NHS
Royal Cornwall Hospitals
NHS Trust

Integrated Performance Report

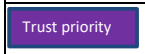
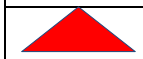




April 2025

Abbreviation Glossary

Symbol key:

	Broken blue border around a graph indicates the metric has a local target.
	Solid blue border around a graph indicates the metric has a national target.
	Metric is in the NHS PAF
	Metric is one of the Trust's Priorities.
	Measure shows a decline in performance over the previous 5 month period.
	Straight broken green lines within a graph indicate upper or lower control limit. The line closest to the direction the KPI should be going in will be green.
	Straight broken amber lines within a graph indicate upper or lower control limit. The line furthest away from the direction the KPI should be going in will be amber.
	Straight broken dark red lines within a graph indicate either KPI average or the KPI standard.
	Light blue lines within a graph indicate a local trajectory.
	Purple lines within a graph indicate a standard, target or threshold.

Abbreviation Glossary:

ACCT	Anaesthetics, Critical Care and Theatres Care Group
AEM	Acute and Emergency Medicine Care Group
ASC	Adult Social Care (Cornwall County Council)
CATU	Community Assessment and Treatment Units (typically for care of the elderly)
CEO	Chief Executive Officer
CFT / CPFT	Cornwall Partnership NHS Foundation Trust
CNO	Chief Nursing Officer
CS	Clinical Support Care Group
DOSA	Day of surgery admission
DTOC	Delayed transfer of care
ECIP	Emergency Care Improvement Programme
ECIST	Emergency Care Improvement Support Team (clinically led national NHS team)
ESR	Electronic Staff Record

Abbreviation Glossary Continued:

FTE	Full time equivalent
FUW / FUWL	Follow up waiting / Follow up waiting list
HASU	Hyper-acute stroke unit
HAT	Hospital acquired thrombosis
HSCIC	Health and Social Care Information Centre
HSMR	Hospital Standardised Mortality Ratio
ICB	Integrated Care Board
ICC	Incident Command Centre (RCHT)
IPAC	Infection Prevention and Control
KPI	Key performance indicator
MDT	Multidisciplinary Team
MIU	Minor Injury Unit
NHSE	NHS England
NIHSS	National Institutes of Health Stroke Scale
PSCL	Patient Safety Checklist
PTL	Patient tracking list
RCA	Root cause analysis
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
RTT	Referral to treatment
SHMI	Summary Hospital Level Mortality Indicator
PSII	Patient Safety Incident Investigation
SMH	St Michaels Hospital
SMR	Standardised Mortality Ratio
SOP	Standard Operation Procedure
SRO	Senior Responsible Officer
SS&S	Specialist Services and Surgery Care Group
SSNAP	Sentinel Stroke National Audit Programme
STEPs	Short Term Enablement and Planning service (for over 65's)
SWASFT	South Western Ambulance Service Foundation Trust
TR	Treliske Hospital Emergency Department
UTC	Urgent Treatment Centre
WCH	West Cornwall Hospital Emergency Department / West Cornwall Hospital
WC	Women and Children Care Group
YTD	Year to date

Strategic Objectives

Outstanding Care for One + All

1

SAFE, HIGH QUALITY CARE

We will provide safe, high quality care, refining our model of care to be person-centred and as close to home as possible

2

SUPPORTED AND VALUED PEOPLE

We will become a great University Hospital, known for its excellence in supporting staff in wellbeing, training and development and career pathways

3

JOURNEY OF IMPROVEMENT

We will embed a culture of learning, leadership and improvement across the Trust, focussed on core business, and grow our reputation for research

