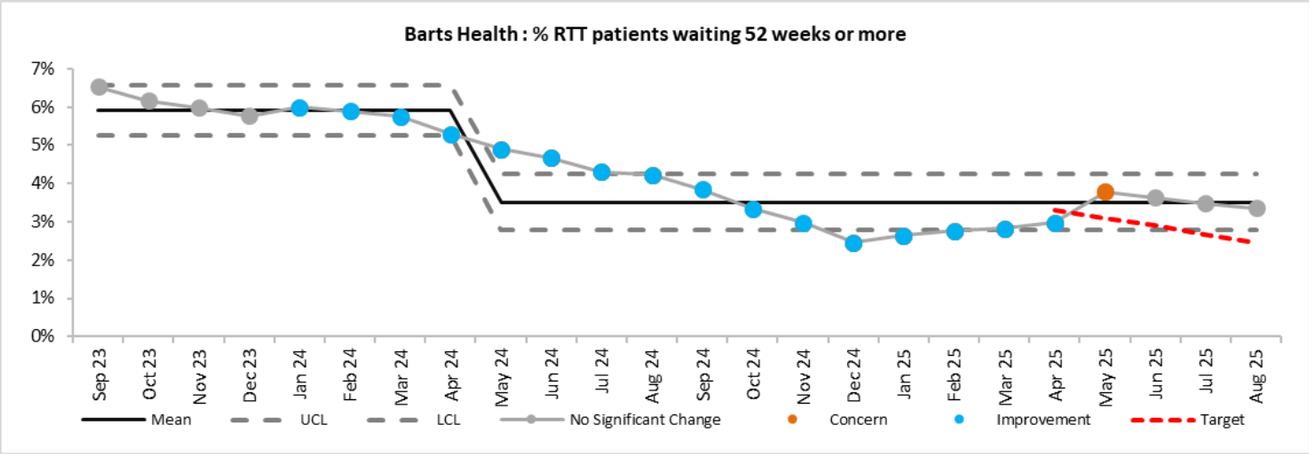
The Trust has reduced 65-week breach volumes by 256 pathways between June and August. A significant increase in capacity throughout September is intended to deliver a breach volume no greater than 150 at the end of September.

Non-admitted and admitted waiting list initiatives have been established at the Royal London Hospital to support a reduced dataset in Oral surgery, Paediatric Dentistry, ENT and Vascular. The team have also delivered additional activity through increasing cases per list in month and have implemented a standard operating procedure which enables activity to be suspended across low risk/low week wait specialities which in turn releases theatre sessions for high-risk specialties. This approach has been endorsed through Hospital Executive Boards and the Surgical optimisation and Assurance Group chaired by the Chief of Surgery. Regular patient contact has enabled timely movement and scheduling of patients where short notice additional capacity has been deployed.

Operational and clinical validation targeting non-admitted and mid-pathway diagnostics is yielding earlier identification of clock stops in patient pathways. A peer review process has been established in recent months to support and challenge specialities in the application of the local access policy rules and will continue as a supportive measure as we move into quarter three elimination plans.

The Trust is committed to delivering less than 150 breaches at the end of September, although recognises there is risk of patients converting from outpatient and diagnostic pathways. Delivery plans are being prepared aligned to the national request to eliminate 65-week waits by mid-December.

% RTT patients waiting 52 weeks or more



Indicator Background:

For 2025/26 the NHS has set a renewed focus on improving compliance with the 18-weeks Referral to Treatment standard. Additionally, as long waiting backlog has been reduced across 104, 78 and 65 week waits there is also a renewed focus on reducing 52-week waiters. By March 26 the NHS has set an expectation that no greater than 1% of the total waiting list will be waiting over 52 weeks.

What are the Charts Telling us:

The chart is telling us that across the period September to December 23 there is no significant change in the volume of 52-week waiters, with a reduction (improving trend) visible between January 24 to April 25, however an increased volume (triggering a concern) is then visible in the data in May. The increased volume of 52-week waiters in May relates solely to the implementation of the new LUNA patient tracking list technology during May 25, thereby resolving several data quality issues. For the period June to August 25 volumes stabilise resulting in a period of no significant change.

Trust Performance Overview

The volume of 52-weeks pathways was 4,508 at the end of August, 169 fewer than reported in July.

Trust Responsible Director Update

Since June 2025, the Trust has reduced the 52-week wait cohort by 386 pathways. The total PTL percentage volume of 52 week waits in August was 3.4%, an adverse variance of 0.9% against plan.

The specialities impacting performance in August were Vascular, Paediatric Dermatology and Paediatric Dentistry. Retrospective clinical triage has commenced in Vascular, which will see circa 2500 pathways clinically triaged, in line with the new clinical guidelines introduced for the management of varicose veins. The Trust anticipates approximately 50% of this patient cohort will be discharged back to the care of their GP with advice. As the triaging concludes in the coming weeks the benefit of the process will be transacted and reflected in our PTL.

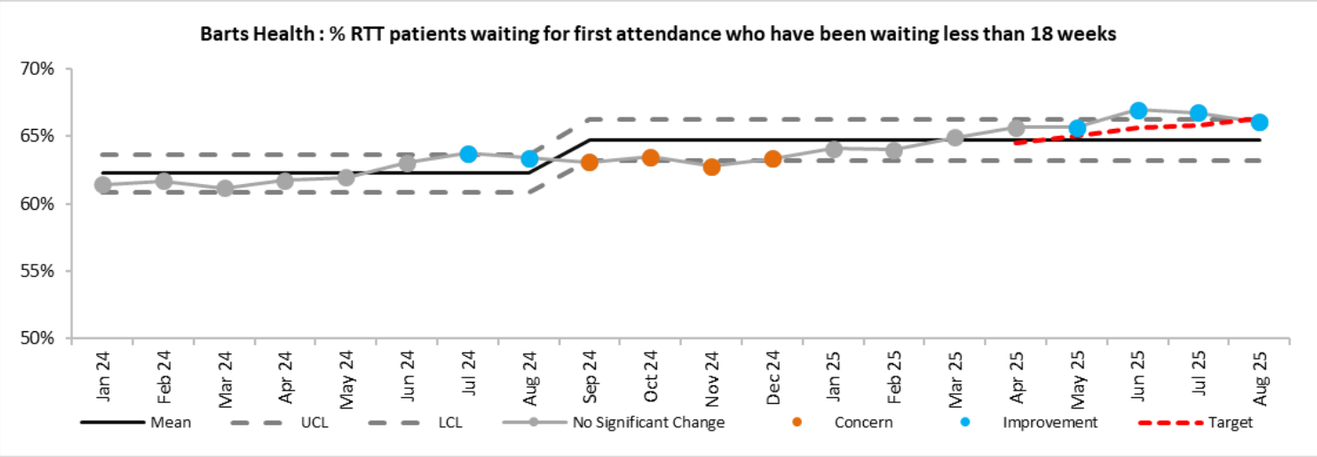
Insourcing capacity continues to support high volume, low complexity pathways in vascular surgery, ENT and Oral Surgery. The contract ceases at the end of September, with positive impacts across the PTL observed in ENT and Vascular. Paediatric Dentistry and Paediatric Dermatology will benefit from additional activity established at the Royal London Hospital. A wider review of paediatric services is required to understand the drivers and medium- and longer-term mitigations required.

An ENT delivery group has been established which is focused on productivity, booking and scheduling and clinical design. The development of a single point of access model for head and neck/paediatric services at the Royal London and high volume, low complexity cases streamlined to Whipps Cross is intended to drive overall service improvements.

A series of deep dives have been prepared and presented through the tier 1 process and these service reviews have focussed on high-risk specialities to date. Paediatric and General Surgery deep dives will be progressed next as they are featuring as two services contributing to the 52-week breach volume.

% RTT patients waiting for first attendance who have been waiting less than 18 weeks

INCREASING PERFORMANCE AND PRODUCTIVITY – ELECTIVE CARE



Indicator Background:

For 2025/26 the NHS has set a renewed focus on improving compliance with the 18-weeks Referral to Treatment standard. A key enabler is improving compliance with 18-weeks from referral to first outpatient appointment, with a Trust level target of 68.8% to be achieved by March 26.

What are the Charts Telling us:

Performance operates within a relatively tight band, within a range of 60% to 67%, with the majority of data points classified as no significant change. However, four improving data points are visible across May to August 25. It should be noted that May 25 represents the first month of LUNA implementation, a new patient tracking list technology, which has supported resolution of several data quality issues.

Trust Performance Overview

For August, the Trust just missed the monthly 18-weeks wait for first outpatient appointment objective, recording 66.0% against the monthly trajectory of 66.3%.

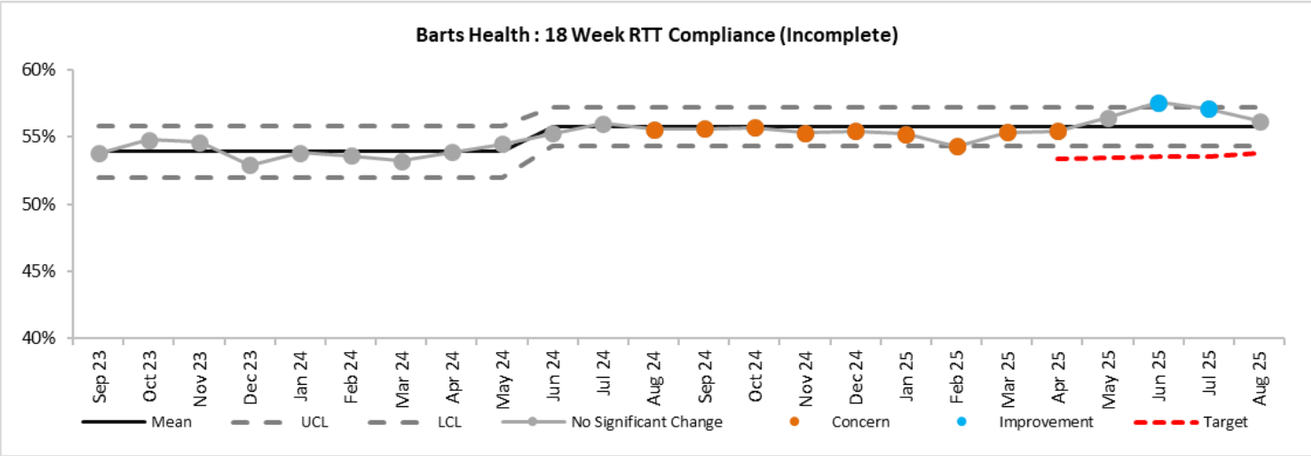
Trust Responsible Director Update

Progress against this metric has been positive since May. August performance deteriorated due to the impact of seasonality factors over the summer months.

Respiratory was furthest behind plan in August. A service deep dive has been completed with encouraging improvements observed at Whipps Cross with the introduction of advice and guidance, additional outpatient activity through locum appointments and implementing Patient Initiated Follow Up (PIFU). Sleep studies are a recognised pressure point for many Providers, St Bartholomews and Whipps Cross teams are working collaboratively to reduce delays within the sleep study pathway.

A review of General Surgery will be completed to understand demand and capacity across the group and consider options to improve the elective metrics aligned to year end delivery. Cardiology demand has increased in recent weeks, the St Bartholomews team are investigating the root causes and will consider mitigations to respond to where required.

18 Week RTT Compliance (Incomplete)



Indicator Background:

For 2025/26 the NHS has set a renewed focus on improving compliance with the 18-weeks Referral to Treatment standard. Requiring an improvement in the percentage of patients waiting no longer than 18 weeks from referral to treatment to 65% nationally by March 2026, with every Trust expected to deliver a minimum 5 percentage point improvement, for Barts Health the March 26 objective is 60.3%.

What are the Charts Telling us:

The chart is telling us that performance between September 23 to July 24 was a period of no significant change, however this was followed by a period of reducing performance, across the period August 24 to April 25, triggering a concerning trend. The most recent period, May to August 25, records variable performance with two data points recording an improvement and two no change. Throughout the entire data period performance operates within a relatively tight range of between 53% and 57%. During May the trust implemented the new LUNA patient tracking list technology, thereby resolving several data quality issues.

Trust Performance Overview

For August, the Trust exceeded the monthly 18-weeks wait for first treatment objective, recording 56.2% against the monthly trajectory of 53.8%

Trust Responsible Director Update

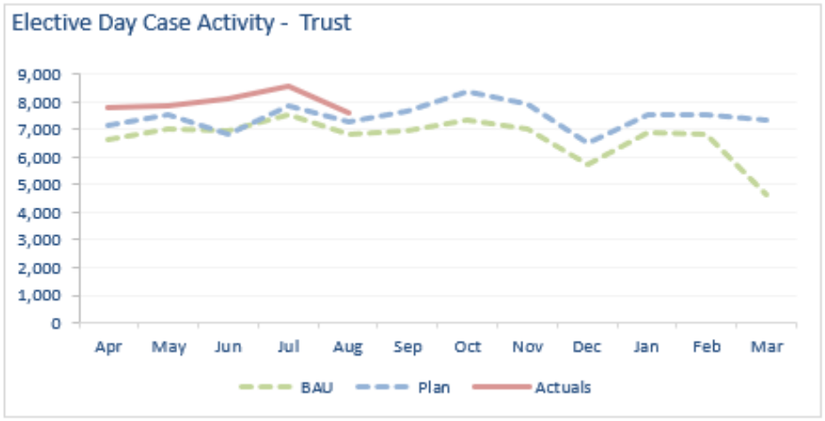
The Trust is ahead of trajectory and showing positive improvements in this standard. Improvement has been observed in all specialities with only respiratory being 2.4% adverse to their plan, this speciality is now the only non-complaint speciality against the plan.

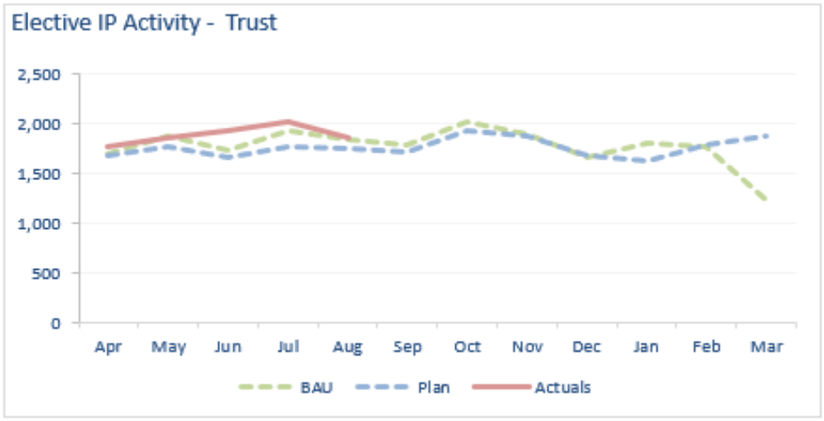
Focussing on operational and digital validation and ensuring all activity has an outcome early in the patient's pathway is critical to improved performance and reducing pathways tipping into longer wait bands. Deep dives across the high-risk specialities have set out their ambition to improve performance linked to the year end elective performance metrics. Streamlining our most challenged clinical pathways and improving productivity in line with Getting It Right First Time (GIRFT) recommendations are critical elements that will support the Trust achieving the year end metrics.

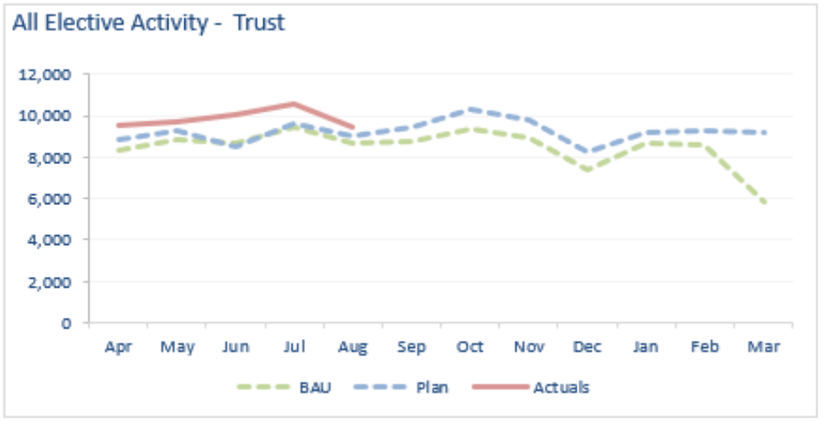
The Operational Delivery Networks are driving key elements of performance and productivity where performance needs to improve aligned to business planning trajectories. GIRFT are supporting the development of the ENT single point of access model which will see the service implement best practice aligned to increasing new outpatient appointments, accelerating PIFU pathways, reducing new to follow up ratios and improving theatre cases per session.

Admitted Activity against Plan

INCREASING PERFORMANCE AND PRODUCTIVITY – ELECTIVE CARE







		Barts Health						Last Month's Site Position				
		Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Royal London	Whipps Cross	Newham	St Bart's	Other
All Elective Activity	Plan	8,916	8,855	9,318	*8,469*	9,613	**9,049**	*3,992*	*1,717*	*1,314*	*2,026*	-
	Actuals	8,779	9,426	9,550	*9,799*	10,127	**9,452**	*4,043*	*1,874*	*1,213*	*2,322*	-
	Mth variance plan	*-137*	*571*	*232*	*1,330*	*514*	*403*	*51*	*157*	*-101*	*296*	-
Elective Day Case Activity	Plan	7,292	7,179	7,541	*6,801*	7,847	**7,298**	*3,358*	*1,417*	*1,021*	*1,502*	-
	Actuals	7,105	7,663	7,678	*7,881*	8,102	**7,593**	*3,438*	*1,505*	*836*	*1,814*	-
	Mth variance plan	*-187*	*484*	*137*	*1,080*	*255*	*295*	*80*	*88*	*-185*	*312*	-
Elective IP Activity	Plan	1,624	1,676	1,777	*1,668*	1,766	**1,751**	*634*	*300*	*293*	*524*	-
	Actuals	1,674	1,763	1,872	*1,918*	2,025	**1,859**	*605*	*369*	*377*	*508*	-
	Mth variance plan	*50*	*87*	*95*	*250*	*259*	*108*	*-29*	*69*	*84*	*-16*	-

Data as at 26/09/2025

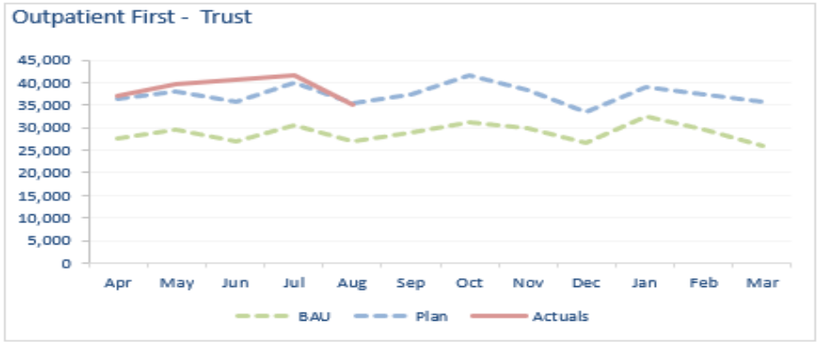
Performance Overview

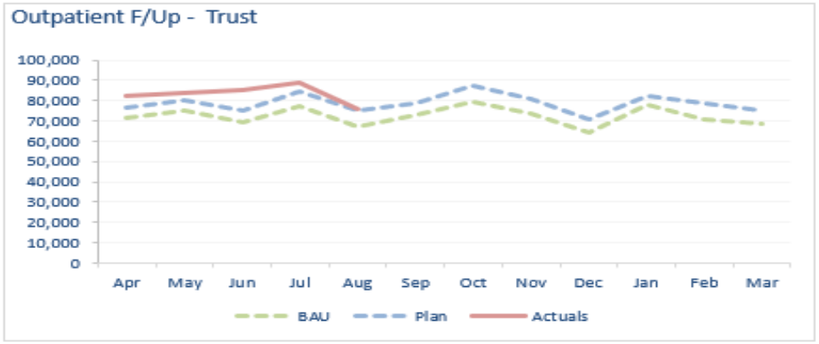
- For 2025/26 the NHS has set all Trusts elective activity targets designed to pivot towards 18-week performance improvement.
- Elective activity for the first five months of the financial year is tracking against planned levels of activity across the Barts Health group.
- For August 25, the Trust admitted (inpatient and day case) trajectory set a target of 9,049 admissions against which the Trust delivered 9,452 (+403 admissions).

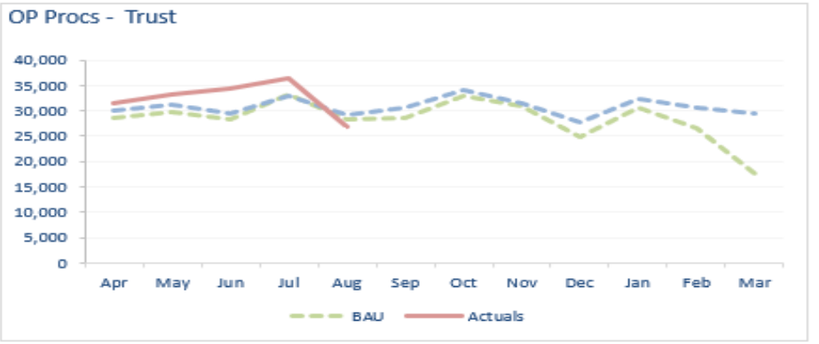
Responsible Director Update

- At the end of August, there were 133,989 open referral to treatment pathways. This is a further reduction on the position in June (134, 686) and July (134,381)
- Elective activity across Barts Health continues to exceed plan. Royal London, Whipps Cross and St Barts have all exceeded planned levels of activity in August, with a slight underperformance at Newham Hospital.
- The Trust is working with the GIRFT and Emergency Care Improvement Support Team (ECIST) teams in the delivery of an integrated improvement plan for ENT. Monthly "drumbeat" meetings with GIRFT commenced in September. These are supported by the ENT Delivery Group, which brings together hospital operational and clinical leads for ENT across the Group. The key areas of focus include improving equity of access across the Group for outpatient and surgical appointments, the management of demand with appropriate capacity, improving the interface with the community provider and the implementation of PIFU pathways.

Non-Admitted Activity against Plan







Data as at 26/09/2025

		Barts Health						Last Month's Site Position				
		Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Royal London	Whipps Cross	Newham	St Bart's	Other
Total OP Activity	Plan	134,435	143,016	149,725	140,665	157,267	**139,743**	*60,320*	*30,538*	*22,738*	*26,147*	*0*
	Actuals	138,401	154,662	160,543	158,591	163,901	**138,745**	*59,178*	*31,724*	*22,583*	*25,235*	*25*
	Mth variance plan	*3,966*	*11,646*	*10,818*	*17,926*	*6,634*	***-998***	*-1,142*	*1,186*	*-155*	*-912*	*25*
Outpatient Attendances (All) - First Attendance Excluding Procedures	Plan	32,769	36,375	38,082	35,777	40,000	**35,543**	*15,010*	*10,310*	*4,660*	*5,563*	*0*
	Actuals	33,981	36,950	39,451	*40,148*	*40,919*	**35,424**	*14,605*	*10,984*	*4,663*	*5,172*	*0*
	Mth variance plan	*1,212*	*-254*	*283*	*4,371*	*919*	***-119***	*-405*	*674*	*3*	*-391*	*0*
Outpatient Attendances (All)- Follow-Up Attendance Excluding	Plan	74,973	76,711	80,310	*75,450*	*84,355*	**74,955**	*33,611*	*14,512*	*14,259*	*12,573*	*0*
	Actuals	78,741	82,271	83,918	*85,172*	*89,099*	**75,229**	*33,756*	*14,902*	*14,281*	*12,269*	*21*
	Mth variance plan	*3,768*	*6,272*	*5,145*	*9,722*	*4,744*	***274***	*145*	*390*	*22*	*-304*	*21*
Outpatient Attendances (All)- with a Procedure	Plan	26,692	29,929	31,333	*29,437*	*32,912*	**29,245**	*11,699*	*5,716*	*3,819*	*8,011*	*0*
	Actuals	25,679	31,320	33,050	*33,314*	*33,910*	**28,092**	*10,817*	*5,838*	*3,639*	*7,794*	*4*
	Mth variance plan	-1,013	5,629	5,436	*3,877*	*998*	***-1,153***	*-882*	*122*	*-180*	*-217*	*4*

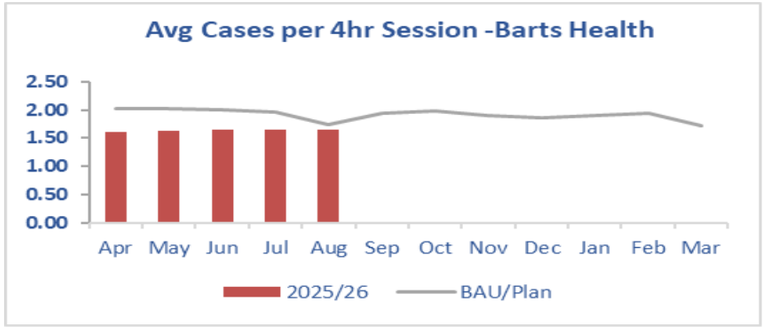
Performance Overview

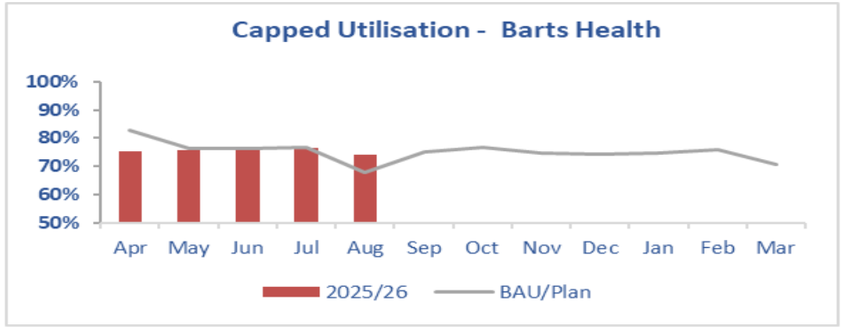
- For 2025/26, the NHS has set all Trusts elective activity targets designed to pivot towards 18-week performance improvement.
- For the first five months of the year total outpatient activity has exceeded plan, however for August total outpatient activity was 998 appointments (0.7%) below plan, with the largest shortfalls at Royal London and St Bart's.
- First outpatient activity across the group is tracking against plan in three of the five months year to date, with underperformance recorded in April and August. For August, the trust was marginally below plan (119 appointments, 0.3%), the largest shortfalls recorded at Royal London and St Bart's.
- Outpatient procedures showed the greatest variance, 1,153 (4.0%) below plan, mainly at the Royal London, Newham and St Bart's.

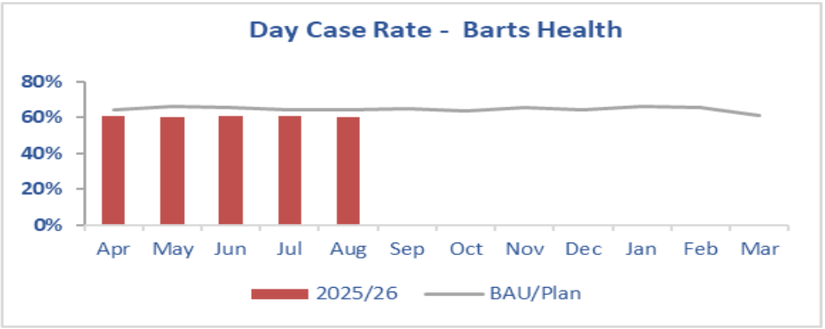
Responsible Director Update

- The Trust Did Not Attend (DNA) rate for August 2025 was 10.4%. Our DNA rate for the first 4 months of the year remains below the 12% average DNA rate for 24/25. This has been achieved with the implementation of Dr Doctor, which includes text message reminders to patients. Further improvements have plateaued in the last two months. Each hospital has been asked to review DNA position and identify opportunities to improve DNA rates over the next 3 months. Discussions at the Outpatient Board identified seasonal variation (summer holiday) as a potential contributing factor to DNA rates Approximately 70% of clinics are now configured to connect to Dr Doctor. Clinic template changes and re-profiling will enable the remainder of clinics to be connected to Dr Doctor during this financial year.
- Rapid Improvement work in Respiratory medicine commenced on 16th September with a joint workshop with clinical and operational leads from across all Hospital sites. This was an interactive session that used data to understand challenges to long wait times. Key themes include managing demand through A&R and community spirometry, diagnostics and how to use PIFU in a more effective way. As part of the 12-week programme, observation days are being booked in the coming weeks to finalise tests of change, driven by short- and medium-term productivity goals.
- In September 2025, GIRFT published guidance on improving Clinic Templates in Outpatients. Barts Health is aligned with the approach set out in the guidance, driven by the Clinic Template Optimisation Project. The Trust has used a benefits tracker to quantify productivity gains from this project, which include reduction in DNA rates across the cardiology Network (21% to ~5%); increases in new appointment capacity in orthopaedics (+15/week) and reduction in follow-ups activity in gastroenterology (–20/week).

Theatre Utilisation







Theater Efficiency Activity

		Barts Health						Last Month's Site Position			
		Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Royal London	Whipps Cross	Newham	St Bart's
Avg Cases per 4hr Session	Actuals	1.59	1.60	1.60	1.63	1.65	1.65	1.57	2.23	1.97	1.04
	BAU	1.90	1.94	1.72	2.03	2.01	1.74	1.71	2.22	2.06	1.05
	Mth variance plan	*-0.31*	*-0.34*	*-0.12*	*-0.40*	*-0.36*	*-0.09*	*-0.14*	*0.01*	*-0.09*	*-0.01*
Capped Utilisation	Actuals	74.6%	75.2%	75.4%	75.8%	76.1%	74.0%	74.3%	66.4%	75.4%	81.0%
	BAU	74.9%	76.0%	71.1%	76.4%	76.5%	67.8%	69.2%	62.1%	62.5%	73.2%
	Mth variance plan	-0.2%	-0.8%	4.3%	-0.6%	-0.3%	6.3%	5.1%	4.3%	13.0%	7.8%
Day Case Rate	Actuals	59.3%	59.4%	59.0%	60.0%	60.6%	60.1%	61.5%	70.8%	71.8%	15.8%
	BAU	66.1%	65.6%	61.2%	65.9%	65.7%	64.2%	65.9%	77.9%	67.3%	16.2%
	Mth variance plan	-6.8%	-6.2%	-2.2%	-5.9%	-5.1%	-4.1%	-4.4%	-7.1%	4.5%	-0.5%

Data as at 20/08/2025

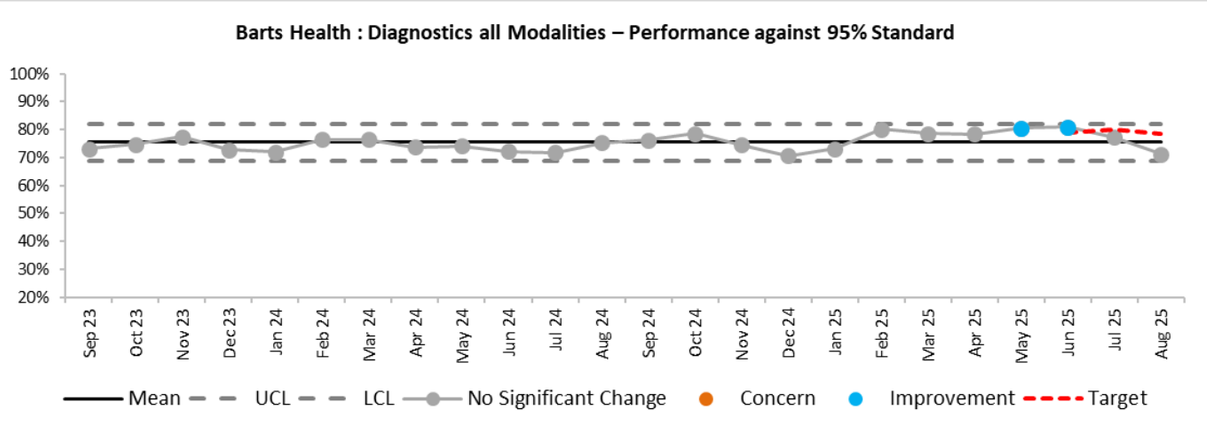
Performance Overview

- Set against internal Trust data for August, 1.65 cases per list were achieved against a BAU of 1.74 (-0.09%).
- For the same month, a capped utilisation rate of 74.0 was recorded, against a BAU of 67.8% (-6.3%) with a day case rate of 60.1% recorded against a BAU of 64.2% (-4.1%).
- Average cases per list have remained stable over the last 6 months but continue to track below the 19/20 BAU average. However, this has not impacted negatively on theatre utilisation, which for the period March to July 25 remained above 75%, however for August this fell to 74.0%. Day case rates are stable at around 60%. This is lower than 19/20 BAU levels, increasing case complexity and a shift from day case to outpatient procedures influences comparison with 19/20 BAU.

Responsible Director Update

- Whipps Cross Hospital have submitted evidence to NHSE for surgical hub accreditation. The NHSE accreditation visit takes place on Tuesday 7th October. The visit will involve 15 min introduction presentation about the surgical hub followed by tours of the area and interviews with staff and patients. There will be a debrief and feedback on the day. The NHSE accreditation panel meets on 13th November.
- The Central BIU team presented a speciality level benchmarking report to the Surgical Optimisation Group in September. This facilitates inter Trust/Site/Speciality benchmarking. This also enables hospitals and services within the group to benchmark capped theatre utilisation and average cases per list and to understand where there are opportunities for improvements in productivity. Data is available to support comparison with GIRFT standards for cases per list.
- The pre-operative assessment workstream on the Theatres Improvement Programme has agreed plans to complete e-consent roll-out and switch off paper consent for all procedures, including non-surgical procedures, by June 2026.
- The care co-ordination solution (CCS) for theatre booking and scheduling is in place at Royal London Hospital, Whipps Cross andNewham. Implementation plans have been agreed for roll-out to St Barts Hospital and the Dental Hospital. Proposal for moving CCS to a 'business as usual' tool are being developed and will be discussed by the Surgical Optimisation Group in October. These proposals will support and enable the close down of the implementation project in March 2026.

Diagnostic Waits Over 6 Weeks



Trust Performance Overview

- Diagnostic waiting time performance has been steadily improving across the Barts Health Group since December, however, capacity challenges in imaging modalities has led to a reduction in performance in July and August.
- For August, 71.5% diagnostic tests were undertaken within 6 weeks, with a mean of 75.4%.
- The diagnostic waiting list has reduced in August to 33,969 from 34,822 in July.
- National benchmarks for diagnostic waiting lists are available for July 2025. Barts had the 2nd largest diagnostic waiting list in England and the 4th largest in London.
- In July, as a proportion of the diagnostic waiting list, Barts Health had the 12th highest proportion of 6+ week waiters out of 17 acute trusts in London.
- Diagnostic (DM01) waiting list performance for Barts Health is ranked 3rd against the top 10 acute Trusts with the largest waiting lists in England.
- In July 2005, the North East London Health System was ranked 4th best performing system in England for diagnostic waiting times.

Indicator Background:

During the period when Referral to Treatment was being introduced across the NHS three key stages of treatment were identified, each to take no longer than six weeks, 18 weeks in total. The three key stages of treatment were:

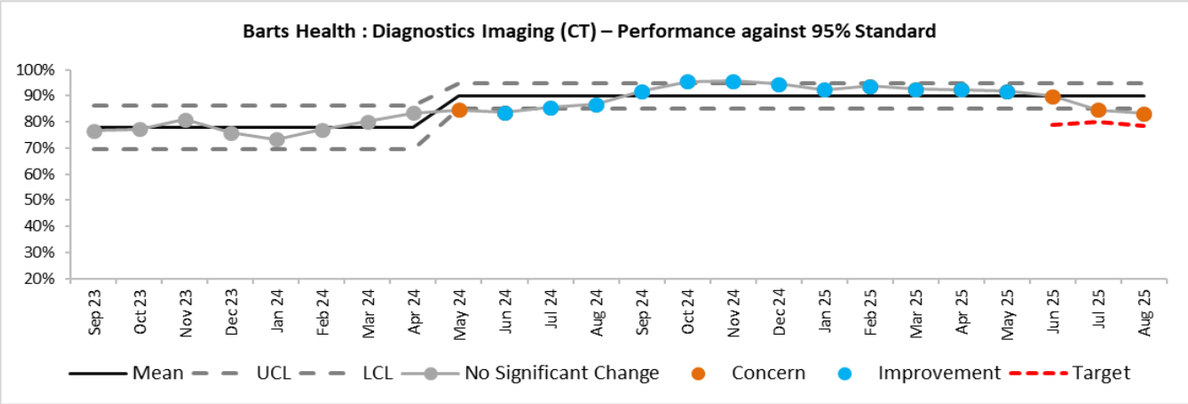
1. Outpatient Pathway
2. Diagnostic pathway
3. Admitted pathway

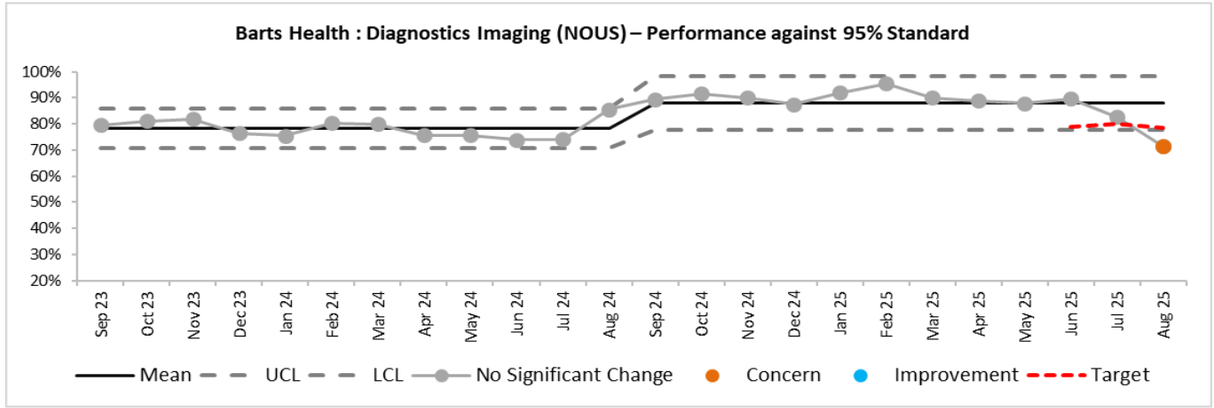
As part of the drive to reduce overall waiting times a 6-week maximum wait was set to receive a diagnostic test following referral for a test with an operational standard set of 99% of patients receiving their test within 6-weeks. The standard applies to a basket of 15 diagnostic modalities across imaging, endoscopy and physiological measurement. As part of the Covid pandemic recovery process a target of 95% was set across the NHS to be achieved by March 2025. No national standard has been set for 2026/27.

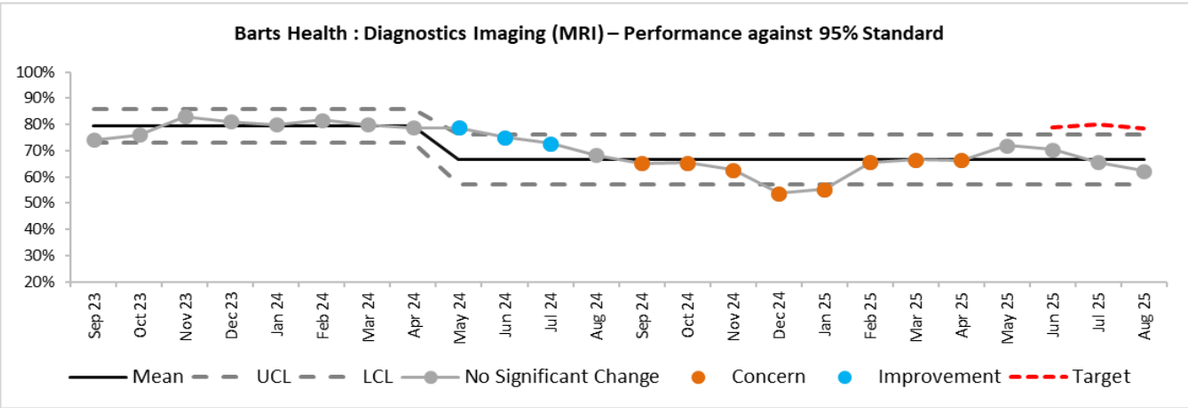
What is the Chart Telling us:

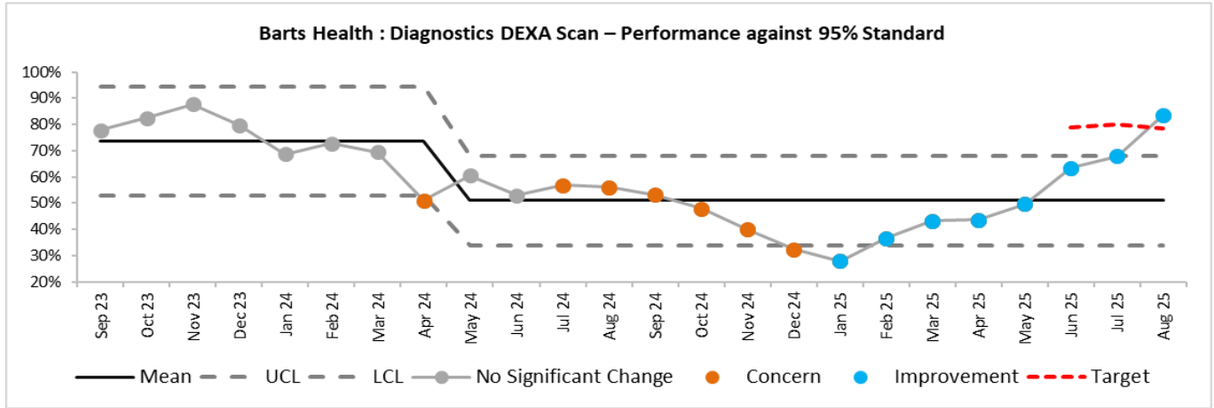
The chart presents a relatively narrow range of performance variability for the period September 2023 to August 2025, with performance operating just above or below the mean, in effect operating within a 10% band from 70% to 80%. In statistical process control terms, there is no significant change across the entire date range, apart from an improving trend recorded across May and June 25, however a reduction in performance of 9.8% is recorded across July and August, with August recording 71.2% against June's 81.0%.

Diagnostic Waits Over 6 Weeks





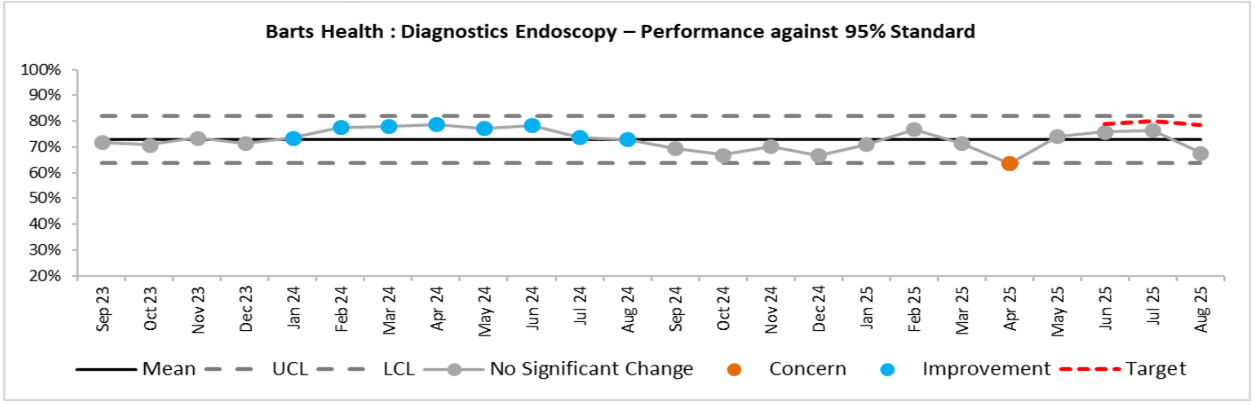


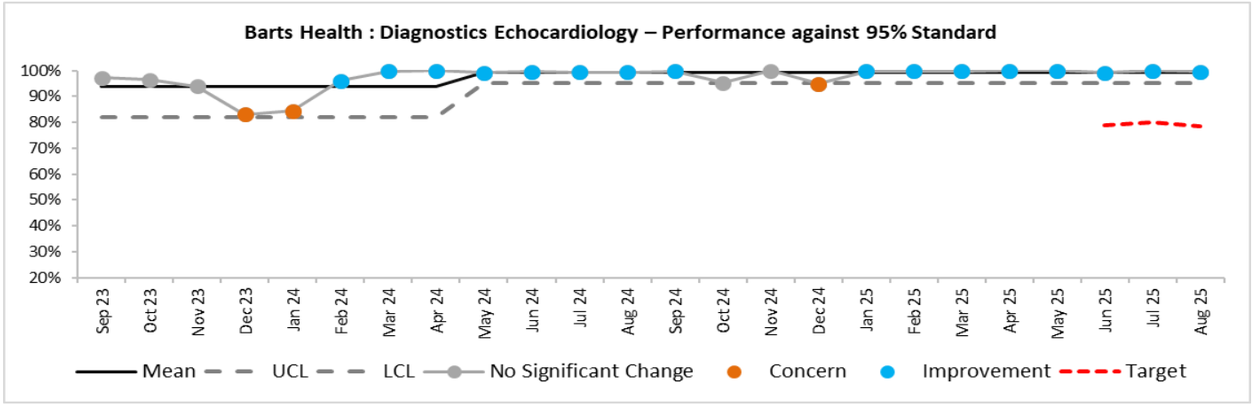


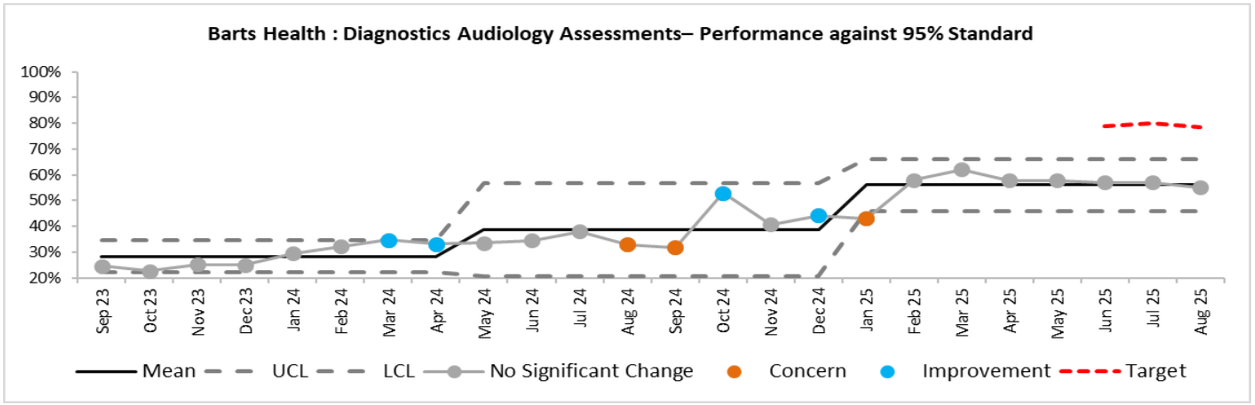
Trust Responsible Director Update

- MRI performance against the DM01 standard remains challenged and has deteriorated at Royal London, Whipps Cross and Newham in August. Recruitment to the new MRI scanner at Newham continues with NHS capacity expected to be fully available in October. A detailed review of the Barts Health's MRI service was commissioned by the Group Imaging Board in April 2025. This followed a review of the three core imaging modalities (CT, MRI, and NOUS) which identified MRI as the modality with the highest risk across the group. The initial phase of the review has focused on acquisition capacity and demand from 2022 to 2027. The outcome of the review is being presented to the Group Imaging Board in September and includes recommendations for optimising existing capacity, reducing variation in operating hours and addressing unfunded capacity.
- The withdrawal of access to the Integrated Care Board (ICB) funded contracted with OMNES continues to impact on waiting times for non-obstetric ultrasound (NOUS). Access to capacity within the independent sector has been reduced due to financial pressures and significant overperformance against the ICB contract baseline. NHS London have undertaken a review of NOUS across the capital as all London systems are struggling to provide NOUS within the 6-week waiting time standard. Additional NOUS capacity will be available in the Mile End CDC from October. However, recruitment to sonography vacancies across Barts Health is challenged and poses a risk to full utilisation of all available capacity. A deep dive into NOUS demand and capacity has commenced across Barts Health and will report to the Group Imaging Board in November.
- The impact of the loss of a CT scanner at Newham Hospital continues to have an impact on CT performance across the Group. Additional capacity has been provided from the Mile End Hospital (90 per month), but this has not mitigated the loss of around 480 slots per months. Newham Hospital are finalising plans to secure a mobile scanner from an independent sector provider. The final stage business case for the replacement of the condemned CT scanner at Newham will be submitted to NHSE at the end of September. This business case is expected to be approved, and a new scanner will be in situ by April 2026.