A guide to SPC charts

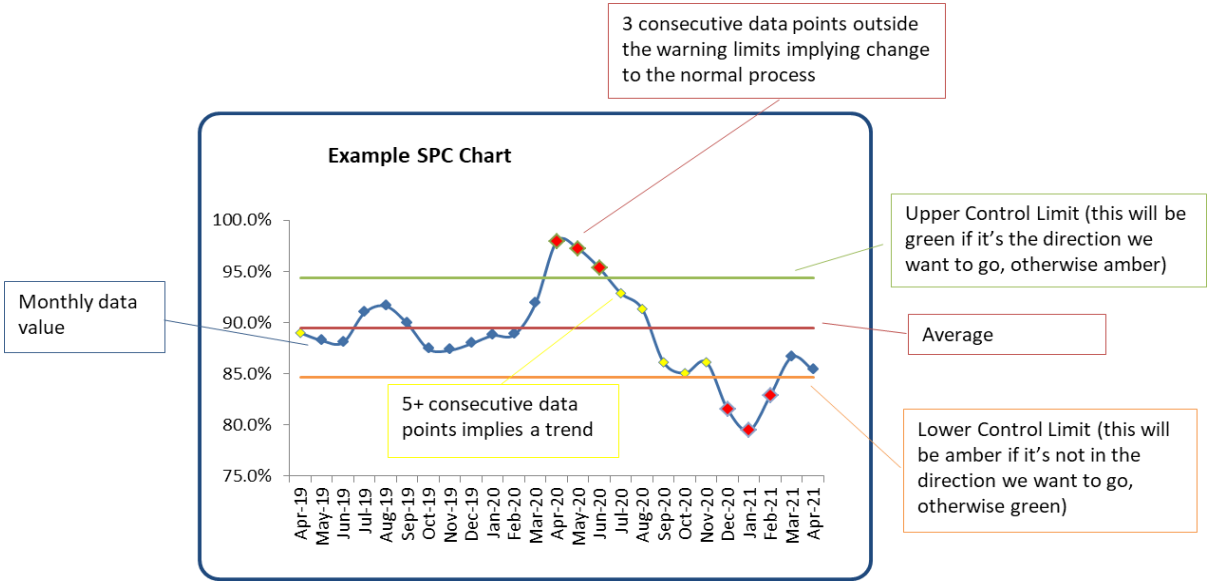
Within the Integrated Performance Report (IPR), statistical process control (SPC) charts are used where approriate.

SPC is an analytical technique that plots data over time. The main aim is to understand whether what is going on is normal or different to the norm, and in doing so guides us to take the most appropriate, if any, action. This also aids against providing false reassurance often gained with trend lines, which can suggest trends which are not genuine depending on the date range and/or the amount of data points selected.

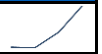
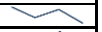
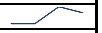
SPC is widely used in the NHS to understand whether change results in improvement from a transformation project (which is cha nging a process), but also in performance management. The most common SPC tool is a control chart which is a graph used to study how a the process, or performance, changes over time. Data are plotted in sequential time order. A control chart always has a central line for the average, an upper line for the upper control limit and a lower line for the lower control limit. On the SPC charts within the IPR, straig ht lines at the top of the chart indicate the upper control limit, and the bottom line the lower control limit. The lines will be green to indicate the direction the KPI should be going in, whilst amber is used for t he limit which lies furthest away from the intended direction of the KPI. Straight red lines show the average. Light blue coloured lines are used for local trajectories, and purple lines are used for targets or thresholds.

SPC uses rules to help interpret the data being presented. Here are some of the rules:

- 1 point outside the warning limits (upper or lower limits) of two standard deviations – this indicates where the data is not the norm for this process or measure.
- 3 consecutive data points outside the warning limits of two standard deviations - implies a change to the normal process (red markers).
- 5 or more consecutive points going in the same direction - implies a trend (yellow markers).
- 7 consecutive points in an upward or downward direction - implies a change in the process.



Strategic Objectives: Summary Scorecard

Strategic Objective	Metric	25/26 Target/Standard	23/24	24/25	Jan-25	Feb-25	Mar-25	Apr-25	Variation	YTD 25/26	Sparkline
Safe, High Quality Care (Reviewed by Quality Assurance Committee)	Treliske ED attenders - 4 hours arrival to discharge, admission or transfer	TBC	44.24%	43.92%	46.03%	45.98%	47.29%	49.53%	+2.24%	49.53%	
	RCHT Delayed Patients (P0-P3)	TBC			106	98	96	82	-14.69	82	
	Inpatient Elective Activity				105.21%	105.18%	108.32%	105.21%		105.21%	
	Total general and acute (G&A) bed occupancy (%)	TBC			95.57%	95.26%	95.54%	95.35%	-0.19%	95.35%	
	Infection control: C-difficile cases	TBC	98	115	12	8	11	6	-5	6	
Supported and Valued People (Reviewed by the People and OD Committee)	Recommend the Trust as a Place to Work	51%	52.16%	48.41%	48.13%	48.13%	48.13%	37.88%	-10.25%	37.88%	
	% Appraisals completed of eligible staff	85%	72.32%	75.41%	76.74%	76.74%	77.61%	77.30%	-0.31%	77.30%	
	% Sickness absence	3.75%	5.00%	4.96%	5.22%	4.92%	4.57%	4.44%	-0.13%	4.44%	
	Staff turnover	7-15%	9.38%		8.34%	8.60%	8.48%	8.50%	+0.02%	8.50%	
Journey of Improvement (Reviewed by Finance and Performance Committee)	Monthly financial position (£m)				-0.01	-0.02	-0.90	2.12			
	Year to date financial position	83.0			2.63	0.81	-0.09	2.12			
	Monthly agency spend (£m)		22.53		0.98	0.99	0.94	0.71			
	Capital spend (£m) (year to date)		44.10		27.84	32.62	56.54	1.21			
	CIP % delivery at year end		100.00%		97%	100%	100%	91%	-9%		
	CIP delivery - forecast year end CIP that is recurring (%)		41.00%		45%	45%	45%	75%	30%		