Other Diagnostic Waits Over 6 Weeks







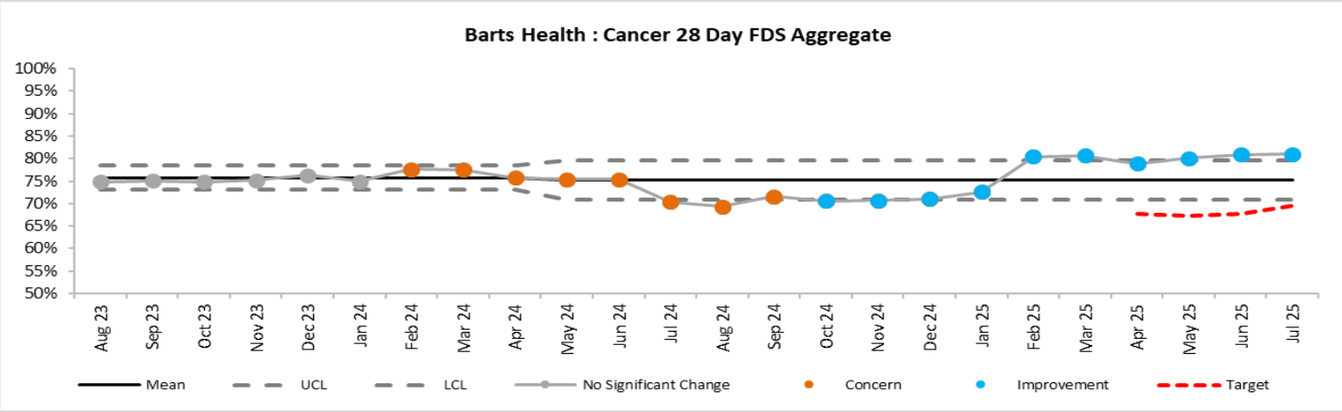
DM01 Breakdown by Test

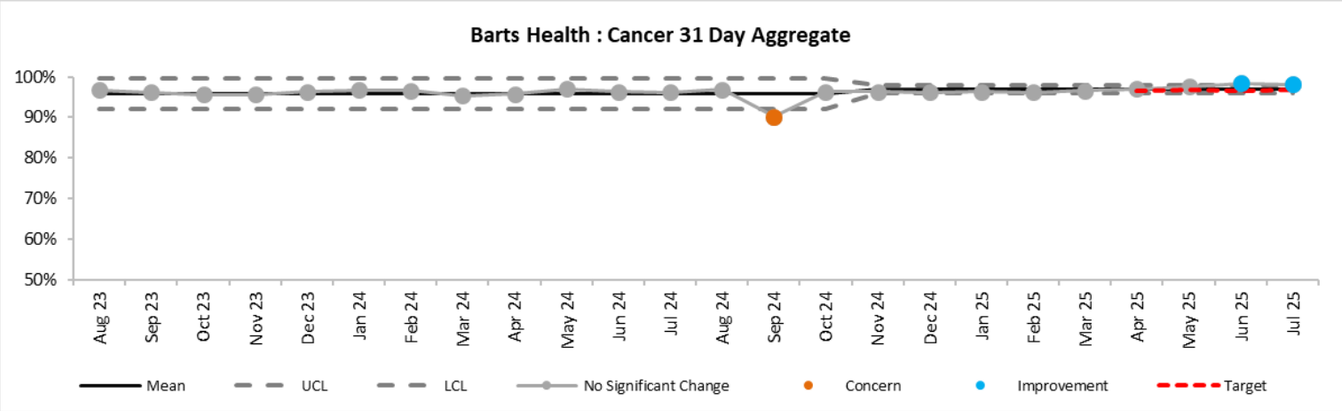
	Jul-25			Aug-25			
Test Name	**Waiting**	**Breaches**	**Performance**	**Waiting**	**Breaches**	**Performance**	**Variance in Performance**
Cardiology - Electrophysiology	1	0	100.0%	3	3	0.0%	-100.0%
Cystoscopy	450	265	41.1%	473	286	39.5%	-1.6%
Respiratory physiology - sleep studies	219	79	63.9%	185	89	51.9%	-12.0%
Urodynamics - pressures & flows	227	80	64.8%	216	102	52.8%	-12.0%
Audiology - Audiology Assessments	2,835	1,218	57.0%	2,415	1,084	55.1%	-1.9%
Gastroscopy	1,561	401	74.3%	1,264	454	64.1%	-10.2%
Flexi sigmoidoscopy	339	45	86.7%	259	85	67.2%	-19.5%
Colonoscopy	1,378	166	88.0%	1,213	210	82.7%	-5.3%
Neurophysiology - peripheral neurophysiology	135	5	96.3%	161	3	98.1%	1.8%
Cardiology - echocardiography	1,545	0	100.0%	1,389	6	99.6%	-0.4%
Grand Total	**8,690**	**2,259**	**74.0%**	**7,578**	**2,322**	**69.4%**	**-4.6%**

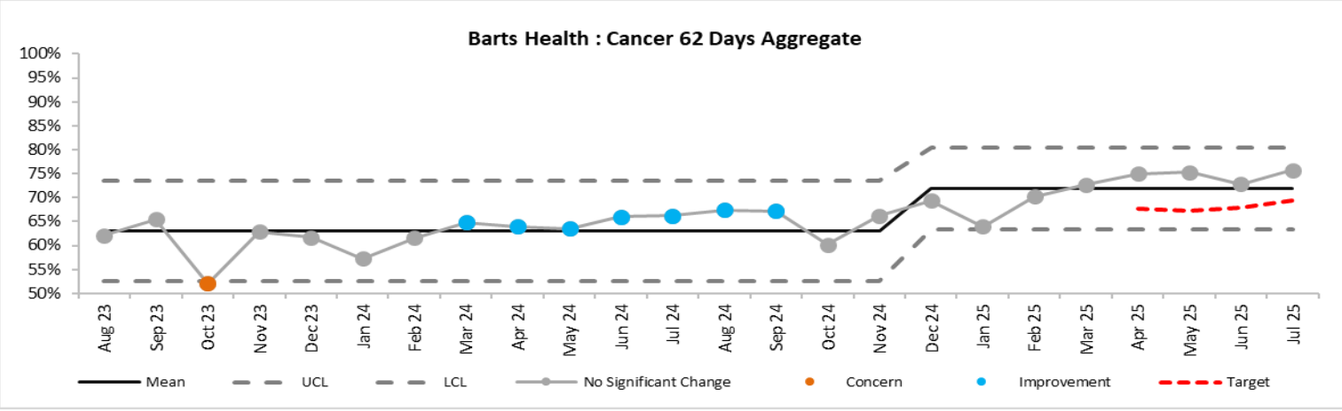
Trust Responsible Director Update

- Consultant vacancies at Newham Hospital have led to a reduction in endoscopy performance. A new consultant commences in post in November.
- The Endoscopy ODN held its first 'away day' on 12 September. Medical, nursing and operational leaders from across Barts Health attended to session. There was a high level of engagement and enthusiasm for working together across the Group to address challenges as a network together. Actions were agreed to develop a single point of access and booking function for routine endoscopy appointments. Opportunities to develop nurse endoscopists across the network were identified to improve recruitment, retention, training and development. There was a commitment to improve productivity on endoscopy lists and book to a standard points system across the Group. The ODN will meet monthly to track actions. A weekly endoscopy utilisation and scheduling meeting has been established to support the work of the ODN.
- A procurement plan for securing a paediatric audiology insourcing partner has been agreed. This should enable a new provider to be in place before the end of the year. With the support of an in-sourcing partner, the service aims to reduce the backlog over the next 6-9 months and return to a compliant DM01 position.
- Actions taken to deliver consistently high performance in echocardiology at Barts Health have been shared with NHSE national and regional colleagues.

Cancer Waiting Times Standards







The national targets Trusts will be measured against for Cancer performance in 2025/26 are:

- 80% 28-day Faster Diagnosis Standard (FDS) aggregate by March 2026
- 75% 62-day treatment aggregate by March 2026

In July 25, the Trust achieved both the monthly Aggregate Faster Diagnosis objective, as well as the March 26 target, recording a performance of 81.1% against the monthly trajectory of 76.1% and the year-end target of 80%. The Trust position benchmarked against other London providers was 8/19. The Trust position benchmarked against national providers was 31/118. North East London were the 2nd best Cancer Alliance in England with an aggregated performance of 80.6%.

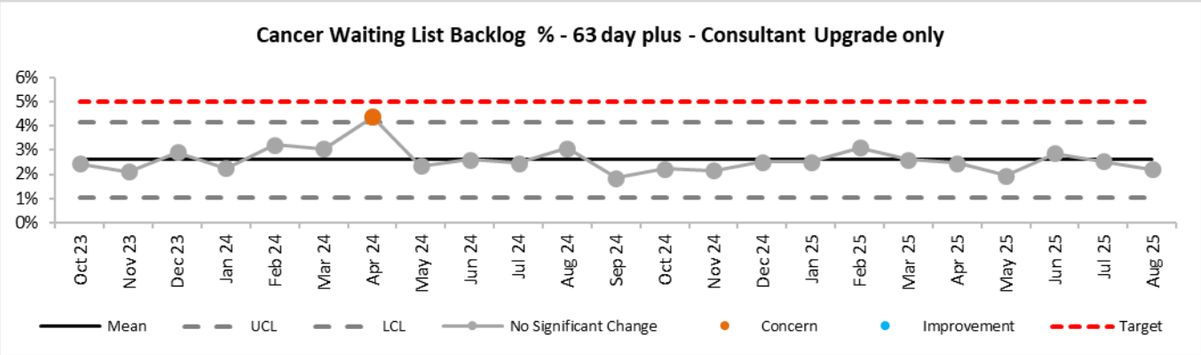
While no longer a national objective, during July 25, the Trust achieved the Aggregate 31-day Decision to Treat standard, recording a performance of 98.2% against the previous 96% standard, this is the tenth consecutive month the standard has been achieved. The Trust position benchmarked against other London providers was 10/20. North East London were the 3rd best performing Cancer Alliance in England with an aggregated performance of 96.5%.

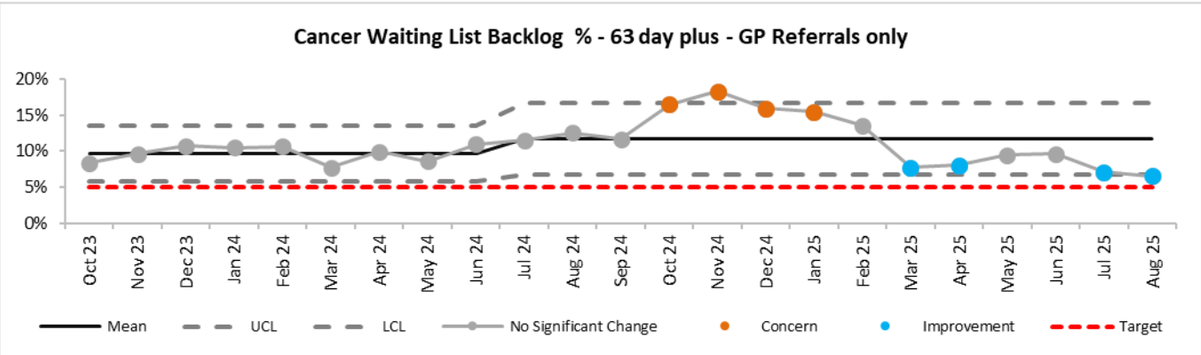
For July 25, the Trust achieved the monthly Aggregate 62-day objective, recording a performance of 75.7% against the monthly trajectory of 69.5%. The Trust position benchmarked against other London providers was 10/20. The Trust position benchmarked against national providers was 34/118. North East London were 7/20 on performance across Cancer Alliances in England with an aggregated performance of 72.9%.

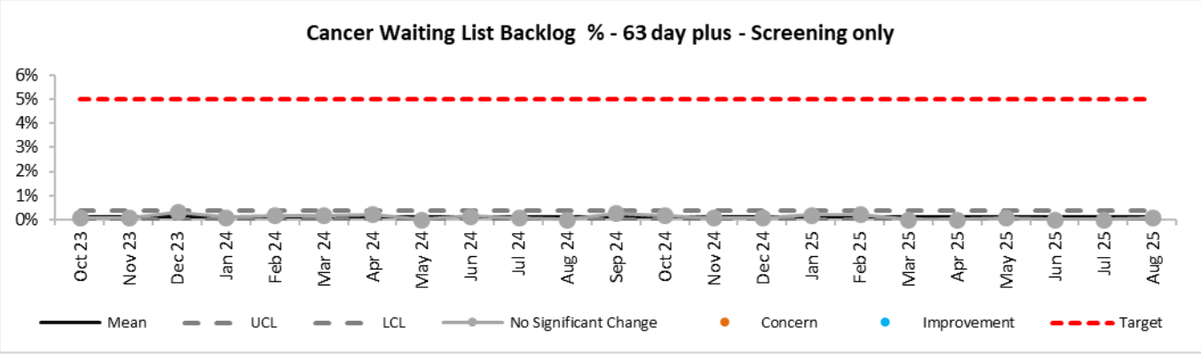
The most recent submitted backlog position (w/e 21.09.25) was 6.47%.

During June and July 2025, a significant increase was observed on the number of referrals for patients on an urgent and suspected cancer pathway 4917 and 5125 respectively. Previous monthly referral numbers are around are typically around 4200 – 4500 analysis is being understand what is driving this and which tumour groups are seeing ongoing growth.

Cancer 63 Day Plus Waiting List Backlog %







Indicator Background:

The NHS has for many years set a standard that 85% of patients urgently referred by their GP for suspected cancer or urgently referred from a cancer screening programme or by a consultant upgrading the urgency of the referral should be treated within 62 days. Managing a reduction in long waiting 63-104+ days pathways is key to improving outcomes for patients and waiting times overall.

What is the Chart Telling us:

The three charts break out 63-day+ backlog for GP referrals as well as for Consultant Upgrade and Screening referrals. One of the charts, Screening referrals (bottom chart), presents effectively zero or single figure breaches (0% as a proportion of the waiting list), meaning there has been virtually no backlog recorded over the course of the charts time-series.

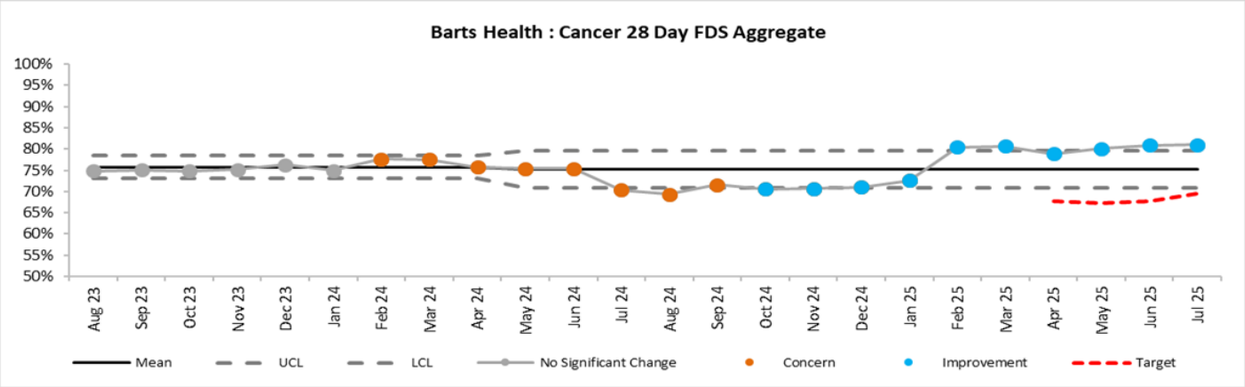
However, despite Consultant Upgrade breaches (top chart) being maintained at a relatively low volume and proportion, circa 2-3%, over the course of the chart's time series there has been no significant change for virtually the entire reporting period.

For GP referrals (middle chart), there is a period of no change between October 23 to September 24, followed by a concerning trend between October 24 and January 25. This is followed by variable performance with the next six months characterised by four improving data points and two no change data points, with July and August showing improvement.

Trust Performance Overview

- The charts opposite represent the 456 cancer patients waiting longer 63-days at the end of August 2025, an increase of eight against the July 2025 position of 448. Of the 448, 94 of the patients are waiting over 104+ days.
- The charts present the number of patients waiting by GP referrals (332), Consultant Upgrade (109) and Screening service referrals (15).
- In August 2025, the specialties with the highest number of patients waiting longer than 63 days were; Urology (127), Colorectal (89), Gynae (75) and Head and Neck (43).

Cancer Faster Diagnosis Standard Metrics (FDS)



Indicator Background:

The 28-day Faster Diagnosis standard requires at least 77% of people who have been urgently referred for suspected cancer, have breast symptoms, or have been picked up through cancer screening, to have cancer ruled out or receive a diagnosis within 28 days.

The 28-day Faster Diagnosis standard replaced the former 2-week to first appointment standard and is considered a better measure for clinical care and patient experience. The two-week wait target simply measured the time from referral to seeing a specialist, it did not measure waiting times for diagnostic tests, results reporting and for the patients to be told whether or not they have cancer. However two-week waiting times continue to be reported to the NHS and are included on a later slide.

Trust Performance Overview

In July 25, the Trust achieved both the monthly Aggregate Faster Diagnosis objective, as well as the March 26 target, recording a performance of 81.1% against the monthly trajectory of 76.1% and the year-end target of 80%.

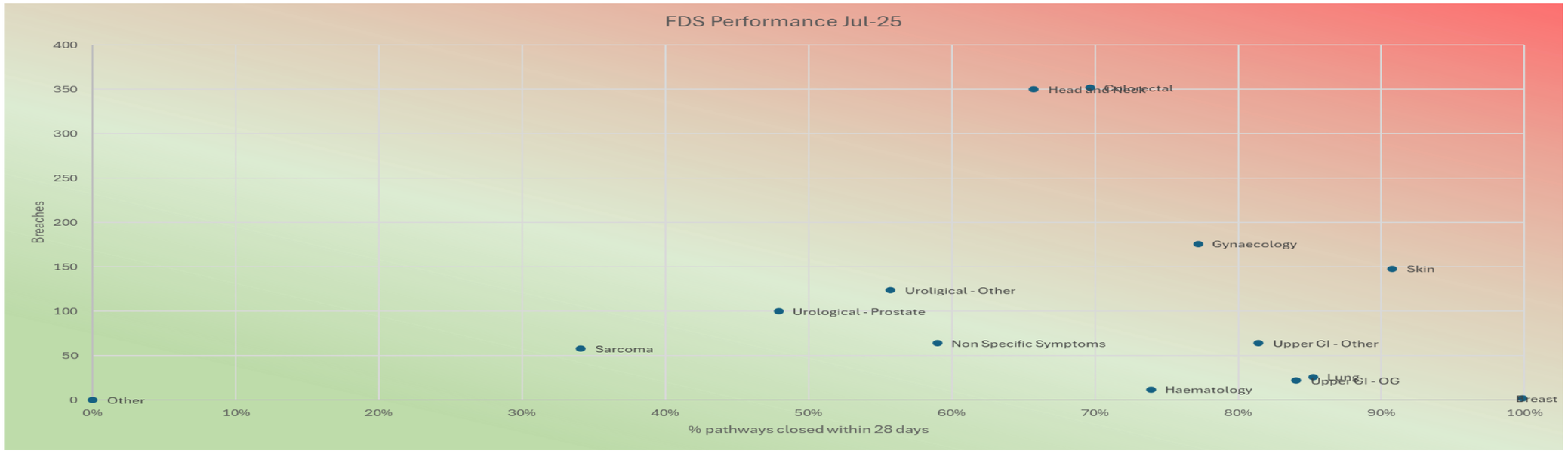
What is the Chart Telling us:

The chart presents two significant periods, February to September 2024 where reducing performance triggered a concern, and October 2024 to July 2025 where performance recorded an improving trend, particularly from February 2025. For most of the time series performance operates within an extremely tight margin of between 65% to 80%, a 15% band. However, for the period February to June 25 performance pushes up to 80%. 80% is the March 26 national objective with this threshold achieved across the period February to July 25, apart from 79.0% recorded in April 25.

Trust Responsible Director Update

- FDS performance continues to be strong and is above the monthly trajectory as well as the standard the trust is expected to deliver by March 2026. The final position for August 2025 will be submitted on 01.10.25 . The current provisional position is 80.3% and it is hoped that this may further improve through validation before final submission.
- In July 2025, the performance position at each hospital for FDS was; 96.7% SBH, 78.3% WX, 88.5% NUH, 75.5% RLH. The position for RLH continues to show an improving trajectory which is supported by recovery in Gynae, Head and Neck and maintaining a strong position in colorectal and Upper GI.
- NEL Cancer alliance service development funding that was underutilised during Q1 2025/26 has been repurposed to support recruitment to clinical nurse specialist support at RLH for H&N. The Cancer alliance have been working with GPs on the quality of referrals to help manage demand coming through this pathway.
- The Urology Deep Dive will be held w/c 06.10.25 and led by the Group Clinical Director for Cancer. A pack has been prepared to support the conversation with clinical and operational teams and to understand what actions can be taken to improve the position. These actions will be tracked through the Drive to 85 group which meets fortnightly and reports to the Trust Cancer Board.
- A Cancer equity dashboard has been developed, and this is due to be discussed at the next Drive to 85 meeting on 02.10.25 to understand what the data is telling us and consider how we might use this across the organisation.
- The Single point of access presented the IPOP in September to the ODN Board, with the plan to launch in Q3 starting with Prostate and Haematuria, which is linked to the Community Diagnostic Centre (CDC) opening.
- The Hysteroscopy working group presented the IPOP in September, which is looking to change pain control offered to patients, this is being presented to Formulary and Pathways Group (FPG). A new patient video has been launched and all hospitals are now using E Consent.

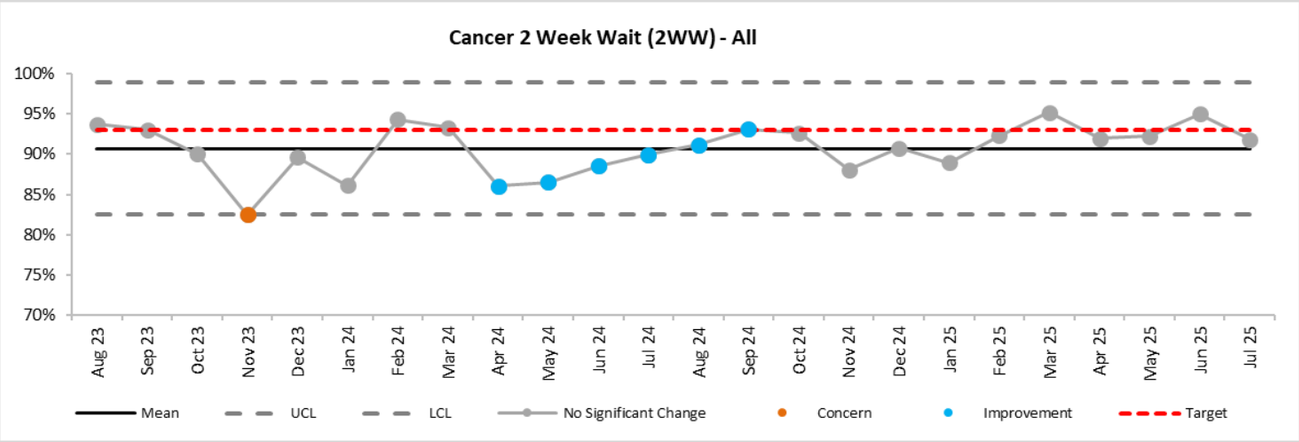
Cancer Faster Diagnosis Standard Heat Map



Month	Breast	Colorectal	Gynaecology	Haematology	Head and Neck	Lung	Non Specific Symptoms	Other	Sarcoma	Skin	Upper GI - OG	Upper GI - Other	Uroligical - Other	Urological - Prostate	Total
Jul-25	-150	85	-2	1	115	-1	40	-	37	-220	-10	-16	59	55	-330
Jun-25	-146	62	10	10	136	-7	-	1	36	-237	3	20	67	44	-305
May-25	-143	128	51	9	136	2	21	-	-8	-229	-9	-19	92	64	-240
Apr-25	-119	158	48	9	135	8	10	-	-16	-216	-2	29	51	45	-146
Mar-25	-121	74	80	11	3	-9	3	3	13	-200	3	54	74	36	-264
Feb-25	-129	24	10	6	62	3	21	1	116	-153	-9	-2	73	41	-233
Jan-25	-87	207	219	-2	40	36	27	-1	74	-170	20	14	141	63	303
Dec-24	-127	288	189	-3	6	8	222	2	40	-154	11	44	116	59	386
Nov-24	-123	284	205	1	24	-3	157	75	41	-167	17	4	161	53	437
Oct-24	-102	507	179	2	69	-1	35	30	13	-210	23	31	131	48	474
Sep-24	-121	373	153	3	118	10	28	40	32	-188	38	19	85	19	333
Aug-24	-100	380	146	11	106	17	41	79	39	-205	49	32	111	27	494

Cancer First New (2WW)

INCREASING PERFORMANCE AND PRODUCTIVITY - CANCER



Cancer 2WW Breakdown by Site - Jul-25

Site	Seen	Breaches	Performance	Target
Royal London	1,145	221	80.7%	93.0%
Whipps Cross	1,998	81	95.9%	93.0%
Newham	709	17	97.6%	93.0%
St Bart's	392	28	92.9%	93.0%
Barts Health	**4,244**	**347**	91.8%	**93.0%**

Indicator Background:

The 28-day Faster Diagnosis standard replaced the former 2-week to first appointment standard and is considered a better measure for clinical care and patient experience. The two-week wait target simply measured the time from referral to seeing a specialist, it did not measure waiting times for diagnostic tests, results reporting and for the patients to be told whether or not they have cancer. However two-week waiting times continue to be reported to the NHS and are included on this slide.

What is the Chart Telling us:

The chart presents significant performance variability across the 24-month time series, the target was achieved in seven months and not achieved in seventeen. However, an improving trend is recorded across the period April to September 2024. But the more recent data points between October 24 to July 25 record a period of no significant change.

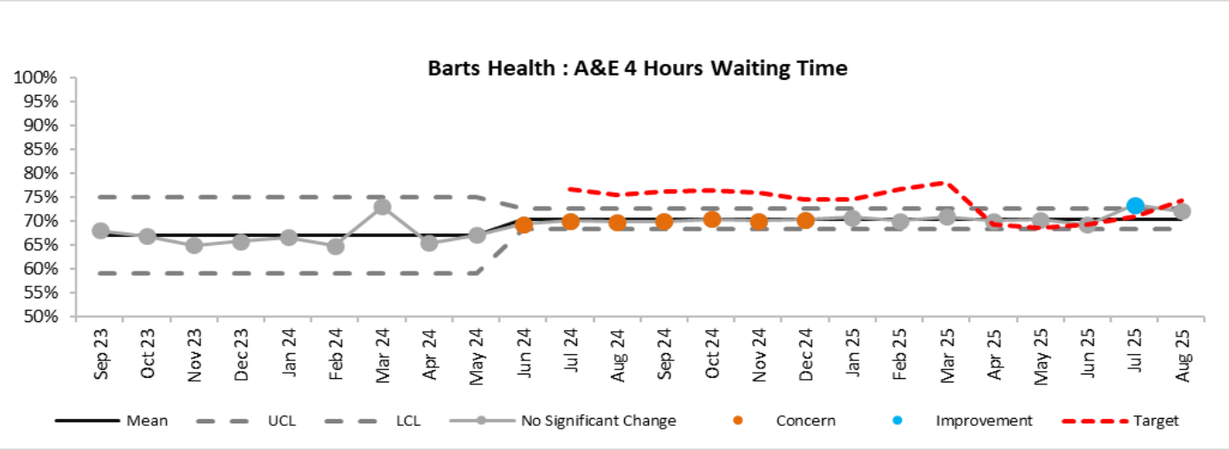
Trust Performance Overview

The Trust did not achieve the former 93% standard in July 25, recording a performance of 91.8%.

Trust Responsible Director Update

- July 2025 performance was at 91.8%, a deterioration of 3.3%
- At Royal London 2 week wait demand has increased for Urology and Skin and a review of referrals is being undertaken with the support of BIU to try and understand this is more detail. If required, the Cancer Alliance will be asked to support next steps.
- At SBH, Breast was a challenge during July due to staffing in Breast Radiology. This is expected to improve over the coming months
- A meeting is planned with secondary and primary care clinicians during October 2025 to discuss the mechanism for ensuring there is robust communication when it is considered that a referral does not need intervention from secondary care.

A&E Performance against 4 Hour Waiting Time



Indicator Background:

The A&E four-hour waiting time standard requires patients attending A&E to be admitted, transferred or discharged within four hours. From 2010 the four-hour A&E waiting time target required that at least 95% of patients were treated within four-hours. As a consequence of the impact of the Covid pandemic, during December 2022 an intermediary threshold recovery target of 76% was set to be reached by March 2024 with further improvement expected in 2024/25, now set at 78% by March 2025, the 78% target has also been set for March 26. Fundamentally the four-hour access target is a clinical quality and patient experience measure.

What is the Chart Telling us:

Over the course of the time series performance against the 4-hour standard has been consistent, operating within a relatively narrow range of 65% to 75%, with most of the data points operating just on or close to the mean of just under 70%. The highest performance during the time-series is recorded in March 24.

During April 24 performance reduced significantly against March's exceptionally high performance, with a new patient administration module deployed at this time, however for the period June 24 to June 25 there is no significant change, however July's data records an improvement before slightly falling away in August.

Trust Performance Overview

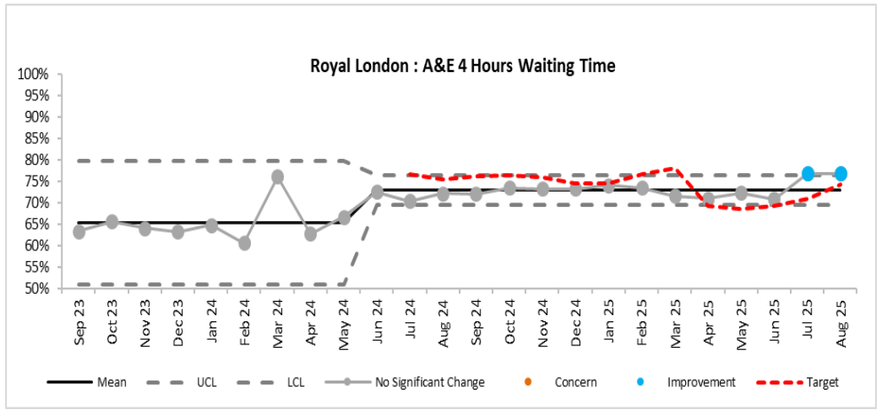
- For 2025/26 the NHS has set all Trusts the objective of delivering an A&E 4-hour performance standard of 78% by March 26.
- For August 25, Barts Health recorded the highest volume of A&E attendances of any Trust in England as well as the highest volume in London. In terms of performance against the 4-hour standard, the Trust was ranked 15th out of 17 acute Trusts in London and was ranked 8th out of the top 10 English acute Trusts (ranked by volume of attendances).
- In August 25 the Trust did not achieve the monthly 4-hour objective, recording a performance of 72.0% against a monthly trajectory of 74.1%.
- In August, 42,424 attendances were recorded, 3,069 less than the 45,493 recorded in July 25 (-6.8%).

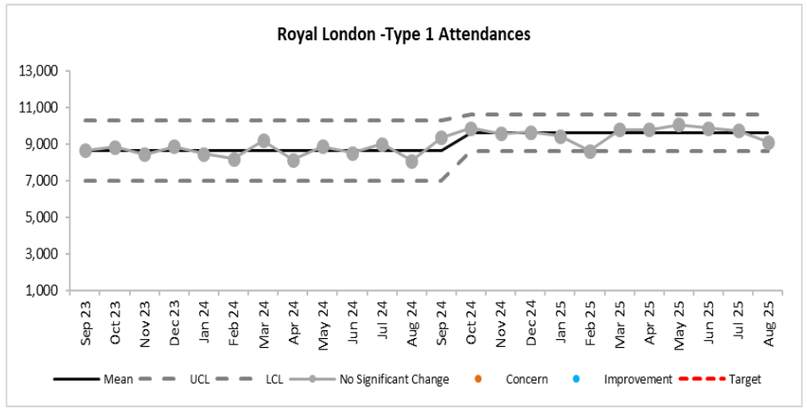
Trust Responsible Director Update

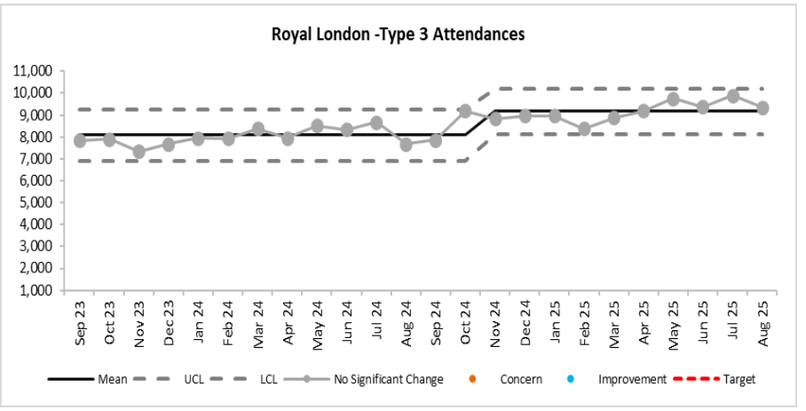
- **Overall Trust performance:** In August Trust performance was 72.0%, a stable position Trust wide with the Trust ranked 15 out of 17 London reporting Trusts on the four-hour standard, and 8/10 nationally for performance of the largest. A&Es in the country. In August Barts Health saw the highest number of A&E attendances in England.
- **Urgent Treatment Centre (UTC) performance:** Type 3 performance improved to 93.20%. Both RLH and NUH saw an increase in performance to 91.4% and 93.0%, WXH performance remained static 98.5%. NEL are undertaking a UTC review including a tendering process to understand productivity, value for money and best service for patients. This work will support Barts Health to improve performance in this area, and the Trust is an active stakeholder in this process.
- **Type 1 Admitted performance:** Type 1 admitted performance declined to 17.1%, with WXH at 7.5%, NUH at 15.5% and RLH at 25.8%. Our admissions continue to decline with 399 less admissions than July.
- **Type 1 Non-admitted performance:** Type 1 Non admitted performance for the Trust was 63.2%, 2.8% down on July. This was driven by a 5.3% decline at the NUH and a 3.2% decline at WXH. Whilst the RLH position remains static at 69% in August this is the second consecutive month there has been performance of this level and performance is 11.8% higher than August 24. Work is continuing on the development and utilisation of Same Day Emergency Care pathways as well as working with support services to improve access to diagnostics.
- **Attendances**: In August we saw 42,424 attendances. Type 1 non-admitted attendances remain our highest number of attendances, and our front door teams are focussing on alternative pathways to redirect this group of patients.
- **Ambulances:** We continue to see an increase in Ambulance activity across our Hospitals. Across Barts Health 64.71% of Ambulances were handed over within 30 minute. Work is continuing across all of the Hospitals to eradicate 60 minute breaches.

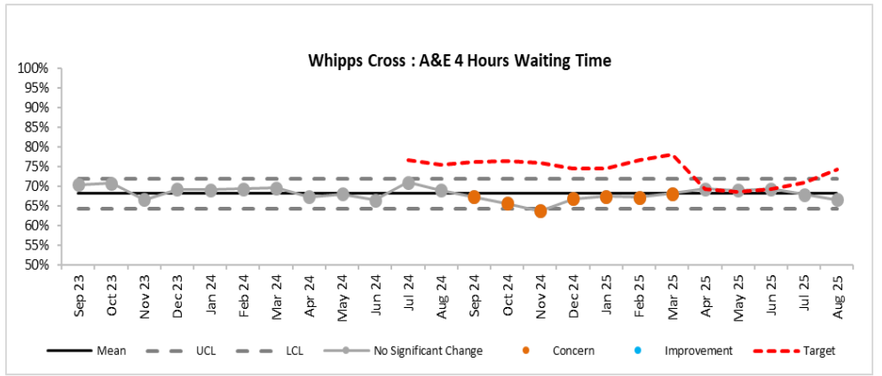
A&E Attendances & Performance against 4 Hour Waiting Time

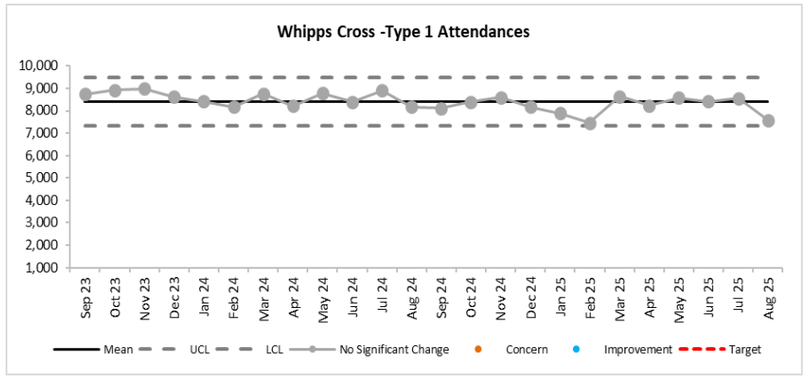
INCREASING PERFORMANCE AND PRODUCTIVITY URGENT AND EMERGENCY CARE

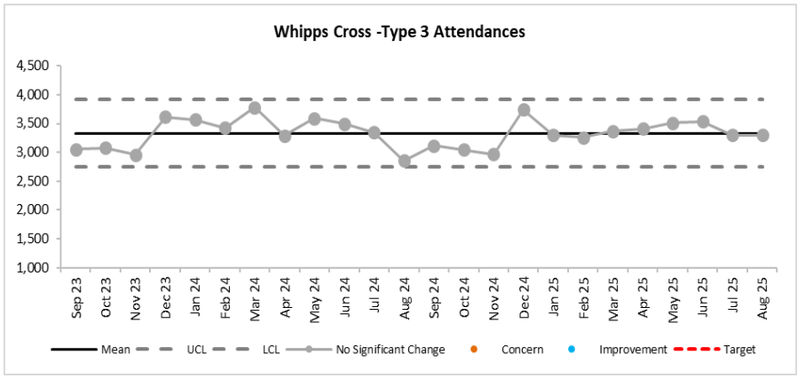


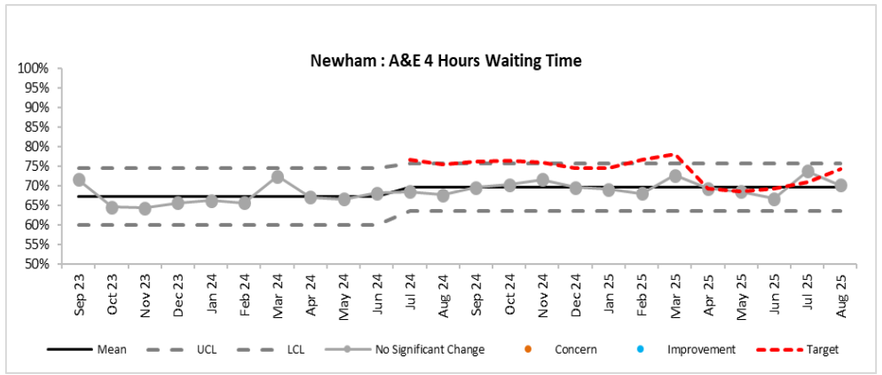


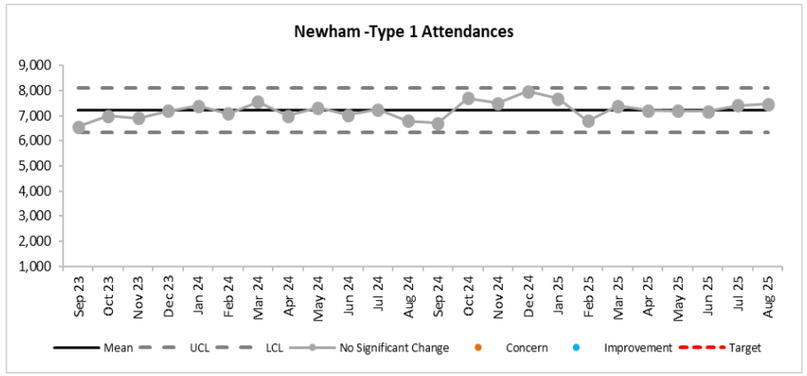


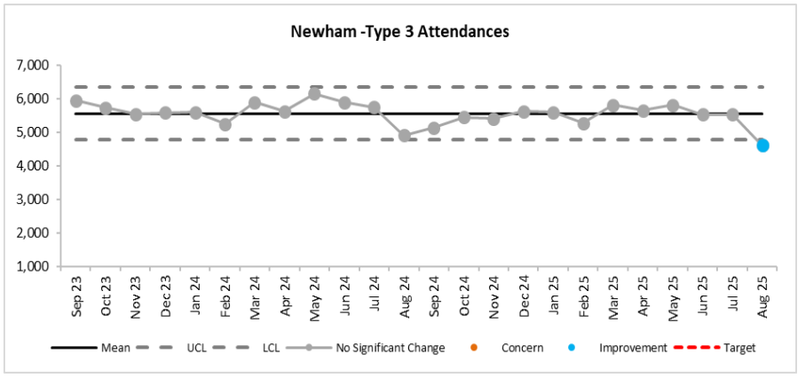




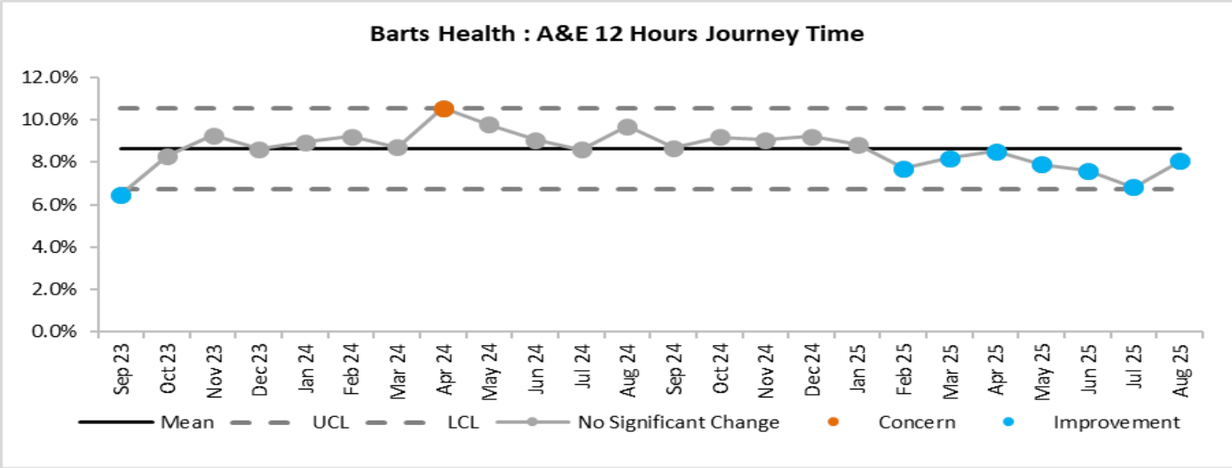








A&E 12 Hrs Journey time



Indicator Background:

12-hours journey time measures the elapsed time from the moment a patient attends A&E to the time they are admitted, discharged or transferred. As such the standard is referred to as the "total journey time" as it measures all elements of the patients journey regardless of whether or not they require admission.

The standard is designed to measure and improve patient experience and clinical care. As such it is a key performance and safety metric with the Royal College of Emergency Medicine noting a correlation of long waits in A&E's to potential patient harm and clinical outcomes.

What is the Chart Telling us:

The chart presents considerable data-variability above and below the mean, for most of the period September 23 to January 25, there is no significant change. However, for the period February to August 25 there is an improving trend, with the final data point recording a breach rate of 8.0%.

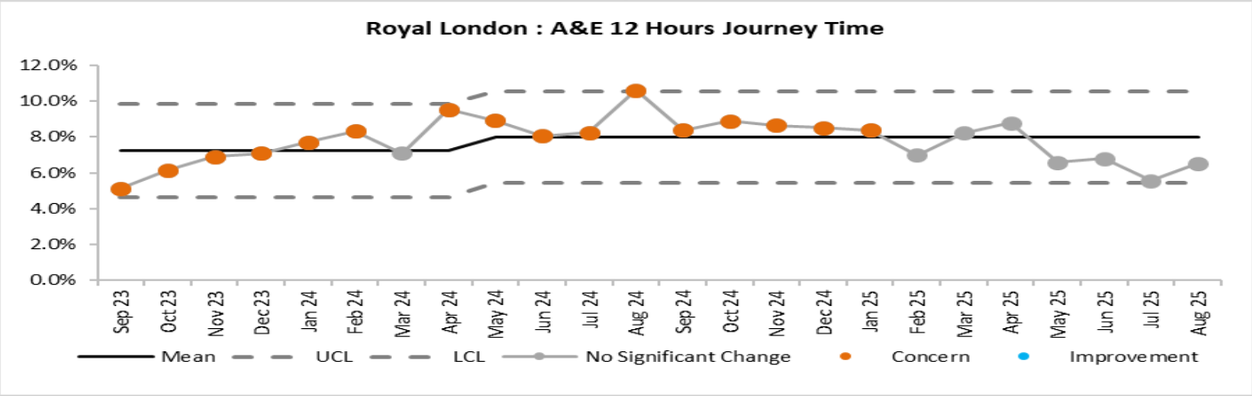
Trust Performance Overview

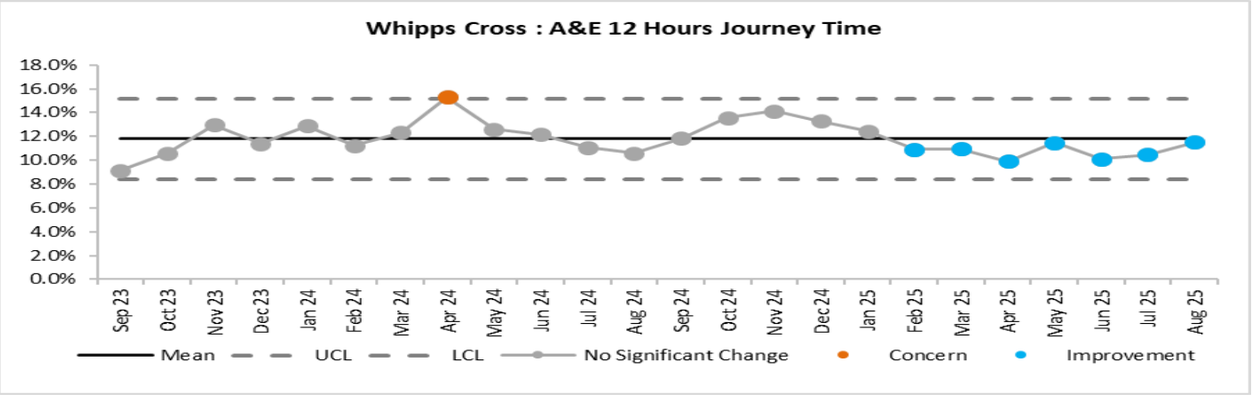
- The proportion of patients with an A&E 12-hour journey time was 8.0% in August against a mean of 8.9%, with the national expectation that this should be a reducing trend.

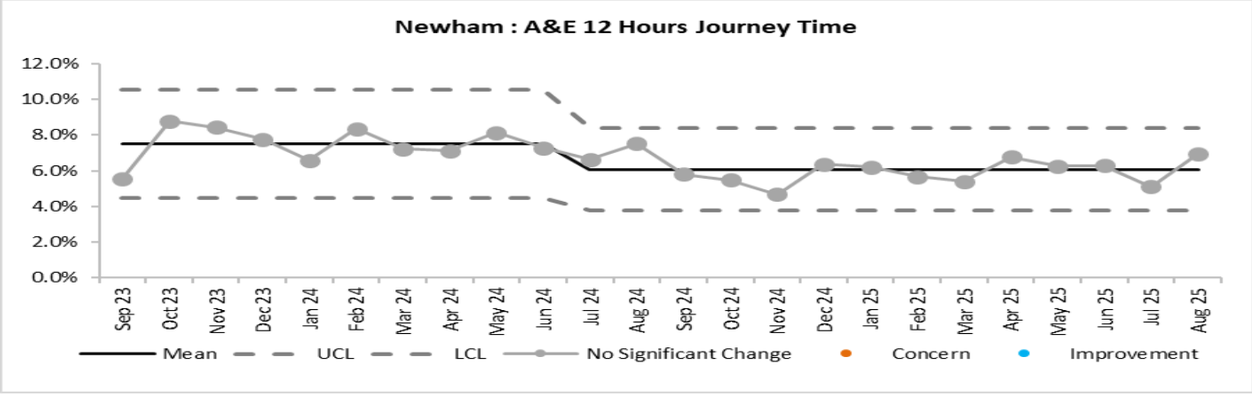
Trust Responsible Director Update

- **Trust wide**: Our 12-hour all type position declined to 8.0% in August. Despite this decline in performance 440 less patients waited >12 hours compared to August 24. Type 1 12-hour performance also declined in August by 2% to 13.9% and remains above the 10% target with NUH closest to achieving this at 11.2%
- **Mental Health**. In August, our average Length of Stay (LoS) was 19 hrs hours, which has remained static for the 2nd consecutive month. This has continued into September with high volumes and extended waits being experienced. We continue to work with our mental health providers to reduce LOS for this group of patients. There is a clear exec level escalation process in place for any patient waiting over 72 hours.
- **Same Day Emergency Care (SDEC):** The number of patients attending SDEC was >4500 across the Trust, our current focus is on increasing the number of direct access attendances to SDEC to eliminate patients attending ED first.

A&E 12 Hrs Journey time







Hospital Site Performance Overview

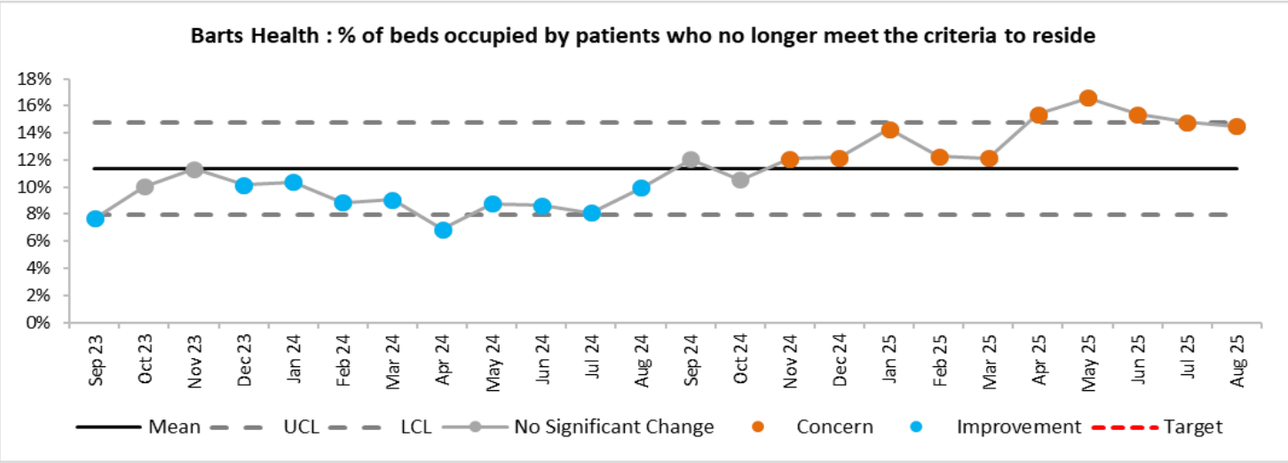
Royal London:
The proportion of 12-hour wait times recorded at the Royal London was 6.5% for August 2025, an increase of 0.9% against July's 5.6%.

Whipps Cross:
The proportion of 12-hour wait times recorded at Whipps Cross was 11.4% for August 2025, an increase of 1.0% against July's 10.4%.

Newham:
The proportion of 12-hour wait times recorded at Newham was 7.0% for August 2025, an increase of 1.9% against July's 5.1%.

The number and proportion of 12-hour breaches is heavily influenced by the pressure A&E's are under, including patient flow challenges for example the early availability of inpatient beds and general availability of beds due to increased length of stay.

Discharge Activity



Indicator Background:

Once people no longer need hospital care, being at home or in a community setting (such as a care home) is the best place for them to continue recovery. However, unnecessary delays in being discharged from hospital are a problem that too many people experience. Not only is this bad for patients but it also means the bed cannot be used for someone who needs it, either waiting for admission from A&E or waiting for an elective admission from the waiting list.

In order to focus attention on this issue all hospitals are required to review their patients every day against what are known as the "criteria to reside". Where a patient no longer needs to be in a hospital bed then they also no longer meet the criteria to reside and should have an active plan in place to discharge them, in some cases with support from health and social care services, or they may require a residential placement in a community setting. Lack of community resources or inefficient hospital discharge processes can result in such patients remaining in a hospital bed.

It is these patients that are reported in this section of the Board report. While there is no national target, the number and proportion of no criteria to reside patients should be as small as possible and reducing over time.

A new national discharge ready metric will be reported on a daily basis and replaces the 'no criteria to reside' category. This return and discharge processes requires continuing close partnership working between Local Authorities, social care colleagues and acute providers.

What is the Chart Telling us:

The chart presents considerable data-variability above and below the mean, however, there is a period of improvement between December 23 and August 24, but this is followed by a period of concern, where the percentage of beds occupied by no criteria to reside patients increases across November 24 to August 25. For the months of April to June 25 the upper confidence limit is breached, a statistically significant, or special cause event, suggesting a change in process or environmental factors.