Urgent Emergency Care

Metric Highlights:
For the second consecutive month, ED and MIU 4 hour arrival to discharge, admission or transfer met the 78% standard, the best performance since April 2024, with Treliske ED 4 hour performance reaching 49.5%, the best position since December 2024. All Emergency Department metrics remained within control limits demonstrating no special cause variation.
All stroke metrics remained within control limits in April, although only stroke patients receiving CT scan within 12 hours met the 90% standard. The percentage of patients with a fractured neck of femur receiving an operation within 36 hours remains favourably above the mean and within control limits for a third month at 46%, though a way off meeting the standard of 70%.
From a patient flow perspective, all metrics are within the control limits demonstrating no special cause variation. April saw the lowest number of super stranded patients with a length of stay above 21 days since October 2021, and the lowest number of delayed patients since May 2024.

Stroke:
An invited RCP peer review of the Stroke service took place on 1 and 2 May. The recommendations will form an action plan to improve all key indicators for stroke.
Access to the Stroke Unit within 4 hours (target 90%) – 42.4%of patients in April were admitted to the stroke unit. A new escalation plan has been implemented from May allowing the HASU beds to be ringfenced.
30-day Stroke Mortality - remains the service's highest risk (rated extreme) due to the inability to maintain mortality rate below 10% (12.6% in April). A data quality issue was identified with incomplete NIHSS scores which should see our HSMR data improve, however annual reporting is not yet available to prove this.
Patients seen by Stroke consultant within 14 hours (target 85%) – improvement to 74.7% in April due to the medical model which now provides a senior decision maker to 21:30 during weekdays and 20:00 at weekends to complete post-take reviews.
Thrombolysis (target 12%) – in April only 6.9% of patients received thrombolysis. In response to the peer review, longer term plan is to move to a consultant-led thrombolysis service (not ED-led). This is dependent on the full implementation of the medical model and no medical patients being in ED, therefore allowing consultants to be released for thrombolysis.
The Trust's acute stroke unit (Phoenix ward) continues to host an additional five escalation beds without increased therapy staffing. Proposals are underway to relocate Phoenix ward and return to the 21-bed base for which there is adequate focussed therapy staffing.

Fractured Neck of Femur Pathway
NOF Time To Theatre within 36 hours - 46 %, with NOF Admissions up from previous month (68 Admissions).
Medical patients continue to occupy Trauma beds which impacts our ability to bring NOFs up from ED within a 4-hour target. The 4 hours KPI is being monitored daily to facilitate actions to improve the pathway to ward.
A review of trauma capacity across the service is underway with Kingsgate. The modelling of the service is expected to complete by the end of May 2025. This review will consider if we have enough capacity to affectively deliver trauma within our existing theatre allocations.
NOF improvement works have been reviewed and new actions have been identified to improve our 36 hours turnaround time to theatre and time to ward KPI.
NOF Best Practice Tariff (BPT) at 27 %- Post op mobilisation at 66%

Key actions we are taking this month to further improve performance, through our Clinical Vision of Flow Programme:

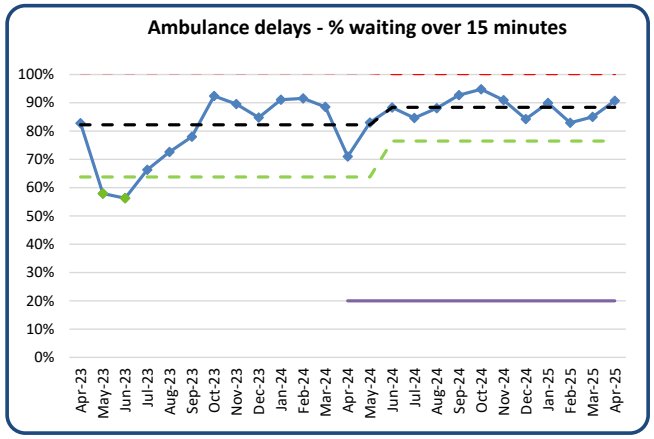
RCHT and SWASFT continued operating the Timely Handover Protocol (THP) for 90 minutes between 8.00 am and 6.00 pm daily. This moved to 60 minutes in early May and continues to reduce average ambulance handover time across the day and night, reducing SWASFT's CAT 2 response time across Cornwall. RCHT intends to progress from THP 60 to THP 45 from the end of May. Work continues on flow, including a "Every minute counts – every patient counts" week in May to focus on reducing stay below 8 hours (and ultimately 4 hours) within ED. The whole of RCHT is working to identify suitable beds for patients in ED and move them to a base ward within 8 hours of admission. This target will be adjusted as flow improves to achieve the national 4-hour target. Other metrics (4-hour breaches & 12-hour breaches in ED as well as aiming for earlier discharges across the hospital) are being focussed upon to improve performance and reduce patient harm.

Environmental work continues in the Acute Medical Unit (AMU) to create an admitting area so the Medical Take can be removed from ED. This will ensure patients referred to the Acute Medics are triaged and assessed on AMU reducing the pressure on ED. Tight control over bedding the Same Day Medical Assessment (SMDA) overnight has enabled this to function as designed, helping to pull patients from ED and deliver the appropriate same day hospital care.

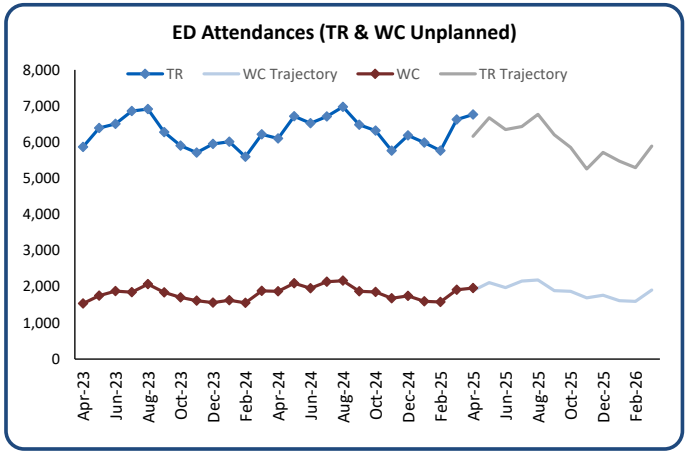
The business case to adjust Middle Grade doctor cover in the ED was approved in early May. Work is now underway to recruit suitable staff into these new roles, with a plan to have cover in place by August 2025.

Safe, High Quality Care

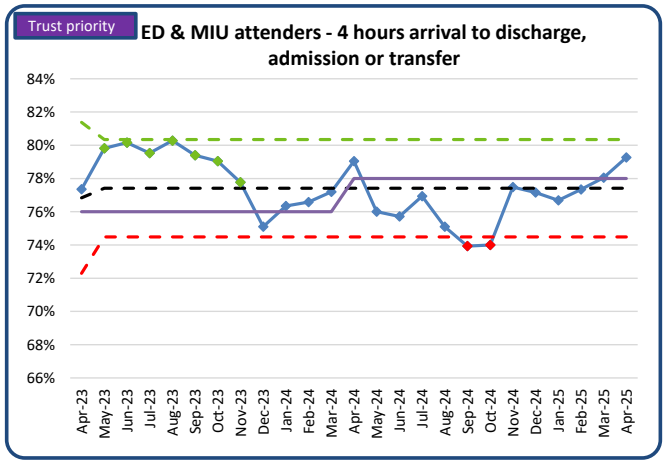
Improving urgent and emergency care performance. By March 2026: improve system 4hr performance to 85.8%(ED to 62.9%), reduce ambulance holds to an avg of 27 mins, reduce waits over 12hrs in ED to 5%