Trust Performance Overview

In August 2025, 14.5% of our occupied bed base was occupied by those with no criteria to reside. Trust wide this is the equivalent of 187 beds occupied per day on average, for a total of 5,800 bed days lost, across 803 patients.

- Royal London: 18.7% of beds occupied, equivalent to 90 beds per day, across 400 patients
- Whipps Cross: 15.4% of beds occupied, equivalent to 57 beds per day, across 244 patients
- Newham: 17.1% of beds occupied, equivalent to 38 beds per day, across 148 patients
- St Bart's: 0.9% of beds occupied, equivalent to 1 bed per day, across 11 patients

Trust Responsible Director Update

- **Trust wide:** In August our Discharge ready position across our acute hospitals was 17.2% this is down by 0.8% from July. WXH at 15.4%, NUH at 17.1%, and RLH at 18.7%. Our Hospitals are progressing with the roll out the Command Centre as a digital enabler to improve the discharge processes. As we do this, we see a shift from NC2R transfers to lost bed days post the discharge ready date for a patient. This enables us to work with commissioners to see which pathways require investment and are the largest contributor to delays.
- **Pre- 11am and 5pm discharges.** Remains static at 8.70% and 56.51%. Efforts are ongoing to improve performance on these metrics and all hospitals now have established full capacity protocols to incentivise wards to send well patients to the discharge lounge earlier. Work is continuing to improve the DRD completion rates across the trust which will help improve advanced discharge planning and increase the volume of discharges pre 11am.
- **Non-elective LOS**: In August Adult non elective Length of stay remained static at 8.1 which is an improvement of 0.1 days compared to July. Hospitals have clinically led weekly long length of stay reviews to unblock challenges related to discharge and task wards to improve discharge pre 11am. This should facilitate flow earlier in the day to support ED and reduce long waits for our patients.
- **UEC Delivery Group**: The UEC delivery group is now shifting its focus to discharge pathways and in particular pre 11am and 5pm discharges.

Our People - Culture

'Becoming an outstanding, inclusive place to work'

Our People Summary

SUMMARY

Creating a fair and just culture (We Belong & We Lead)

- The percentage of BAME staff in 8a+ roles remained at 40.2% against the year end target of 42%.

Supporting the wellbeing of our people (Retain)

- Overall annualised sickness absence remained at 4.37%
- Recorded appraisals for non-medical staff reduced from 62.4% to 62.2%.
- The medical staff appraisal rate reduced to 84.2%.
- Job planning increased to 40% with St Bartholomew's having the highest level of completion at 85%
- Statutory and Mandatory Training (all) compliance reduced to 87.5% but remains above target. More detail is provided in the relevant exception page.
- Annualised voluntary turnover reduced further to 8.1%.

Working differently to transform care (Innovate)

- Roster compliance – approval on time increased from 82.8% to 84.3% with the average lead time for approval improved to 44.4 days - above the 42 day target.
- Net hours balance was at 2.3%.

Recruiting a permanent, stable workforce (Attract)

- In August we were 552 WTE above the plan submitted to NHS England with substantive staff 36 WTE under plan, agency59 WTE under plan and bank 648 WTE above plan reflecting our ongoing challenge to reduce temporary staffing.
- The substantive fill rate increased to 91.7% for all staff and remained at 91.5% for registered nursing and midwifery. Further information is provided in the subsequent exception page.
- Time to Hire achieved target at group level for non-medical staff (9.0 weeks) and marginally exceeded for medical staff (15.6 weeks) with St Bartholomew's and The Royal London exceeding target for medical staff. This is a reflection of the impact of early recruitment being commissioned to ensure new starts were in place for August and employment checks only being able to be completed near the start date.
- In July temporary staff accounted for 11.9% of the workforce. Temporary spend was at 11.4% of the pay bill YTD, with agency spend at 1.1% YTD, delivering against target, and bank spend at 10.3% YTD above the 7.9% target.

Further information is provided in the subsequent exception page.

Domain Scorecard

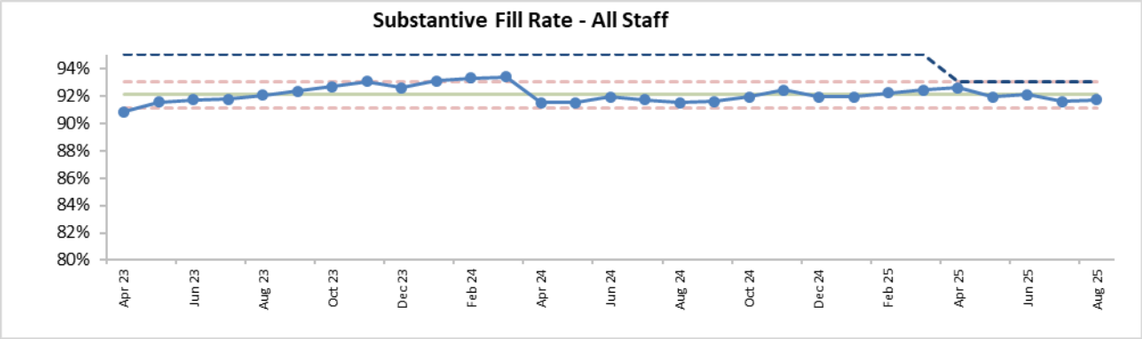
SUMMARY

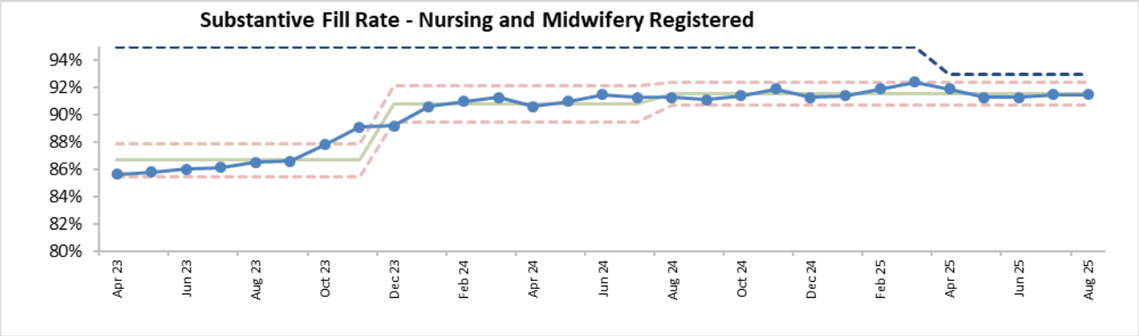
	Indicator	This Period	Target	Performance		Site Comparison						
				Last Period	This Period	Royal London	Whipps Cross	Newham	St Bart's	Pathology Partnership	Group Support Services	Other
Creating a fair and just culture	**Percentage of BAME staff in 8a+ roles**	**Aug-25**	**42%**	**40.2%**	**40.2%**	**38.6%**	**49.5%**	**57.1%**	**29.2%**	**32.9%**	**36.5%**	**56.7%**
Supporting the wellbeing of our colleagues	Turnover Rate	Aug-25	<11%	8.3%	8.1%	8.82%	7.88%	7.69%	9.37%	8.88%	5.60%	12.25%
	Sickness Absence Rate	Jul-25	<=4.0%	4.37%	4.37%	4.26%	4.52%	4.65%	3.40%	3.93%	5.54%	2.06%
	Appraisal Rate - Non-Medical Staff	**Aug-25**	**>= 90%**	**62.4%**	**62.2%**	**57.4%**	**75.6%**	**51.9%**	**70.7%**	**55.4%**	**63.5%**	**25.1%**
	Appraisal Rate - Medical Staff	**Aug-25**	**>= 90%**	**84.7%**	**84.2%**	**82.6%**	**83.6%**	**85.2%**	**88.3%**			
	Mandatory and Statutory Training - All	Aug-25	>= 85%	88.2%	87.5%	85.2%	88.8%	86.4%	91.4%	93.9%	87.9%	

	Indicator (Jan 25)	This Period	Target	Last Period	This Period	Royal London	Whipps Cross	Newham	St Bart's	Pathology Partnership	Group Support Services	Other
Fostering new ways of working to transform care	Roster compliance - Nursing Units Approved on Time %	Aug-25		82.8%	84.3%	93.0%	74.4%	85.2%	85.7%			
	Roster compliance - Nursing Average Approval Lead Time (Days)	Aug-25	>=42	43.9	44.4	46.0	42.4	46.5	42.6			
	Roster compliance - Nursing Net Hours Balance %	Aug-25	<=7.6%	7.2%	2.3%	2.8%	5.2%	-1.1%	0.4%			
	Medical and Dental Job planning completion	**Aug-25**	**>=95%**	30.9%	40.2%	18.6%	38.9%	61.3%	84.9%			
Recruting a permanent and stable workforce	Substantive fill rate - all staff	Aug-25	>=93%	91.6%	91.7%	93.1%	90.7%	91.1%	96.3%	90.7%	85.0%	104.5%
	Substantive fill rate - nursing and midwifery	**Aug-25**	**>=93%**	91.5%	91.5%	**90.7%**	**90.8%**	**93.4%**	**91.5%**			
	Time to Hire (Advert to All Checks Complete) - Median Weeks (Non Medical)	Aug-25	10.4	9.1	9.0	9.2	12.0	8.8	8.7	10.0	9.0	
	Time to Hire (Advert to All Checks Complete) - Median Weeks (Medical)	Aug-25	15.00	13.6	15.6	15.70	12.80	13.40	20.00			
	Temporary staff as a % of workforce	Aug-25		12.1%	11.9%	11.6%	16.6%	14.1%	6.2%	11.4%	12.0%	6.5%
	Pay Spend as % Pay Budget (YTD)	**Aug-25**		101.3%	101.2%	102.4%	103.5%	104.6%	99.3%	96.7%	99.0%	83.9%
	Bank Spend as % Paybill (YTD)*	**Aug-25**	**<=7.9%**	10.0%	10.3%	9.3%	16.0%	14.8%	6.3%	5.7%	7.4%	15.4%
	Agency Spend as % Paybill (YTD)*	**Aug-25**	**<=1.2%**	1.1%	1.1%	**1.4%**	**1.8%**	**1.6%**	**0.2%**	**0.9%**	**0.0%**	**0.0%**
	Agency Spend as % Paybill (In Month)*	**Aug-25**	<=1.2%	**0.9%**	**0.9%**	1.4%	0.9%	0.5%	0.5%	0.0%	0.0%	0.0%

*Sites have site specific targets

Permanent Staffing





Indicator Background:

The substantive fill rate is an indicator of the contracted Whole Time Equivalent (WTE) employed by Barts Health NHS Trust against budgeted WTE. A long-term goal is to deliver a fill rate between 93% and 95%, minimising vacancies and the need to use temporary staffing.

What is the Chart Telling us:

The charts here are showing our overall substantive fill rate as well as that for our registered nursing and midwifery staff group against the 93% target, the latter being our most challenging in terms of reducing gaps.

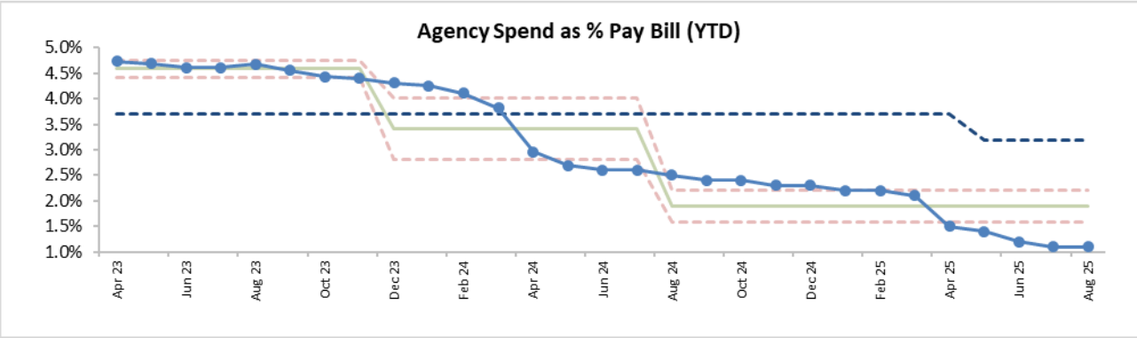
For registered nursing and midwifery, we have seen fill rate increase to 91.5%

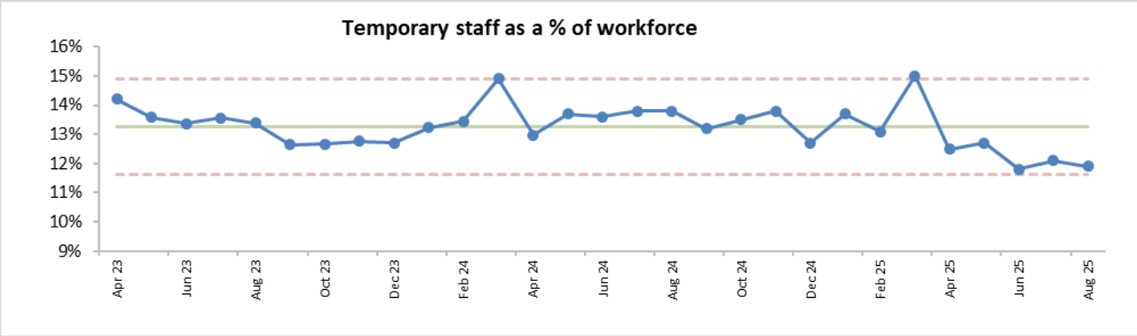
For all staff we saw the substantive fill rate reduce to 91.6%, continuing to oscillate around the 91.7% mark as it has since April 2024

Trust Responsible Director Update

- The overall substantive fill rate increased to 91.7% in August 2025, largely driven by a 36 WTE increase in the budgeted establishment, alongside an increase in substantive staff in post of 50 WTE.
- The increase in reported establishment is primarily driven by additional budget coming online for the community diagnostics hub at Mile End. As flagged last month we have seen the reduction in medical staffing reverse out with the August rotation with a growth of 66 WTE medics, alongside a reduction of 11 WTE admin and clerical.
- The registered nursing and midwifery fill rate remained at 91.5% with marginal growth of 2 WTE.

Temporary Staffing





Indicator Background:

The Agency Spend as a % Pay Bill is a national indicator to demonstrate the proportion of pay spend on agency staff. In 23/24 the national target was 3.7% and in 24/25 it was 3.2%. For 25/26 we have set a target of 1.2% to reflect the

Temporary staff as a % of workforce is an indicator of how reliant the trust is on the temporary workforce. The target for this is to be below 10%, factoring in vacancies, sickness and parental leave

What is the Chart Telling us:

The charts here are showing our agency spend as a % pay bill against the relevant target since April 2022 and the proportion of the workforce that is temporary overall.

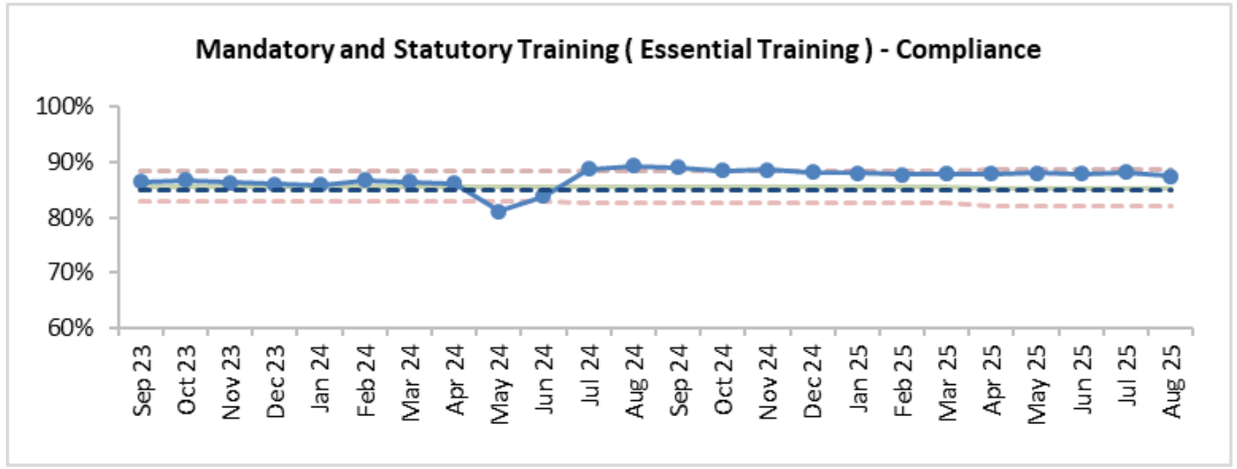
Agency spend as a proportion of pay spend has been following a downward trajectory since August 2023 when it was at 4.7%. In August 2025 the YTD figure stands at 1.1%, delivering against the 1.2% target.

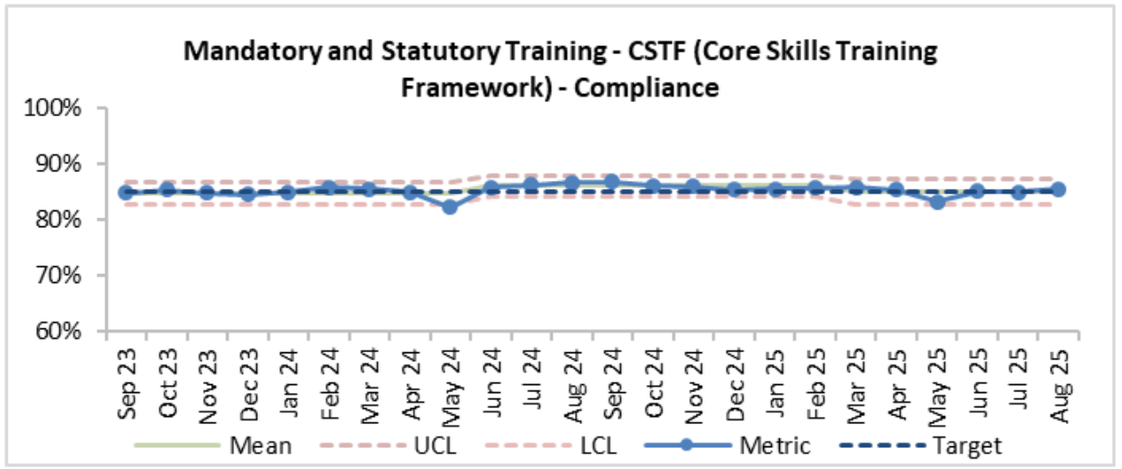
For temporary Staff as a % workforce we remain above target, with a small decrease to 11.9%. The last 5 months have been below the long-term average of 13.3%

Trust Responsible Director Update

- In August we saw agency spend as a % pay bill (YTD) remain at 1.1%, delivering against the 1.2% target for the year. The overall agency usage reduced further by 57 WTE to 222 WTE.
- St Bartholomew's, Newham, Whipps and Pathology Partnership are delivering against their target, Royal London marginally above target.
- Overall temporary staff demand reduced to 11.9% of the workforce, with a 58 WTE decrease in bank. Overall temporary staffing use was at 2,672 WTE, down by 66 WTE.
- When compared to July 2024 there has been a reduction of 469 temporary WTE (from 3,191)

Mandatory and Statutory Training

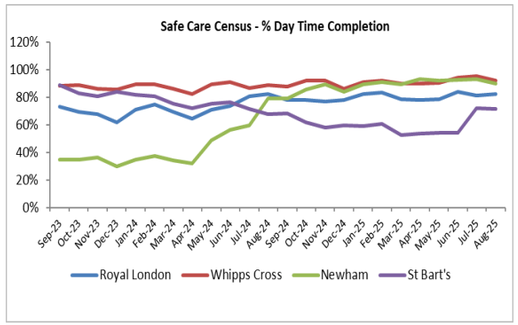


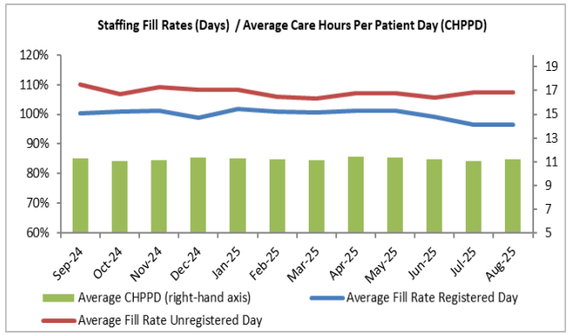


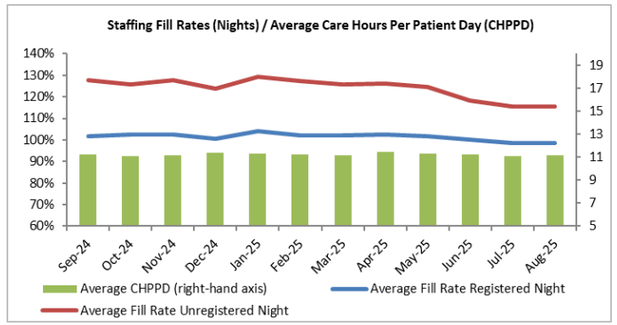
Non-mandatory competencies have been excluded from the above tables

Performance Overview	Responsible Director Update
• Mandatory and Statutory Training CSTF (Core Skills Training Framework) compliance currently stands at 85.6%, a increase of 0.6% from the last Board report but remains above the Trust target of 85% this month. Mandatory and Statutory Training (Essential Skills Training) compliance stands at 87.5% down from 88.2% reported in the last board report, and above the Trust target of 85%. • The total number of staff currently on WIRED stands at 22,196 and the team monitors over 572,739 compliance items yearly. • 8 of the Core Skills Training Framework subjects currently reported on WIRED are above the Trust target of 85%.Fire Safety is below target at 79.96%, with Infection Prevention and Control, Information Governance and Resuscitation all below 80% at 79.73%, 76.36% and 79.08% respectively. Safeguarding Children Level 3 is also below the target at 80.59%. All of these subjects are showing an upwards trajectory. • Those subjects which are below target are highlighted at site PR's, together with staff groups where there is a concern and staff continue to be sent monthly reminders to complete their training.	• Work is being undertaken to review the provision of Violence and Abuse training given the recent upturn in incidents. There is a need for increased face to face training in this sensitive subject with the Security team leading on the review of training delivery. • The Head of Information Governance has been sending out additional reminders to staff who are non-compliant for this subject, which is proving to be successful, and has resulted in a 2% increase in compliance rates this month. • The Oliver McGowan Mandatory Training face to face training is being led by the Homerton and will be supported by a private training provider. This provider is being commissioned by the ICB and we await details of the training to be offered. • Work is being undertaken to review the effectiveness of reminder emails in stopping staff becoming non-compliant, with a view to looking at alternative timeframes for reminder emails. This work will be carried out over the next 6 months with a recommendation made to the Education Committee in q1 of 2026. Investigative work is also being out on the use of AI in the early identification of staff at risk of non-compliance.

Safe Staffing







	Staffing Figures by Site - Aug-25						
	Average Fill Rate (Day)		Average Fill Rate (Night)		Average Care Hours Per Patient Day (CHPPD)	Safe Staffing Maternity Red Flag Incidents	Safe Staffing Nursing Red Flag Incidents
Site	Registered Nurses / Midwives (%)	Care Staff (%)	Registered Nurses / Midwives (%)	Care Staff (%)			
Trust	**96.6%**	**107.3%**	**98.6%**	**115.5%**	**11.2**	**134**	**16**
Royal London	105.4%	121.0%	107.4%	137.4%	11.9	33	4
Whipps Cross	89.3%	100.8%	91.5%	105.3%	10.5	39	12
Newham	96.7%	99.0%	100.0%	101.2%	9.9	62	8
St Bart's	87.0%	99.1%	86.8%	103.4%	12.0	-	0

Trust Responsible Director Update

The Trust has continued to maintain average fill rates exceeding 90% for Registered Nurses (RNs), Midwives (RMs), and Healthcare Assistants (HCAs) across both day and night shifts for most periods. Exceptions were day shifts at SBH, associated with fluctuating activity, staffing being dynamically adjusted in line with actual demand. WXH also saw average RN fill rate on days below marginally below 90% however HCAs fill rare was above 100%.

Average Care Hours Per Patient Day (CHPPD) for the trust were calculated at 11.2; Model Hospital shows an average of 9.1 for 'recommend peers' (last reported in July 2025). For the same period last year, the CHPPD was 11.1 for the Trust showing stability in the rate. The elevated CHPPD at organisational level is attributed primarily linked to the presence of a relatively large number of specialist and critical care services within the Barts Health Group, demonstrated by St Barts Hospital (SBH) having the highest figures as it hosts a significant proportion of specialist and critical care units. Senior Nursing Workforce Leads continue to undertake specialty mapping across wards reported through the monthly safe staffing return to support appropriate benchmarking at ward level.

All four hospitals within the Trust continue to experience demand for enhanced therapeutic observation of care (EToC) for at-risk patients, often resulting in staffing levels exceeding planned establishments. Spend on ETOC decreased by £308K compared to July 2025 but was higher than in the same period last year. A comprehensive cross trust improvement programme is in place refine ETOC models to meet the dual objective of ensuring quality care and effective use of resources.

Patient safety remains a key priority. Senior nursing teams continue to address staffing concerns through safety huddles, dynamically reallocating staff or deploying senior clinical staff where necessary to maintain safe care.
In August, general nursing Red Flag incidents (RFIs) were12, compared to 4 in July. Newham reported 50% as there has been focussed work to drive reporting. None were associated with patient harm. The overall low rate aligns with the good shift fill. Maternity services recorded134 RFIs via BirthRate which is a significant increase from last month. All incidents were addressed in real-time and reviewed through maternity governance processes. It should be noted that maternity red flags have broader range of triggers than are used in nursing, hence the large difference seen in reported numbers.

Underlying workforce trends: overall substantive fill rates across nursing and midwifery are in an increasingly strong position, and in line with the trust target. Senior nurses from each hospital are working in partnership with People team colleagues to address remaining gaps and evolve recruitment process to maximise productivity and efficiency. Sickness absence continues to affect staffing rosters; however, sustained fill rates provide assurance that shift coverage has remained largely unaffected.

Safe Care Compliance: Acuity and dependency scoring compliance via the Safe Care reporting tool increased to 85.6% for day shifts. Although this a slight increase from July 2025, this remains on an upward trajectory compared to the 68.2:% compliance for the same period in 2024. Continued emphasis is placed on embedding Safe Care into daily practice, particularly within safety huddles, to support real-time identification of staffing gaps and dynamic redeployments to facilitate balanced, prioritised staffing.

Supporting Enablers

Finance Summary

- 'The Trust is reporting a (£30.3m) deficit for the year to date at Month 5, which is (£20.3m) adverse against plan. The variance is primarily due to the impact of medical industrial action, the costs of treating elective long waiters and slippage on efficiency savings targets including for system supported schemes related to mental health and medically optimised patients.

- This overall position reported to NHS England is in line with the submitted Financial Recovery Plan with the exception of the £2.5m costs of resident doctors industrial action. This cost consists of the additional expenditure on staff cover net of payroll deductions for striking doctors.

- 'Income is £0.7m favourable against plan for the year to date at Month 5. Hospital sites and group services income is £0.4m favourable. Elective Recovery Funding (ERF) income is reported in line with plan in month 5. The effective ERF cap in 2025/26 means that the plan cannot be delivered through ERF overperformance. It is assumed that ERF will not underperform plan therefore no ERF clawback will be incurred, these assumptions will be reviewed once fully coded data for the period becomes available. Central income is £0.3m favourable.

- Expenditure is (£21.0m) adverse against plan for the year to date at Month 5. Hospital sites and group services pay expenditure is (£11.5m) adverse. The year to date variance is due to pay savings targets (£18.2m) net of underspends against base budgets of £6.7m. Key underspends against base establishment budgets are for non-clinical staff vacancies of £7.5m (primarily GSS £6.1m). Hospital sites and group services non-pay expenditure is (£15.9m) adverse, key overspends include non-pay savings targets (£5.7m), non-clinical non-pay (£2.9m), independent outsourcing costs (£2.6m), drugs and clinical supplies (£2.2m) and pass through drugs and devices (£2.5m), which is offset by the associated pass-through income overperformance. Central areas including reserves are £6.5m favourable, this is mainly due to release of non-recurrent benefits and reserves ahead of the original plan schedule.

- The Trust plan for 2025/26 is to reduce overall staffing levels by over 1,000wte primarily through reducing non-clinical staffing and reducing the use of temporary (bank and agency) clinical staffing, while maintaining strong control of clinical substantive staffing levels. Actual total WTE in month 5 is 21,772wte for the year to date which compares to 22,242wte in month 10 2024/25 , a reduction of 470wte.

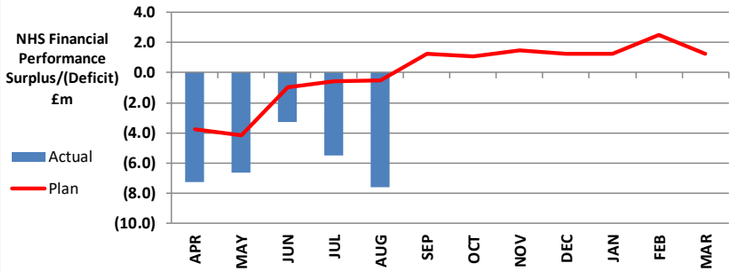
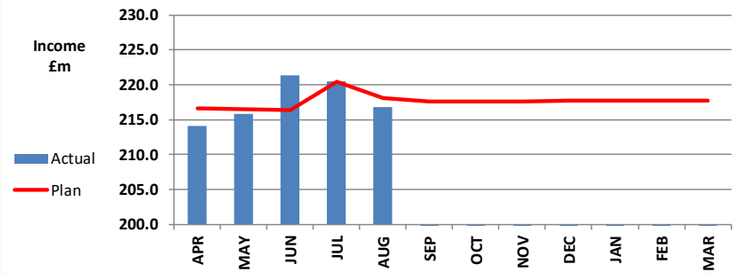
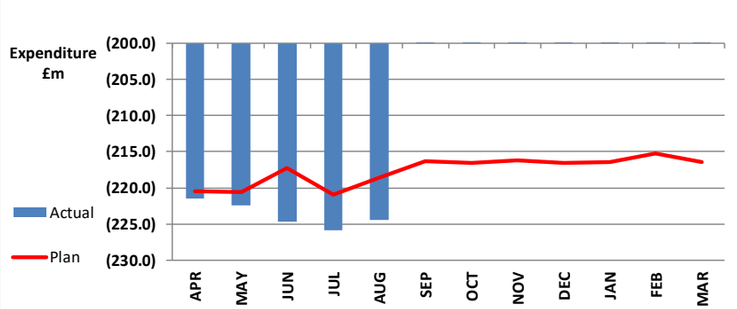
- Capital expenditure for the year to date is £30.7m, which is (£18.5m) behind plan. Charitable funded expenditure for the year to date is £0.6m.

- Cash balances in August 2025 are higher by £0.7m compared to the plan figure of £20.0m.

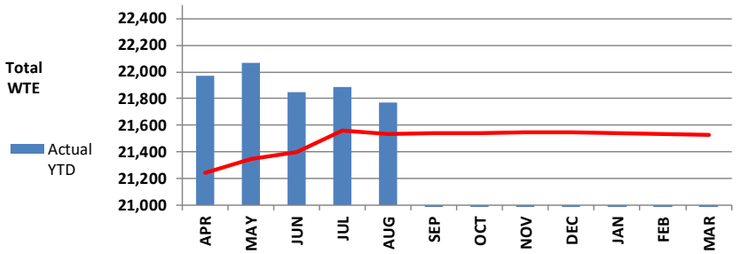
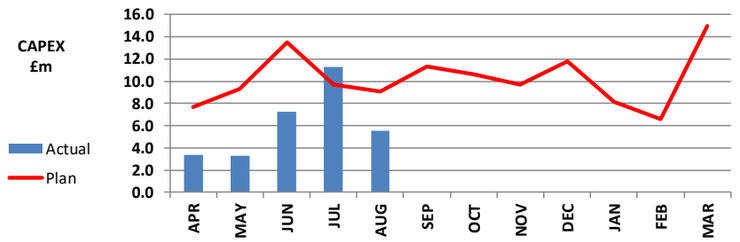
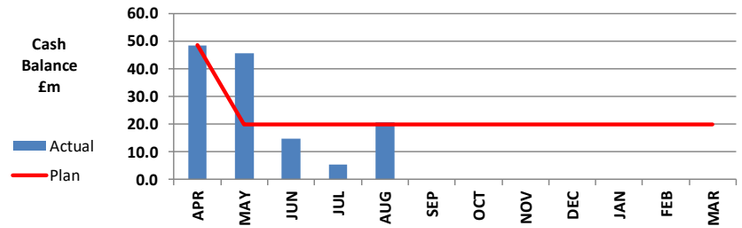
- The Trust has submitted a Financial Recovery Plan to NEL ICB and NHSE with the aim of achieving financial balance across the system in 2025/26. The key financial challenges for the Trust in achieving its plan for this financial year include:

    - Delivering increased efficiency savings to meet the forecast outturn control totals for sites and group services aligned to the Financial Recovery Plan.
    - Working with system partners to reduce delays in transfers of medically optimised and mental health patients out of acute hospitals to more appropriate care settings and to secure funding for the impact of delays for the year to date.
    - Minimising additional costs of managing elective wating times particularly in relation to long waiter

Finance Key Metrics

Metrics	Current Performance Year To Date £millions	Trend	Comments
NHS Financial Performance Surplus / (Deficit)	Plan (10.0) Actual (30.3) Variance (20.3)		The Trust is reporting a (£30.3m) deficit for the year to date at Month 5, which is (£20.3m) adverse against plan. The variance is primarily due to the impact of medical industrial action, the costs of treating elective long waiters and slippage on efficiency savings targets including for system supported schemes related to mental health and medically optimised patients. This overall position reported to NHS England is in line with the submitted Financial Recovery Plan with the exception of the £2.5m costs of resident doctors industrial action. This cost consists of the additional expenditure on staff cover net of payroll deductions for striking doctors.
Total Income	Plan 1,087.8 Actual 1,088.5 Variance 0.7		Income is £0.7m favourable against plan for the year to date at Month 5: - Hospital sites and group services income is £0.4m favourable. Elective Recovery Funding (ERF) income is reported in line with plan in month 5. The effective ERF cap in 2025/26 means that the plan cannot be delivered through ERF overperformance. It is assumed that ERF will not underperform plan therefore no ERF clawback will be incurred, these assumptions will be reviewed once fully coded data for the period becomes available. - Central income is £0.3m favourable.
Total Expenditure	Plan (1,097.8) Actual (1,118.8) Variance (21.0)		Expenditure is (£21.0m) adverse against plan for the year to date at Month 5: - Hospital sites and group services pay expenditure is (£11.5m) adverse. The year to date variance is due to pay savings targets (£18.2m) net of underspends against base budgets of £6.7m. Key underspends against base establishment budgets are for non-clinical staff vacancies of £7.5m (primarily GSS £6.1m). -Hospital sites and group services non-pay expenditure is (£15.9m) adverse, key overspends include non-pay savings targets (£5.7m), non-clinical non-pay (£2.9m), independent outsourcing costs (£2.6m), drugs and clinical supplies (£2.2m) and pass through drugs and devices (£2.5m), which is offset by the associated pass through income overperformance. - Central areas including reserves are £6.5m favourable, this is mainly due to release of non-recurrent benefits and reserves ahead of the original plan schedule.

Finance Key Metrics

Metrics	Current Performance Year To Date	£millions	Trend	Comments
Whole Time Equivalent (Worked WTE)	Target YTD Actual YTD Variance YTD	21,417 21,909 (492)		The Trust plan for 2025/26 is to reduce overall staffing levels by over 1,000wte primarily through reducing non-clinical staffing and reducing the use of temporary (bank and agency) clinical staffing, while maintaining strong control of clinical substantive staffing levels. Actual total WTE in month 5 is 21,772wte for the year to date which compares to 22,242wte in month 10 2024/25 , a reduction of 470wte.
Capital Expenditure	Plan Actual Variance	49.2 30.7 (18.5)		The current capital plan of £138.7m is unchanged from Month 4; it comprises an Exchequer programme of £122.3m and £16.5m programme funded from grants and charitable donations. Capital expenditure for the year to date is £30.7m, which is (£18.5m) behind plan. Charitable funded expenditure for the year to date is £0.6m.
Cash	Plan Actual Variance	20.0 20.7 0.7		Cash balances in August 2025 are higher by £0.7m compared to the plan figure of £20.0m because of other movements in working capital. The 2025/26 pay award for Agenda for Change (AfC) staff (3.6%) and Doctors & Dentists (4%) was paid in August 2025 and backdated to April 2025. The additional cash to cover the award payment was drawn down and passed to the Trust by NEL ICB.

Key Issues

The Trust is reporting a (£30.3m) deficit for the year to date at Month 5, which is (£20.3m) adverse against plan. This overall position reported to NHS England is in line with the submitted Financial Recovery Plan with the exception of the £2.5m costs of resident doctors industrial action, this cost consists of the additional expenditure on staff cover net of payroll deductions for striking doctors.

Key Risks & Opportunities

The key financial challenges for the Trust in achieving its plan for this financial year include:

- Delivering increased efficiency savings to meet the forecast outturn control totals for sites and group services aligned to the Financial Recovery Plan.
- Working with system partners to reduce delays in transfers of medically optimised and mental health patients out of acute hospitals to more appropriate care settings and to secure funding for the impact of delays for the year to date.
- Minimising additional costs of managing elective wating times particularly in relation to long waiters.

Income & Expenditure - Trustwide

Last Year		In Month				Year to Date				Annual
YTD Actual	*£millions*	Plan	Actual	Variance		Plan	Actual	Variance		Plan
772.7	NHS Patient Treatment Income	171.9	173.2	1.3		844.2	847.4	3.2		2,029.9
1.9	Other Patient Care Activity Income	0.7	0.3	(0.3)		3.3	2.1	(1.2)		7.9
59.8	Other Operating Income	13.2	12.8	(0.4)		64.1	62.4	(1.7)		154.6
834.3	**Total Sites & Group Services Income**	**185.7**	**186.3**	**0.6**		**911.6**	**912.0**	**0.4**		**2,192.3**
19.4	Pathology Partnership Income	4.3	4.3	0.0		20.3	20.6	0.3		48.7
25.9	Research & Development Income	7.4	6.8	(0.6)		35.9	36.0	0.0		86.3
134.4	Central NHS PT Income	19.3	18.1	(1.2)		111.8	109.2	(2.7)		264.6
8.1	Central RTA & OSV Income	1.7	1.3	(0.4)		8.5	6.9	(1.6)		20.5
1,022.5	**Total Income**	**218.1**	**216.8**	**(1.3)**		**1,087.8**	**1,088.5**	**0.7**		**2,611.5**
(568.1)	Pay	(141.3)	(141.6)	(0.3)		(618.9)	(630.5)	(11.5)		(1,489.5)
(103.2)	Drugs	(19.8)	(19.3)	0.5		(102.5)	(105.0)	(2.5)		(248.8)
(87.4)	Clinical Supplies	(17.9)	(18.1)	(0.1)		(91.4)	(93.6)	(2.2)		(219.2)
(130.8)	Other Non Pay	(24.3)	(26.5)	(2.2)		(120.9)	(132.1)	(11.2)		(285.8)
(889.6)	**Total Site & Group Services Expenditure**	**(203.4)**	**(205.5)**	**(2.1)**		**(933.8)**	**(961.2)**	**(27.4)**		**(2,243.4)**
(40.8)	Pathology Partnership Expenditure	(9.0)	(9.0)	(0.1)		(42.1)	(42.9)	(0.7)		(101.2)
(25.9)	Research & Development Expenditure	(7.4)	(6.8)	0.6		(35.9)	(36.0)	(0.0)		(86.3)
(3.5)	Central RTA & OSV Recievables Provisions	(0.6)	(0.3)	0.3		(3.1)	(3.3)	(0.2)		(7.4)
(3.4)	Central Expenditure & Reserves	18.2	13.6	(4.7)		(1.1)	5.0	6.1		**22.3**
(963.2)	**Total Operating Expenditure**	**(202.1)**	**(208.1)**	**(6.0)**		**(1,016.1)**	**(1,038.4)**	**(22.3)**		**(2,416.0)**
(32.6)	Depreciation and Amortisation (net)	(6.6)	(6.6)	-		(32.8)	(32.8)	-		(78.7)
(45.3)	Interest	(9.9)	(9.8)	0.1		(49.0)	(47.7)	1.3		(116.9)
0.2	Profit On Fixed Asset Disposal	0.0	0.0	0.0		0.1	0.1	0.0		0.1
(1,041.3)	**Total Expenditure**	**(218.6)**	**(224.4)**	**(5.8)**		**(1,097.8)**	**(1,118.8)**	**(21.0)**		**(2,611.5)**
(55.3)	**Sites & Group Services Contribution**	**(17.7)**	**(19.2)**	**(1.5)**		**(22.2)**	**(49.3)**	**(27.1)**		**(51.0)**
36.5	**Central Income & Expenditure**	**17.2**	**11.6**	**(5.6)**		**12.2**	**19.0**	**6.8**		**51.0**
(18.8)	**NHS Reporting Surplus/(Deficit)**	**(0.5)**	**(7.6)**	**(7.1)**		**(10.0)**	**(30.3)**	**(20.3)**		**0.0**

Capital Expenditure Summary - Trustwide

24/25 YTD	Programme Area	In Month				Year to Date				Annual			
Prev Yr Actual	*£millions*	Plan	Actual	Variance	%	Plan	Actual	Variance	%	Capital Plan	Approved Capital Programme	Variance	%
2.1	Equipment (Medical and Other)	0.5	0.1	0.5	*90 %*	2.8	2.2	0.6	*21 %*	23.1	23.1	-	- %
1.2	Informatics	-	0.3	(0.3)	*- %*	0.6	2.6	(1.9)	*(302)%*	3.8	3.8	-	- %
2.3	Estates	4.4	2.0	2.4	*54 %*	17.3	7.8	9.5	*55 %*	44.3	44.3	-	- %
4.1	New Build and Site Vacations	2.5	1.5	1.0	*40 %*	20.5	10.2	10.3	*50 %*	32.5	32.5	-	- %
6.3	PFI Lifecycle Assets	1.6	1.6	(0.0)	*(0)%*	7.8	7.8	(0.0)	*(0)%*	18.7	18.7	-	- %
0.3	Finance Lease	-	-	-	*- %*	-	-	-	*- %*	-	-	-	- %
16.3	**Total Trust Funded Assets**	**9.0**	**5.5**	**3.5**	***39 %***	**49.2**	**30.7**	**18.5**	***38 %***	**122.3**	**122.3**	**-**	**- %**
-	Grants	0.1	0.0	0.1	*99 %*	0.4	0.0	0.4	*95 %*	6.5	6.5	-	- %
7.6	Donated	0.4	0.0	0.3	*94 %*	1.3	0.6	0.7	*54 %*	10.0	10.0	-	- %
23.9	**Total Capital Expenditure**	**9.5**	**5.6**	**3.9**	***41 %***	**50.9**	**31.3**	**19.6**	***38 %***	**138.7**	**138.7**	**-**	**- %**

Key Messages

2025/26 position. The current capital plan of £138.7m is unchanged from Month 4; it comprises an Exchequer programme of £122.3m and £16.5m programme funded from grants and charitable donations.

Funding. The Trust CRL allocation for 2025/26 is still not been fully confirmed. NHSE approval of the business cases requested via NEL for Constitutional Standards funded schemes, is awaited. Senior Trust directors continue to make strong representations to NEL and NHSL to have the draft plan confirmed in full. Following guidance from NEL, the draft plan includes overprogramming of 5%, £2.2m. Approval is still awaited from NEL confirming that the Trust can utilise this funding. As the opportunities arise, bids will be made for any central funding that is released for programmes such as diagnostic equipment, digital transformation and cyber security etc.

Performance. The Trust had expenditure of £5.6m in August, down from £11.3m in July, of which a negligible amount was on schemes funded from charitable donations. The capital programme submitted to NHSE in March 2025 is currently £19.6m behind plan. It is noted that once the plan is submitted, the forecast is fixed for the year and cannot be amended. The seeming underspend is a timing difference which has arisen following changes in the profile of expenditure and the delay in commencing the 2025/26 capital programme pending confirmation of funding approval of the NEL Estates Safety fund and Constitutional Standard funded schemes due to the requirement for additional business cases. It is expected that the majority of schemes will catch up and be delivered in year. The Capital Steering and Assurance Group is monitoring the pipeline of 2025/26 schemes not yet at business case stage and has challenged all investment leads to provide a firm date for scheme commencement.

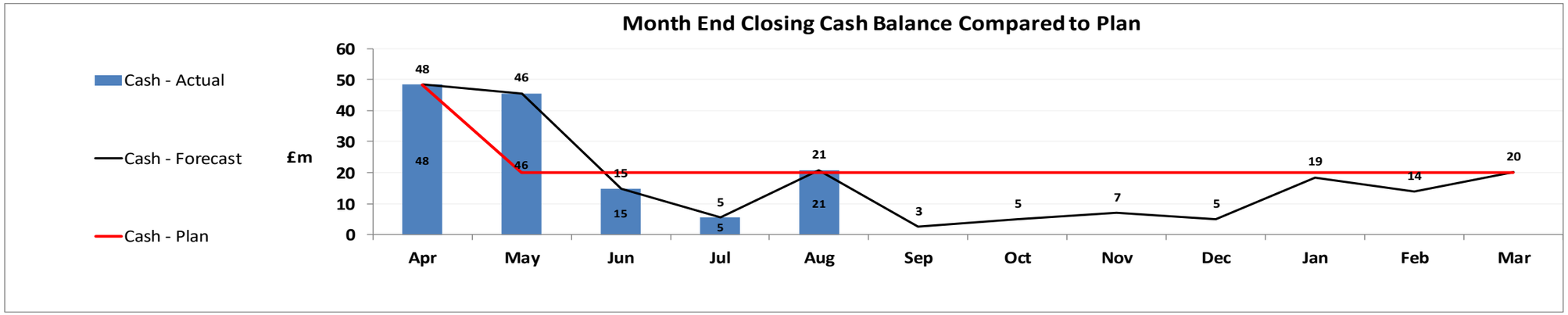
Forecast: As at month 5, in the absence of a fully approved capital plan, the Trust is holding its forecast in line with the draft plan submitted. A full reforecast in underway with outcomes due in October 2025. The process is overseen by the Capital Assurance and Steering Group which will review slippage and suggest recommendations for mitigations as appropriate.

Capital Funding

	Capital Plan	Secured	Not Yet Secured	% Secured
Gross Depreciation	78.7	78.7	-	*100 %*
Repayment of PFI principal	(50.7)	(50.7)	-	*100 %*
Repayment Other Finance Leases (IFRS16)	(14.6)	(14.6)	-	*100 %*
Net Depreciation	**13.4**	**13.4**	**-**	**100 %**
CRL (not cash backed)	52.7	52.7	-	*100 %*
PDC - HIP 1 Whipps Cross Hospital Redevelopment Enabling Works	14.6	14.6	-	*100 %*
PDC - RLH Biplane	0.5	0.5	-	*100 %*
PDC - NHS national energy efficiency funding-SBH & NUH SubMetering	0.1	0.1	-	*100 %*
PDC - SBH Linac	2.4	2.4	-	*100 %*
PDC - Net Zero	0.3	0.3	-	*100 %*
PDC - Estates Safety	27.7	27.7	-	*100 %*
PDC - constitutional standards	10.5	-	10.5	- %
Planned Capital exc. Donated	**122.3**	**111.7**	**10.5**	**91.4 %**
Asset sales	-	-	-	*- %*
Total Approved Exchequer Funding exc. Donations/Grants	**122.3**	**111.7**	**10.5**	**91.4 %**
Grants	6.5	-	6.5	- %
Donations	10.0	-	10.0	- %
Planned Capital inc. Donations/Grants	**138.7**	**111.7**	**27.0**	**80.5 %**

Cashflow

£millions	Actual Apr	May	Jun	Jul	Aug	Forecast Sep	Oct	Nov	Dec	Jan	Feb	Mar	Outturn
Opening cash at bank	**46.4**	**48.4**	**45.6**	**14.7**	**5.5**	**20.7**	**2.5**	**4.8**	**7.0**	**5.0**	**18.5**	**13.8**	**46.4**
Cash inflows													
Healthcare contracts	197.2	184.7	185.4	189.6	197.4	196.5	190.5	192.5	193.5	193.5	192.5	193.6	2,306.9
Other income	47.6	23.2	26.2	46.7	35.7	41.1	34.6	33.1	33.6	30.4	31.1	43.5	426.8
Financing - Revenue Loans /Capital PDC	-	-	-	-	-	-	-	-	15.0	-	-	41.1	56.1
Total cash inflows	**244.8**	**207.9**	**211.6**	**236.3**	**233.1**	**237.6**	**225.1**	**225.6**	**242.1**	**223.9**	**223.6**	**278.2**	**2,789.8**
Cash outflows													
Salaries and wages	(75.7)	(74.6)	(71.1)	(71.0)	(83.0)	(74.2)	(74.2)	(74.2)	(74.6)	(76.2)	(74.2)	(76.7)	(899.7)
Tax, NI and pensions	(56.7)	(57.8)	(56.4)	(58.1)	(56.3)	(68.0)	(58.7)	(58.7)	(58.7)	(58.7)	(58.7)	(58.7)	(705.6)
Non pay expenditures	(96.9)	(73.9)	(112.3)	(109.0)	(68.1)	(111.1)	(84.1)	(85.0)	(106.5)	(70.0)	(86.7)	(114.3)	(1,117.9)
Capital expenditure	(13.5)	(4.4)	(2.7)	(7.4)	(10.4)	(2.5)	(5.8)	(5.5)	(4.3)	(5.5)	(8.7)	(22.3)	(93.0)
Dividend and Interest payable	-	-	-	-	-	-	-	-	-	-	-	-	-
Total cash outflows	**(242.8)**	**(210.7)**	**(242.5)**	**(245.5)**	**(217.8)**	**(255.8)**	**(222.8)**	**(223.4)**	**(244.1)**	**(210.4)**	**(228.3)**	**(272.0)**	**(2,816.2)**
Net cash inflows / (outflows)	**2.0**	**(2.8)**	**(30.9)**	**(9.2)**	**15.3**	**(18.2)**	**2.3**	**2.2**	**(2.0)**	**13.5**	**(4.7)**	**6.2**	**(26.4)**
Closing cash at bank - actual / forecast	**48.4**	**45.6**	**14.7**	**5.5**	**20.7**	**2.5**	**4.8**	**7.0**	**5.0**	**18.5**	**13.8**	**20.0**	**20.0**
Closing cash at bank - plan	**48.4**	**20.0**	**20.0**	**20.0**	**20.0**	**20.0**	**20.0**	**20.0**	**20.0**	**20.0**	**20.0**	**20.0**	**20.0**



Key Messages

Cash balances in August 2025 are higher by £0.7m compared to the plan figure of £20.0m because of other movements in working capital. The 2025/26 pay award for Agenda for Change (AfC) staff (3.6%) and Doctors & Dentists (4%) was paid in August 2025 and backdated to April 2025. The additional cash to cover the award payment was drawn down and passed to the Trust by NEL ICB.

Statement of Financial Position

24/25		Actual					Forecast							
31 Mar 2025	£millions	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	24/25 v 25/26
	Non-current assets:													
1,613.4	Property, plant and equipment	1,612.3	1,606.9	1,607.5	1,612.1	1,610.9	1,635.5	1,641.3	1,648.9	1,656.1	1,659.6	1,662.1	1,670.5	57.1
6.9	Intangible assets	6.7	6.5	6.4	6.2	6.1	6.1	6.0	5.9	5.8	5.7	5.5	5.4	(1.5)
16.1	Trade and other receivables	16.1	16.0	16.0	15.9	15.9	15.8	15.8	15.7	15.7	15.6	15.6	15.6	(0.5)
1,636.4	**Total non-current assets**	**1,635.1**	**1,629.4**	**1,629.9**	**1,634.2**	**1,632.9**	**1,657.4**	**1,663.1**	**1,670.5**	**1,677.6**	**1,680.9**	**1,683.2**	**1,691.4**	**55.1**
	Current assets:													
37.4	Inventories	37.4	38.6	38.8	40.3	40.2	37.4	37.4	37.4	37.4	37.4	37.4	37.4	0.0
139.2	Trade and other receivables	110.0	103.0	150.9	147.4	116.4	126.5	124.4	121.9	124.6	118.5	123.8	137.8	(1.4)
46.3	Cash and cash equivalents	48.4	45.6	14.7	5.5	20.7	2.5	4.8	7.0	5.0	18.5	13.8	20.0	(26.3)
222.9	**Total current assets**	**195.8**	**187.2**	**204.4**	**193.2**	**177.3**	**166.4**	**166.6**	**166.3**	**167.0**	**174.4**	**175.0**	**195.2**	**(27.7)**
1,859.3	**Total assets**	**1,830.9**	**1,816.6**	**1,834.3**	**1,827.4**	**1,810.2**	**1,823.8**	**1,829.7**	**1,836.8**	**1,844.6**	**1,855.3**	**1,858.2**	**1,886.6**	**27.4**
	Current liabilities													
(338.7)	Trade and other payables	(316.2)	(310.9)	(333.2)	(332.5)	(323.7)	(302.5)	(306.3)	(310.8)	(301.2)	(309.5)	(309.2)	(295.8)	42.9
(3.7)	Provisions	(3.7)	(3.7)	(3.6)	(3.6)	(3.6)	(1.0)	(0.9)	(1.0)	(1.0)	(1.0)	(1.0)	(1.0)	2.7
(63.6)	Liabilities arising from PFIs / Finance Leases	(65.3)	(65.3)	(65.3)	(65.3)	(65.3)	(62.6)	(62.6)	(62.6)	(62.6)	(62.6)	(62.6)	(63.8)	(0.2)
0.0	DH Revenue Support Loan (Including RWCSF)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
0.0	DH Capital Investment Loan	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
(406.0)	**Total current liabilities**	**(385.2)**	**(379.9)**	**(402.1)**	**(401.4)**	**(392.6)**	**(366.1)**	**(369.8)**	**(374.4)**	**(364.8)**	**(373.1)**	**(372.8)**	**(360.6)**	**45.4**
(183.1)	**Net current (liabilities) / assets**	**(189.4)**	**(192.7)**	**(197.7)**	**(208.2)**	**(215.3)**	**(199.7)**	**(203.2)**	**(208.1)**	**(197.8)**	**(198.7)**	**(197.8)**	**(165.4)**	**17.7**
1,453.3	**Total assets less current liabilities**	**1,445.7**	**1,436.7**	**1,432.2**	**1,426.0**	**1,417.6**	**1,457.7**	**1,459.9**	**1,462.4**	**1,479.8**	**1,482.2**	**1,485.4**	**1,526.0**	**72.8**
	Non-current liabilities													
(5.3)	Provisions	(5.4)	(5.4)	(5.4)	(5.4)	(5.5)	(5.6)	(5.6)	(5.6)	(5.6)	(5.6)	(5.6)	(5.6)	(0.3)
(1,664.1)	Liabilities arising from PFIs / Finance Leases	(1,715.1)	(1,709.8)	(1,704.0)	(1,698.6)	(1,693.1)	(1,699.0)	(1,694.1)	(1,689.3)	(1,684.4)	(1,679.6)	(1,674.7)	(1,668.6)	(4.5)
0.0	Other Payables	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
0.0	DH Revenue Support Loan (Including RWCF)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
0.0	DH Capital Investment Loan	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
(1,669.4)	**Total non-current liabilities**	**(1,720.3)**	**(1,715.2)**	**(1,709.4)**	**(1,704.0)**	**(1,698.6)**	**(1,704.6)**	**(1,699.7)**	**(1,694.9)**	**(1,690.0)**	**(1,685.2)**	**(1,680.3)**	**(1,674.1)**	**(4.8)**
(216.1)	**Total Assets Employed**	**(274.6)**	**(278.5)**	**(277.2)**	**(278.0)**	**(281.0)**	**(246.9)**	**(239.8)**	**(232.5)**	**(210.2)**	**(203.0)**	**(194.9)**	**(148.1)**	**68.0**
	Financed by:													
	Taxpayers' equity													
1,133.1	Public dividend capital	1,133.1	1,133.1	1,133.1	1,133.1	1,133.1	1,133.1	1,133.1	1,133.1	1,148.1	1,148.1	1,148.1	1,189.1	56.0
(1,780.8)	Retained earnings	(1,839.2)	(1,843.2)	(1,841.9)	(1,842.7)	(1,845.7)	(1,811.6)	(1,804.5)	(1,797.2)	(1,789.9)	(1,782.7)	(1,774.6)	(1,777.4)	3.4
431.6	Revaluation reserve	431.5	431.6	431.6	431.6	431.6	431.6	431.6	431.6	431.6	431.6	431.6	440.2	8.6
(216.1)	**Total Taxpayers' Equity**	**(274.6)**	**(278.5)**	**(277.2)**	**(278.0)**	**(281.0)**	**(246.9)**	**(239.8)**	**(232.5)**	**(210.2)**	**(203.0)**	**(194.9)**	**(148.1)**	**68.0**

Glossary

2024/25 Priorities & Operational Planning

The key 2024/25 NHS England (NHSE) Urgent and Emergency Care, Elective, Cancer and Diagnostic performance objectives and milestones are set-out in the table opposite. However, a number of high-priority operational standards sit alongside these and include:

Urgent & Emergency Care

- ✓ Systems are also asked to reduce the proportion of waits over 12 hours in A&E compared to 2023/24.
- ✓ NHSE will operate an incentive scheme for providers with a Type 1 A&E department achieving the greatest level of improvement and/or delivering over 80% A&E 4-hour performance by the end of the year.
- ✓ Maintain acute G&A beds as a minimum at the level funded and agreed through operating plans in 2023/24

Elective Care

- ✓ Individual system activity targets are the same as those agreed for 2023/24, consistent with the national value weighted activity target of 107%.
- ✓ Make significant improvement towards the 85% day case and 85% theatre utilisation expectations where these are not already being met, using Getting it Right First Time (GIRFT) and moving procedures to the most appropriate settings.
- ✓ Continue to shift the balance of outpatient activity towards clock-stopping, ensuring that the wait to first appointment continues to reduce. To support this, NHSE have introduced a new metric measuring the proportion of all outpatient attendances that are for first or follow-up appointments attracting a procedure tariff (the proportion of activity that is pathway completing). To meet the national ambition of 46% NHSE are asking systems to deliver a 4.5 percentage point improvement against their 2022/23 baseline up to a maximum local ambition of 49%.

The Trust is currently completing performance trajectories and activity plans consistent with delivering the North East London ICB requirements in relation to the national objectives set-out above, with a local submission deadline of 23 April and a national submission deadline of 2 May.

The Operational Performance chapter of this report (pages 18 to 41) will be updated to provide monthly and year to date views of delivery against the performance and activity objectives set out above and opposite for the April 24 edition of the report.

	Objective	Deadline
Urgent & Emergency Care	Improve A&E waiting times, compared to 2023/24, with a minimum of 78% of patients seen within 4 hours in March 2025	Mar-25
Elective Waits	Eliminate waits of over 65 weeks for elective care as soon as possible and by September 2024 at the latest (except where patients choose to wait longer or in specific specialties)	Sep-25
	Deliver (or exceed) the system specific activity targets, consistent with the national value weighted activity target of 107%	Mar-25
	Increase the proportion of all outpatient attendances that are for first appointments or follow-up appointments attracting a procedure tariff to a national value of 46% across 2024/25	Mar-25
Cancer	Improve performance against the headline 62-day standard to 70% by March 2025	Mar-25
	Improve performance against the 28 day Faster Diagnosis Standard to 77% by March 2025 towards the 80% ambition by March 2026	
	Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028	Mar-28
Diagnostics	Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%	Mar-25

Domain Scorecard Glossary

GLOSSARY

Domain	Sub Domain	Metric Ref	Metric Name	Description	Frequency	Target Source
Responsive	Waiting Times	R1	A&E 4 Hours Waiting Time	The number of Accident & Emergency (A&E) attendances for which the patient was discharged, admitted or transferred within four hours of arrival, divided by the total number of A&E attendances. This includes all types of A&E attendances including Minor Injury Units and Walk-in Centres	Monthly	Recovery trajectory
Responsive	Waiting Times	R8	Cancer 2 Week Wait	Percentage of patients first seen by a specialist for suspected cancer within two weeks (14 days) of an urgent GP referral for suspected cancer	Monthly	National
Responsive	Waiting Times	R35	Cancer 62 Days From Urgent GP Referral	Percentage of patients receiving first definitive treatment for cancer within two months (62 days) of an urgent GP referral for suspected cancer. Logic is 50/50 split for referring and treating trust/site up to and including Mar-19 then reallocation from Apr-19 as per national reporting rules	Monthly	National
Responsive	Waiting Times	R36	Cancer 62 Days From Screening Programme	Percentage of patients receiving first definitive treatment for cancer within two months (62 days) of referral from a NHS Cancer Screening Service. Logic is 50/50 split for referring and treating trust/site up to and including Mar-19 then reallocation from Apr-19 as per national reporting rules	Monthly	National
Responsive	Waiting Times	R6	Diagnostic Waits Over 6 Weeks	The number of patients still waiting for diagnostic tests who had waited 6 weeks or less from the referral date to the end of the calendar month, divided by the total number of patients still waiting for diagnostic tests at the end of the calendar month. Only the 15 key tests included in the Diagnostics Monthly (DM01) national return are included	Monthly	National
Well Led	People	W19	Turnover Rate	The number of leavers (whole time equivalents) who left the trust voluntarily in the last 12 months divided by the average total number of staff in post (whole time equivalents) in the last 12 months	Monthly	Local
Well Led	People	OH7	Proportion of Temporary Staff	The number of bank and agency whole time equivalents divided by the number of bank and agency whole time equivalents plus permanent staff in post (whole time equivalents)	Monthly	Local
Well Led	People	W20	Sickness Absence Rate	The number of whole time equivalent days lost to sickness absence (including non-working days) in the last 12 months divided by the total number of whole time equivalent days available (including non-working days) in the last 12 months, i.e. the annualised percentage of working days lost due to sickness absence	Monthly	Local
Well Led	Staff Feedback	C6	Staff FFT Percentage Recommended - Care	The number of staff who responded that they were extremely likely or likely to recommend the trust to friends and family if they needed care or treatment, divided by the total number of staff who responded to the Staff Friends and Family Test (Staff FFT)	Quarterly	Local
Well Led	Staff Feedback	OH6	NHS Staff Survey	The overall staff engagement score from the results of the NHS Staff Survey	Yearly	National
Well Led	Compliance	W50	Mandatory and Statutory Training - All	For all mandatory and statutory training topics, the percentage of topics for which staff were competent (i.e. have completed training and were compliant)	Monthly	Local

Domain Scorecard Glossary

GLOSSARY

Domain	Sub Domain	Metric Ref	Metric Name	Description	Frequency	Target Source
Well Led	Compliance	W11	Mandatory and Statutory Training - National	For the 11 Core Skills Training Framework topics, the percentage of topics for which staff were competent (i.e. have completed training and were compliant)	Monthly	Local
Well Led	Compliance	W29	Appraisal Rate - Non-Medical Staff	The number of appraisals completed for eligible non-medical staff divided by the number of eligible non-medical staff	Monthly	Local
Well Led	Compliance	W30	Appraisal Rate - Medical Staff	The number of appraisals completed for eligible medical staff divided by the number of eligible medical staff (non-compliant if 2 or more months overdue, otherwise compliant)	Monthly	Local
Caring	Patient Experience	C12	MSA Breaches	The number of patients admitted to mixed sex sleeping accommodation (defined as an area patients are admitted into), except where it was in the overall best interest of the patient or reflected their personal choice	Monthly	National
Caring	Patient Feedback	C10	Written Complaints Rate Per 1,000 Staff	The number of initial reportable complaints received by the trust per 1,000 whole time equivalent staff (WTEs), i.e. the number of initial reportable complaints divided by the number of WTEs which has been multiplied by 1,000	Quarterly	SPC breach
Caring	Patient Feedback	C1	FFT Recommended % - Inpatients	The number of patients who responded that they were extremely likely or likely to recommend the inpatient service they received to friends and family, divided by the total number of patients who responded to the inpatient Friends and Family Test (FFT)	Monthly	Local
Caring	Patient Feedback	C2	FFT Recommended % - A&E	The number of patients who responded that they were extremely likely or likely to recommend the A&E service they received to friends and family, divided by the total number of patients who responded to the A&E Friends and Family Test (FFT)	Monthly	Local
Caring	Patient Feedback	C3	FFT Recommended % - Maternity	The number of patients who responded that they were extremely likely or likely to recommend the maternity (birth) service they received to friends and family, divided by the total number of patients who responded to the maternity (birth) Friends and Family Test (FFT)	Monthly	Local
Caring	Patient Feedback	C20	FFT Response Rate - Inpatients	The total number of patients who responded to the inpatient Friends and Family Test (FFT) divided by the total number of patients eligible to respond to the inpatient FFT (i.e. all inpatient discharges in the reporting period)	Monthly	Local
Caring	Patient Feedback	C21	FFT Response Rate - A&E	The total number of patients who responded to the A&E Friends and Family Test (FFT) divided by the total number of patients eligible to respond to the A&E FFT (i.e. all A&E attendances in the reporting period)	Monthly	Local
Caring	Patient Feedback	C22	FFT Response Rate - Maternity	The total number of patients who responded to the maternity (birth) Friends and Family Test (FFT) divided by the total number of patients eligible to respond to the maternity (birth) FFT (i.e. all delivery episodes in the reporting period)	Monthly	Local
Caring	Patient Feedback	OH4	CQC Inpatient Survey	The overall experience score of patients from the CQC inpatient survey, based on the question "Patients who rated their experience as 7/10 or more"	Yearly	National average
Caring	Service User Support	R78	Complaints Replied to in Agreed Time	The number of initial reportable complaints replied to within the agreed number of working days (as agreed with the complainant). The time agreed for the reply might be 25 working days or might be another time such as 40 working days	Monthly	Local

Domain Scorecard Glossary

GLOSSARY

Domain	Sub Domain	Metric Ref	Metric Name	Description	Frequency	Target Source
Caring	Service User Support	R30	Duty of Candour	The percentage of patient incidents (where harm was moderate, severe or death) where an apology was offered to the patient within 2 weeks (14 calendar days) of the date the incident was reported	Monthly	National
Safe	Infection Control	S10	Clostridium difficile - Infection Rate	The number of Clostridium difficile (C.difficile) infections reported in people aged two and over and which were apportioned to the trust per 100,000 bed days (inpatient bed days with day cases counted as 1 day each)	Monthly	National
Safe	Infection Control	S11	Clostridium difficile - Incidence	The number of Clostridium difficile (C.difficile) infections reported in people aged two and over and which were apportioned to the trust	Monthly	National
Safe	Infection Control	S2	Assigned MRSA Bacteraemia Cases	The number of Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemias which can be directly associated to the trust	Monthly	Local
Safe	Infection Control	S77	MSSA Bacteraemias	The number of Methicillin-susceptible Staphylococcus aureus (MSSA) bacteraemias which can be directly associated to the trust	Monthly	Local
Safe	Infection Control	S76	E.coli Bacteraemia Bloodstream Infections	The number of Escherichia coli (E.coli) bacteraemia bloodstream infections at the trust (i.e. for which the specimen was taken by the trust)	Monthly	Local
Safe	Incidents	S3	Never Events	The number of never events reported via the Strategic Executive Information System (STEIS)	Monthly	Local
Safe	Incidents	S09	% Incidents Resulting in Harm (Moderate Harm or More)	The number of patient-related incidents occurring at the trust which caused harm (not including those which only caused low harm) divided by the total number of patient-related incidents occurring at the trust	Monthly	Local
Safe	Incidents	S45	Falls Per 1,000 Bed Days	The total number of patient falls occurring at the trust per 1,000 inpatient bed days, i.e. the total number of patient falls occurring at the trust divided by the number of inpatient bed days which has been multiplied by 1,000	Monthly	National
Safe	Incidents	S25	Medication Errors - Percentage Causing Harm	The number of medication error incidents occurring at the trust which caused harm divided by the total number of medication error incidents occurring at the trust	Monthly	Local
Safe	Incidents	S49	Patient Safety Incidents Per 1,000 Bed Days	The number of reported patient safety incidents per 1,000 bed days. This is the NHS Single Oversight Framework metric "Potential Under-Reporting of Patient Safety Incidents"	Monthly	SPC breach
Safe	Incidents	S53	Serious Incidents Closed in Time	Percentage of serious incidents investigated and closed on the Strategic Executive Information System (StEIS) before the deadline date (this is usually 60 working days after opening but is sometimes extended, e.g. in the case of a police investigation). De-escalated serious incidents are not included	Monthly	Local
Safe	Harm Free Care	S14	Pressure Ulcers Per 1,000 Bed Days	The number of new category 2, 3, 4 or unstageable pressure ulcers acquired at the trust (including those which occurred at the trust and those which deteriorated to one of those categories at the trust) per 1,000 inpatient bed days, i.e. the number of new category 2, 3, 4 or unstageable pressure ulcers acquired at the trust divided by the number of inpatient bed days which has been multiplied by 1,000	Monthly	Local
Safe	Harm Free Care	S35	Pressure Ulcers (Device-Related) Per 1,000 Bed Days	The number of new category 2, 3, 4 or unstageable medical device-related pressure ulcers acquired at the trust (including those which occurred at the trust and those which deteriorated to one of those categories at the trust) per 1,000 inpatient bed days, i.e. the number of new category 2, 3, 4 or unstageable medical device-related pressure ulcers acquired at the trust divided by the number of inpatient bed days which has been multiplied by 1,000	Monthly	SPC breach

Domain Scorecard Glossary

GLOSSARY

Domain	Sub Domain	Metric Ref	Metric Name	Description	Frequency	Target Source
Safe	Harm Free Care	S17	Emergency C-Section Rate	The number of deliveries which were emergency caesarean sections divided by the total number of deliveries. Based on data frozen as at the 12th working day of the month	Monthly	Local
Safe	Harm Free Care	S27	Patient Safety Alerts Overdue	The number of NHS England or NHS Improvement patient safety alerts overdue (past their completion deadline date) at the time of the snapshot. These are a sub-set of all Central Alerting System (CAS) alerts	Monthly	National
Safe	Assess & Prevent	S7	Dementia - Referrals	Percentage of patients aged 75 and above admitted as emergency inpatients, with length of stay > 72 hours, who have had a diagnostic assessment (with an outcome of “positive” or “inconclusive”) and who have been referred for further diagnostic advice in line with local pathways	Monthly	National
Safe	Saving Lives	S87	Saving Lives: Central Venous Catheter Care Bundle (Continuing Care)	The percentage of central venous catheter care bundle audits carried out (for patients with continuing care) in which the results were all found to be fully compliant. The audit consists of monthly observations on catheter injection ports, catheter access, catheter replacement, hand hygiene, etc.	Monthly	TBC
Safe	Saving Lives	S88	Saving Lives: Central Venous Catheter Care Bundle (On Insertion)	The percentage of central venous catheter care bundle audits carried out (on insertion of catheters) in which the results were all found to be fully compliant. The audit consists of monthly observations on catheter type, insertion site, safe disposal of sharps, hand hygiene, etc.	Monthly	TBC
Effective	Mortality	E1	Summary Hospital-Level Mortality Indicator	The ratio between the actual number of patients who died following hospitalisation at the trust and the number who would be expected to die on the basis of average England figures (given the characteristics of the patients treated at the trust), multiplied by 100	Monthly	National
Effective	Mortality	E3	Risk Adjusted Mortality Index	The ratio of the observed number of in-hospital deaths with a Hospital Standardised Mortality Ratio (HSMR) diagnosis to the expected number of deaths, multiplied by 100, at trust level. This metric considers mortality on weekdays and weekends	Monthly	National
Effective	Outcomes	0502	Cardiac Arrest 2222 Calls (Wards) Per 1,000 Admissions	The number of 2222 emergency calls which were for cardiac arrests on wards (including medical emergencies leading to cardiac arrests) per 1,000 admissions, i.e. the number of calls divided by the number of admissions which has been multiplied by 1,000	Monthly	Local

Workforce Summary Glossary

Sub-Section	Metric	Description	Notes
Planned vs Actual WTE	% Utilisation (Total Fill Rate)	Contracted substantive WTE (plus Bank and Agency, less maternity leave) as a % of total budgeted WTE	The target is <= 100% but the figure is also of concern if it falls too far below 100% so an amber rating is applied if the figure is < 95%
Planned vs Actual WTE	Staff in Post - Actual	Substantive staff in post - actual	
Planned vs Actual WTE	Staff in Post - Plan	Substantive staff in post - plan	
Planned vs Actual WTE	Bank WTE - Actual	Bank Whole Time Equivalents (WTE) - actual	
Planned vs Actual WTE	Bank WTE - Plan	Bank Whole Time Equivalents (WTE) - plan	
Planned vs Actual WTE	Agency WTE - Actual	Agency Whole Time Equivalents (WTE) - actual	
Planned vs Actual WTE	Agency WTE - Plan	Agency Whole Time Equivalents (WTE) - plan	
Planned vs Actual WTE	Total Staffing - Actual	Substantive staff in post plus bank WTE plus agency WTE (actual)	
Planned vs Actual WTE	Total Staffing - Plan	Substantive staff in post plus bank WTE plus agency WTE (plan)	
Recruitment Plans	Substantive Fill Rate - Actual	Percentage of substantive staff in post against the substantive and locum establishment - actual	
Recruitment Plans	Substantive Fill Rate - Plan	Percentage of substantive staff in post against the substantive and locum establishment - plan	
Recruitment Plans	Unconditional Offers - Actual	Offers achieved	
Recruitment Plans	Unconditional Offers - Plan	Offers planned	
Rosters	Roster Compliance - % Approved on Time (>20 WTEs)	Percentage of rosters fully approved between 42 and 70 days in advance of the roster starting, for units with 20 WTE or more	Based on the week in which the roster was due to be approved
Rosters	Nursing Roster Quality - % Blue or Cloudy Sky	Percentage of rosters with good data quality based on 6 domains such as budget, safety, annual leave, etc. "Blue Sky" and "Cloudy Sky" rosters meet 5 or 4 of the domains respectively	Based on the week in which the roster was due to be approved
Rosters	Additional Duty Hours (Nursing)	Total nursing additional duty hours	No target can be set due to the nature of this metric
Diversity	% of BME Staff at Band 8a to VSM	Percentage of whole time equivalent staff from band 8a to very senior managers (VSM) who are black and minority ethnic	

Appendix

Interpretation SPC Charts

APPENDIX

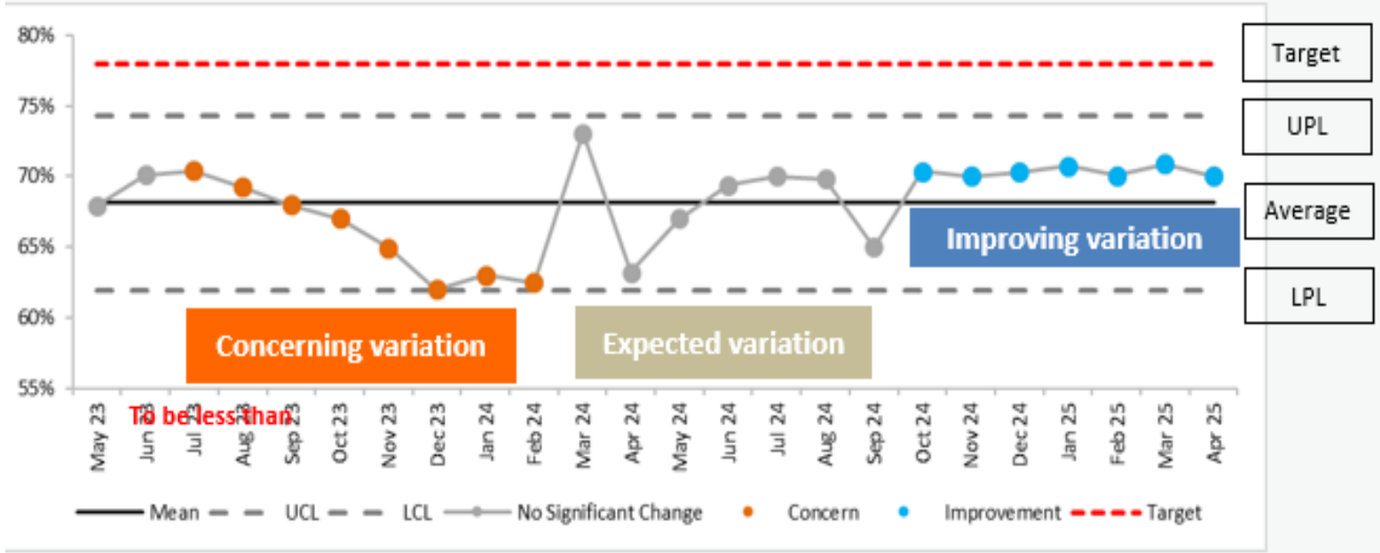
A statistical process control (SPC) chart is a useful tool to help distinguish between signals (which should be reacted to) and noise (which should not as it is occurring randomly).

The following colour convention identifies important patterns evident within the SPC charts in this report.

Orange – there is a concerning pattern of data which needs to be investigated and improvement actions implemented;

Blue – there is a pattern of improvement which should be learnt from;

Grey – the pattern of variation is to be expected. The key question to be asked is whether the level of variation is acceptable.



The dotted lines on SPC charts (upper and lower process limits) describe the range of variation that can be expected.

Process limits are very helpful in understanding whether a target or standard (the **red** line) can be achieved always, never (as in this example) or sometimes.

SPC charts therefore describe not only the type of variation in data, but also provide an indication of the likelihood of achieving target.

Summary icons have been developed to provide an at-a-glance view. These are described on the following page.

Barts Health Performance Scorecard - Summary

APPENDIX

	NOF SCORE			Trust Performance			NOF			
ACCESS TO SERVICES	3.0	Metric	Latest data	Barts latest performance	Barts agreed trajectory	SPC Trend (monthly - 24 months)	Current NOF	NOF stretch	Objective	Variance to objective
		18 Week RTT Compliance (Incomplete)	Jun-25	57.6%	53.5%	Improvement	3.2	2	59.5%	-1.9%

Aggregated NOF score, provided by NHS England for each domain

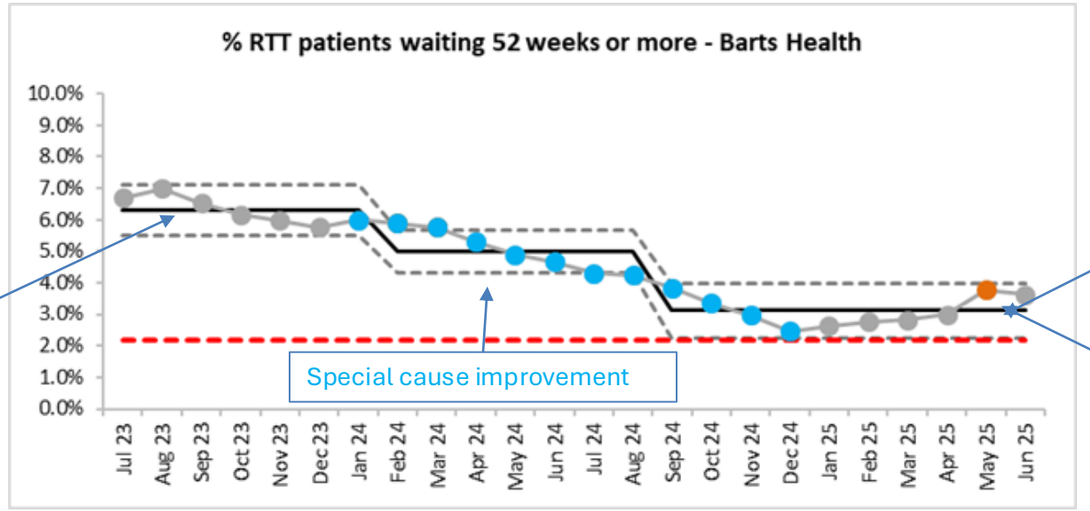
Latest performance Vs. Barts Health operational plan trajectory as submitted in the annual plan

SPC trend determined by evaluating the latest data point variation SPC type by Making Data Count methodology

This describes the current NOF score as available in the model health data set based on most recent segmentation outcome.

This identifies the next NOF segment improvement target

Estimated performance sufficient to move from the current NOF segment to the next higher segment. In this example targeting a benchmark of ≥59.5%, which represents the median performance across Trusts.



Common cause (no change)

Special cause improvement

Target line - based on the NOF stretch position

Special cause concern

Safe Staffing Fill Rates by Ward and Site

APPENDIX

		Registered midwives / nurses (day)		Care Staff (day)		Registered midwives / nurses (night)		Care Staff (night)		Day		Night		Care Hours Per Patient Day (CHPPD)			
Site	Ward name	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Patients at Midnight	Registered midwives / nurses	Care Staff	Overall
Site for Reporting	Location Original	Staff Hours (Day Planned) - RN/RM	Staff Hours (Day Actual) - RN/RM	Staff Hours (Day Planned) - Care Staff	Staff Hours (Day Actual) - Care Staff	Staff Hours (Night Planned) - RN/RM	Staff Hours (Night Actual) - RN/RM	Staff Hours (Night Planned) - Care Staff	Staff Hours (Night Actual) - Care Staff	Average Fill Rate Registered Day	Average Fill Rate Unregistered Day	Average Fill Rate Registered Night	Average Fill Rate Unregistered Night	CHPPD - Patients at Midnight	CHPPD - RN/RM	CHPPD - Care Staff	CHPPD - Overall
Royal London	10E RLH	2,163.0	2,205.5	1,069.5	1,414.5	2,139.0	2,198.0	1,069.5	1,460.5	102.0%	132.3%	102.8%	136.6%	787	5.6	3.7	9.2
Royal London	10F RLH	1,116.0	1,620.0	744.0	1,089.0	1,023.0	1,181.5	341.0	1,012.0	145.2%	146.4%	115.5%	296.8%	477	5.9	4.4	10.3
Royal London	11C RLH	2,838.5	2,820.7	1,426.0	1,485.5	2,852.0	2,967.5	713.0	1,183.0	99.4%	104.2%	104.0%	165.9%	768	7.5	3.5	11.0
Royal London	11E & 11F AAU	3,798.0	4,206.5	1,770.0	2,201.8	3,565.0	4,074.0	1,426.0	2,219.5	110.8%	124.4%	114.3%	155.6%	1,476	5.6	3.0	8.6
Royal London	12C RLH	1,817.0	2,061.5	1,426.0	1,424.1	1,805.5	2,041.0	1,069.5	1,127.0	113.5%	99.9%	113.0%	105.4%	789	5.2	3.2	8.4
Royal London	12D RLH	1,426.0	2,380.5	1,046.5	1,299.5	1,426.0	2,405.0	690.0	1,288.0	166.9%	124.2%	168.7%	186.7%	511	9.4	5.1	14.4
Royal London	12E RLH	2,744.5	2,815.7	1,426.0	1,540.7	2,495.5	2,586.7	1,426.0	1,580.0	102.6%	108.0%	103.7%	110.8%	712	7.6	4.4	12.0
Royal London	12F RLH	2,022.0	2,288.5	1,782.5	2,132.0	1,782.5	2,311.5	1,782.5	2,150.5	113.2%	119.6%	129.7%	120.6%	772	6.0	5.5	11.5
Royal London	13C RLH	1,932.0	2,357.5	724.5	1,380.0	1,782.5	2,334.5	713.0	1,311.0	122.0%	190.5%	131.0%	183.9%	785	6.0	3.4	9.4
Royal London	13D RLH	1,780.5	2,281.5	713.0	1,347.5	1,424.0	1,945.5	713.0	1,438.5	128.1%	189.0%	136.6%	201.8%	776	5.4	3.6	9.0
Royal London	13E RLH	2,035.5	2,626.5	713.0	1,309.0	1,667.5	2,452.0	713.0	1,334.0	129.0%	183.6%	147.0%	187.1%	757	6.7	3.5	10.2
Royal London	13F RLH	1,781.5	2,016.5	954.5	1,468.5	1,782.5	1,817.0	712.0	1,414.5	113.2%	153.9%	101.9%	198.7%	696	5.5	4.1	9.7
Royal London	14E & 14F RLH	4,013.5	3,576.0	2,196.5	2,834.4	2,852.0	2,995.0	2,139.0	3,081.5	89.1%	129.0%	105.0%	144.1%	1,494	4.4	4.0	8.4
Royal London	3D RLH	4,048.0	4,092.5	2,671.8	2,624.3	3,197.0	3,243.0	2,012.5	1,966.5	101.1%	98.2%	101.4%	97.7%	1,081	6.8	4.2	11.0
Royal London	3E RLH	2,139.0	2,129.5	1,065.3	1,597.5	2,139.0	2,139.0	1,069.5	1,610.0	199.1%	299.9%	200.0%	301.1%	1,544	11.1	8.3	19.4
Royal London	3F RLH	2,057.2	1,933.0	667.0	623.5	1,897.5	1,736.5	563.5	517.5	94.0%	93.5%	91.5%	91.8%	225	16.3	5.1	21.4
Royal London	4E RLH	13,877.3	14,092.4	701.5	644.0	13,834.5	13,960.8	356.5	446.0	203.1%	183.6%	201.8%	250.2%	2,460	45.6	1.8	47.4
Royal London	6C RLH	2,259.0	2,242.3	184.0	195.5	1,978.0	1,897.5	138.0	218.5	99.3%	106.3%	95.9%	158.3%	85	48.7	4.9	53.6
Royal London	6E RLH	1,689.5	2,037.8	713.0	656.0	1,426.0	1,781.0	356.5	356.5	120.6%	92.0%	124.9%	100.0%	331	11.5	3.1	14.6
Royal London	6F RLH	2,936.0	3,361.1	707.5	665.0	2,871.5	3,560.8	713.0	713.0	114.5%	94.0%	124.0%	100.0%	547	12.7	2.5	15.2
Royal London	7C RLH	1,348.0	1,293.5	586.5	1,390.5	1,069.5	1,081.0	540.5	1,092.5	96.0%	237.1%	101.1%	202.1%	369	6.4	6.7	13.2
Royal London	7D RLH	1,414.5	1,800.5	667.0	736.0	1,058.0	1,598.5	701.5	770.5	127.3%	110.3%	151.1%	109.8%	361	9.4	4.2	13.6
Royal London	7E RLH	2,518.5	2,359.2	1,092.5	1,145.7	2,323.0	2,225.2	1,069.5	1,184.3	93.7%	104.9%	95.8%	110.7%	480	9.6	4.9	14.4
Royal London	7F RLH	1,943.5	2,264.0	471.5	425.5	1,771.0	2,105.3	356.5	368.0	116.5%	90.2%	118.9%	103.2%	380	11.5	2.1	13.6
Royal London	8C RLH	1,639.5	1,641.0	712.3	789.3	1,424.0	1,430.0	713.0	826.0	100.1%	110.8%	100.4%	115.8%	566	5.4	2.9	8.3
Royal London	8D RLH	8,742.8	8,750.3	609.5	11.5	8,020.5	8,049.8	0.0	0.0	100.1%	1.9%	100.4%		1,026	16.4	0.0	16.4
Royal London	8F RLH	1,783.3	1,712.8	1,069.5	1,058.0	1,069.5	1,071.5	1,069.5	1,069.5	96.0%	98.9%	100.2%	100.0%	1,452	1.9	1.5	3.4
Royal London	9E RECA	1,069.5	1,069.5	356.5	333.5	1,069.5	1,028.3	356.5	368.0	100.0%	93.5%	96.1%	103.2%	181	11.6	3.9	15.5
Royal London	9E RLH	1,782.5	1,840.0	713.0	1,133.3	1,426.0	1,495.0	713.0	1,161.5	103.2%	158.9%	104.8%	162.9%	635	5.3	3.6	8.9
Royal London	9F RLH	1,782.5	1,760.0	713.0	874.5	1,426.0	1,427.5	713.0	909.0	98.7%	122.7%	100.1%	127.5%	618	5.2	2.9	8.0

Safe Staffing Fill Rates by Ward and Site

APPENDIX

		Registered midwives / nurses (day)		Care Staff (day)		Registered midwives / nurses (night)		Care Staff (night)		Day		Night		Care Hours Per Patient Day (CHPPD)			
Site	Ward name	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Patients at Midnight	Registered midwives / nurses	Care Staff	Overall
Site for Reporting	Location Original	Staff Hours (Day Planned) - RN/RM	Staff Hours (Day Actual) - RN/RM	Staff Hours (Day Planned) - Care Staff	Staff Hours (Day Actual) - Care Staff	Staff Hours (Night Planned) - RN/RM	Staff Hours (Night Actual) - RN/RM	Staff Hours (Night Planned) - Care Staff	Staff Hours (Night Actual) - Care Staff	Average Fill Rate Registered Day	Average Fill Rate Unregistered Day	Average Fill Rate Registered Night	Average Fill Rate Unregistered Night	CHPPD - Patients at Midnight	CHPPD - RN/RM	CHPPD - Care Staff	CHPPD - Overall
Whipps Cross	AAU WXH	4,413.8	4,387.5	2,487.0	2,297.2	3,921.5	4,309.0	2,495.5	2,138.5	99.4%	92.4%	109.9%	85.7%	1,295	6.7	3.4	10.1
Whipps Cross	ACACIA	952.5	944.5	471.5	506.0	712.0	716.5	712.0	712.9	99.2%	107.3%	100.6%	100.1%	374	4.4	3.3	7.7
Whipps Cross	Acorn	3,669.5	2,342.0	356.5	425.5	2,838.8	2,173.0	358.8	299.0	63.8%	119.4%	76.5%	83.3%	380	11.9	1.9	13.8
Whipps Cross	B3 WARD WXH	1,328.0	1,340.8	1,067.0	1,248.5	1,069.5	1,081.0	724.5	977.5	101.0%	117.0%	101.1%	134.9%	524	4.6	4.2	8.9
Whipps Cross	BIRCH	1,069.5	1,296.5	1,079.5	1,451.0	1,069.5	1,069.5	713.0	1,080.0	121.2%	134.4%	100.0%	151.5%	420	5.6	6.0	11.7
Whipps Cross	BLACKTHORN	1,069.5	1,274.5	1,081.0	1,263.5	1,069.5	1,012.0	713.0	1,000.0	119.2%	116.9%	94.6%	140.3%	535	4.3	4.2	8.5
Whipps Cross	Bracken Ward WXH	1,304.0	1,302.5	1,060.5	1,176.5	1,068.5	1,021.8	713.0	964.0	99.9%	110.9%	95.6%	135.2%	521	4.5	4.1	8.6
Whipps Cross	Cedar	1,423.5	1,279.5	1,426.0	1,417.5	1,069.5	1,046.5	1,069.5	1,078.0	89.9%	99.4%	97.8%	100.8%	520	4.5	4.8	9.3
Whipps Cross	CHESTNUT	954.5	954.5	356.5	770.5	713.0	1,058.0	356.5	793.5	100.0%	216.1%	148.4%	222.6%	388	5.2	4.0	9.2
Whipps Cross	Conifer	1,399.5	1,411.5	1,426.0	1,327.8	1,069.5	1,058.0	1,069.5	1,207.5	100.9%	93.1%	98.9%	112.9%	439	5.6	5.8	11.4
Whipps Cross	CURIE	1,425.0	1,288.0	1,066.5	1,537.0	1,069.5	942.0	1,069.5	1,432.3	90.4%	144.1%	88.1%	133.9%	565	3.9	5.3	9.2
Whipps Cross	DELIVERY SUITE WXH	6,527.5	5,838.5	1,398.5	1,232.5	5,347.5	5,325.3	1,426.0	1,333.5	89.4%	88.1%	99.6%	93.5%	550	20.3	4.7	25.0
Whipps Cross	ELIZABETH	1,654.0	1,630.5	356.5	424.5	1,426.0	1,409.0	356.5	367.8	98.6%	119.1%	98.8%	103.2%	490	6.2	1.6	7.8
Whipps Cross	FARADAY	1,426.0	1,355.0	713.0	764.5	1,426.0	1,420.3	356.5	365.0	95.0%	107.2%	99.6%	102.4%	469	5.9	2.4	8.3
Whipps Cross	ICU WXH	6,943.5	4,394.0	1,327.5	456.0	6,345.3	3,856.0	1,364.0	398.0	126.6%	68.7%	121.5%	58.4%	528	62.5	6.5	69.0
Whipps Cross	MARGARET	1,068.5	1,050.0	356.5	366.5	713.0	713.0	356.5	379.5	98.3%	102.8%	100.0%	106.5%	295	6.0	2.5	8.5
Whipps Cross	MULBERRY	2,160.5	2,086.2	1,648.5	1,329.0	1,426.0	1,427.5	1,426.0	1,336.0	96.6%	80.6%	100.1%	93.7%	1,051	3.3	2.5	5.9
Whipps Cross	NEONATAL WXH	2,792.0	2,486.1	396.0	209.0	2,347.0	2,212.1	0.0	0.0	89.0%	52.8%	94.3%		367	12.8	0.6	13.4
Whipps Cross	NIGHTINGALE	1,426.0	1,495.8	356.5	607.8	1,426.0	1,312.0	356.5	566.6	104.9%	170.5%	92.0%	158.9%	390	7.2	3.0	10.2
Whipps Cross	PEACE	1,667.5	1,662.0	1,426.0	1,466.8	1,066.5	1,189.5	1,069.5	1,170.5	99.7%	102.9%	111.5%	109.4%	484	5.9	5.4	11.3
Whipps Cross	Poplar	1,794.0	1,658.0	1,058.0	1,194.5	1,426.0	1,276.5	1,069.5	885.5	92.4%	112.9%	89.5%	82.8%	573	5.1	3.6	8.8
Whipps Cross	Primrose	1,782.5	1,828.5	1,426.0	1,621.5	1,426.0	1,527.8	1,069.5	1,621.5	102.6%	113.7%	107.1%	151.6%	865	3.9	3.7	7.6
Whipps Cross	ROWAN	1,782.5	2,162.5	1,426.0	1,552.5	1,426.0	1,805.5	1,069.5	1,529.5	121.3%	108.9%	126.6%	143.0%	851	4.7	3.6	8.3
Whipps Cross	SAGE	1,663.0	1,650.0	1,453.0	1,569.5	1,426.0	1,426.0	1,069.5	1,242.0	99.2%	108.0%	100.0%	116.1%	791	3.9	3.6	7.4
Whipps Cross	Sycamore	1,662.5	1,652.0	1,424.0	1,495.0	1,425.0	1,424.0	1,058.0	1,115.5	99.4%	105.0%	99.9%	105.4%	824	3.7	3.2	6.9
Whipps Cross	SYRINGA	1,423.5	1,964.5	1,725.0	1,780.8	1,069.5	1,688.3	1,425.5	1,758.5	138.0%	103.2%	157.9%	123.4%	575	6.4	6.2	12.5

Safe Staffing Fill Rates by Ward and Site

APPENDIX

		Registered midwives / nurses (day)		Care Staff (day)		Registered midwives / nurses (night)		Care Staff (night)		Day		Night		Care Hours Per Patient Day (CHPPD)			
Site	Ward name	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses / midwives (%)	Average fill rate - care staff (%)	Patients at Midnight	Registered midwives / nurses	Care Staff	Overall
Site for Reporting	Location Original	Staff Hours (Day Planned) - RN/RM	Staff Hours (Day Actual) - RN/RM	Staff Hours (Day Planned) - Care Staff	Staff Hours (Day Actual) - Care Staff	Staff Hours (Night Planned) - RN/RM	Staff Hours (Night Actual) - RN/RM	Staff Hours (Night Planned) - Care Staff	Staff Hours (Night Actual) - Care Staff	Average Fill Rate Registered Day	Average Fill Rate Unregistered Day	Average Fill Rate Registered Night	Average Fill Rate Unregistered Night	CHPPD - Patients at Midnight	CHPPD - RN/RM	CHPPD - Care Staff	CHPPD - Overall
Newham	BECKTON	1,299.5	1,288.0	1,027.5	1,015.0	1,069.5	1,069.5	0.0	0.0	99.1%	98.8%	100.0%		359	6.6	2.8	9.4
Newham	Custom House NUH	1,422.5	1,414.3	1,066.5	1,115.0	1,069.5	1,069.5	1,069.5	1,124.5	99.4%	104.5%	100.0%	105.1%	603	4.1	3.7	7.8
Newham	DELIVERY SUITE NUH	5,183.5	5,057.9	724.5	711.0	4,991.0	4,926.4	713.0	711.4	97.6%	98.1%	98.7%	99.8%	795	12.6	1.8	14.3
Newham	Gallions Reach (ITU)	4,278.0	3,878.5	713.0	565.5	4,278.0	3,996.5	713.0	609.5	90.7%	79.3%	93.4%	85.5%	281	28.0	4.2	32.2
Newham	HEATHER	2,135.5	2,135.5	1,423.5	1,446.5	1,782.5	1,782.5	1,426.0	1,426.0	100.0%	101.6%	100.0%	100.0%	329	11.9	8.7	20.6
Newham	LARCH	3,124.0	3,516.9	1,691.5	1,624.3	2,091.0	2,481.0	1,426.0	1,426.0	112.6%	96.0%	118.7%	100.0%	2,102	2.9	1.5	4.3
Newham	Manor Park	1,426.0	1,403.0	870.5	713.0	1,426.0	1,426.0	713.0	713.0	98.4%	81.9%	100.0%	100.0%	446	6.3	3.2	9.5
Newham	MAPLE	1,069.5	1,012.0	713.0	690.0	1,058.0	1,035.0	713.0	701.5	94.6%	96.8%	97.8%	98.4%	185	11.1	7.5	18.6
Newham	NEONATAL NUH	3,068.0	2,773.4	0.0	0.0	2,886.5	2,469.5	0.0	0.0	90.4%		85.6%		477	11.0	0.0	11.0
Newham	NUH MIDWIFERY	1,117.7	940.7	356.5	333.5	1,068.0	891.8	356.5	349.0	84.2%	93.5%	83.5%	97.9%	188	9.7	3.6	13.4
Newham	NUH Upton Park	2,490.5	2,149.5	1,426.0	1,736.2	2,492.5	2,472.5	1,426.0	1,426.0	86.3%	121.8%	99.2%	100.0%	777	5.9	4.1	10.0
Newham	PLASHET	1,777.8	1,672.0	1,066.5	1,260.2	1,426.0	1,690.5	1,069.5	1,172.3	94.1%	118.2%	118.5%	109.6%	770	4.4	3.2	7.5
Newham	RAINBOW	2,804.0	2,459.5	1,097.0	818.7	1,782.5	1,759.0	356.5	379.5	87.7%	74.6%	98.7%	106.5%	269	15.7	4.5	20.1
Newham	Silvertown	1,782.5	1,983.3	1,069.5	1,081.0	1,426.0	1,683.0	1,069.5	1,104.0	111.3%	101.1%	118.0%	103.2%	693	5.3	3.2	8.4
Newham	Stratford	1,424.5	1,516.5	1,069.5	1,099.1	1,426.0	1,528.0	1,069.5	1,127.0	106.5%	102.8%	107.2%	105.4%	462	6.6	4.8	11.4
Newham	Tayberry	1,778.5	1,745.5	1,426.0	1,345.5	1,423.5	1,403.0	1,426.0	1,437.5	98.1%	94.4%	98.6%	100.8%	778	4.0	3.6	7.6
Newham	THISTLE	1,776.0	1,756.5	1,424.0	1,445.9	1,426.0	1,437.5	1,426.0	1,449.0	98.9%	101.5%	100.8%	101.6%	777	4.1	3.7	7.8
St Bart's	1C	5,951.0	4,740.0	356.5	345.0	5,669.5	4,462.0	195.5	195.5	79.7%	96.8%	78.7%	100.0%	371	24.8	1.5	26.3
St Bart's	1D	3,208.5	2,587.5	356.5	345.0	2,852.0	2,311.5	356.5	356.5	80.6%	96.8%	81.0%	100.0%	331	14.8	2.1	16.9
St Bart's	1E	4,991.0	3,916.0	356.5	299.0	4,991.0	3,762.5	356.5	299.0	78.5%	83.9%	75.4%	83.9%	215	35.7	2.8	38.5
St Bart's	3A SBH	4,991.0	4,572.5	1,426.0	1,357.0	4,979.5	4,600.0	1,426.0	1,424.5	91.6%	95.2%	92.4%	99.9%	962	9.5	2.9	12.4
St Bart's	3D SBH	1,552.5	1,770.0	1,180.0	1,380.5	1,495.0	1,403.0	954.5	943.0	114.0%	117.0%	93.8%	98.8%	511	6.2	4.5	10.8
St Bart's	4A SBH	1,782.5	1,748.0	1,069.5	1,069.5	1,426.0	1,426.0	356.5	689.5	98.1%	100.0%	100.0%	193.4%	741	4.3	2.4	6.7
St Bart's	4B SBH	1,583.5	1,576.0	1,225.5	1,176.8	1,426.0	1,426.0	713.0	736.0	99.5%	96.0%	100.0%	103.2%	535	5.6	3.6	9.2
St Bart's	4C SBH	1,782.5	1,633.0	954.5	931.5	1,426.0	1,322.5	954.5	840.5	91.6%	97.6%	92.7%	88.1%	609	4.9	2.9	7.8
St Bart's	4D & 4E SBH	1,667.5	1,489.5	713.0	663.6	1,610.0	1,276.5	701.5	611.5	89.3%	93.1%	79.3%	87.2%	447	6.2	2.9	9.0
St Bart's	5A SBH	2,113.8	2,141.6	999.0	1,010.9	1,353.0	1,416.5	341.0	452.2	101.3%	101.2%	104.7%	132.6%	595	6.0	2.5	8.4
St Bart's	5B SBH	1,426.0	1,243.8	713.0	690.0	1,069.5	1,012.0	356.5	402.5	87.2%	96.8%	94.6%	112.9%	424	5.3	2.6	7.9
St Bart's	5C SBH	2,121.0	2,093.0	713.0	701.5	1,782.5	1,761.5	356.5	368.0	98.7%	98.4%	98.8%	103.2%	582	6.6	1.8	8.5
St Bart's	5D SBH	2,127.5	2,085.5	713.0	733.0	1,782.5	1,771.0	713.0	736.0	98.0%	102.8%	99.4%	103.2%	659	5.9	2.2	8.1
St Bart's	6A SBH	7,149.0	4,829.0	356.5	333.5	6,831.0	5,106.0	356.5	356.5	67.5%	93.5%	74.7%	100.0%	285	34.9	2.4	37.3
St Bart's	6D SBH	1,449.0	1,764.0	713.0	701.5	1,081.0	1,460.5	689.8	712.8	121.7%	98.4%	135.1%	103.3%	504	6.4	2.8	9.2