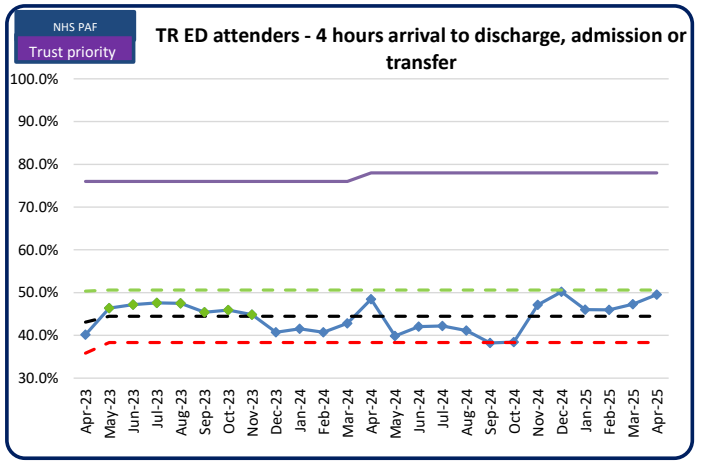
Apr-25
90.70%



Apr-25	
TR	6767
WC	1963

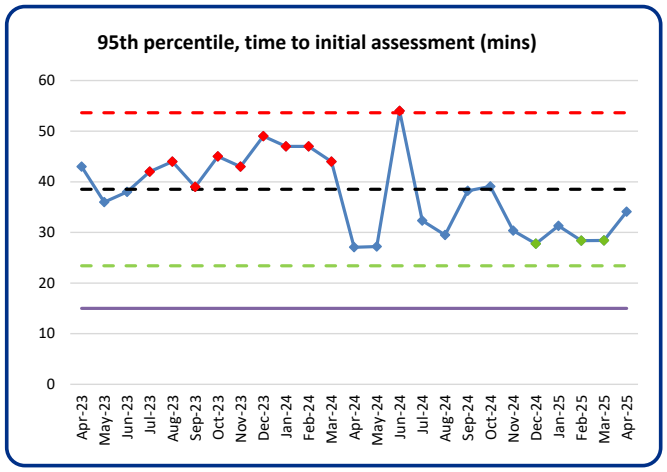


Apr-25
79.26%

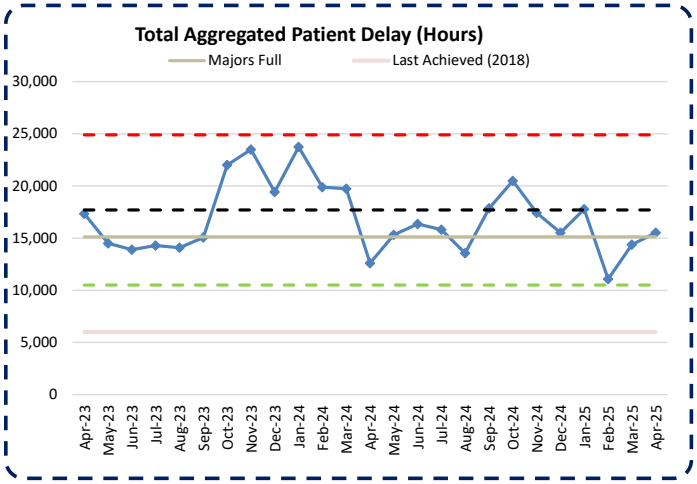


Apr-25
49.53%

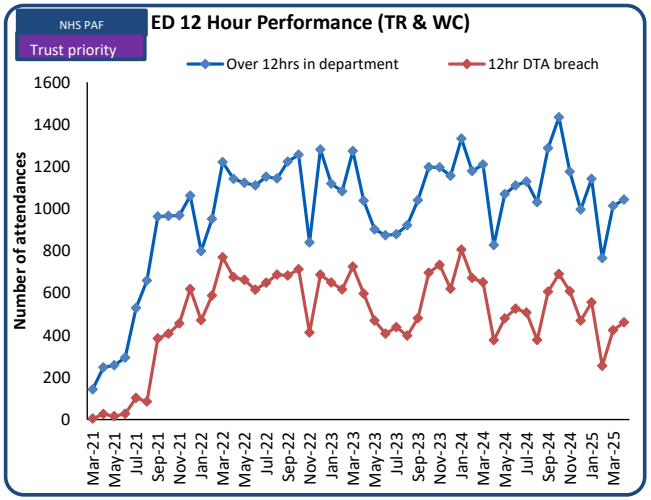
Safe, High Quality Care



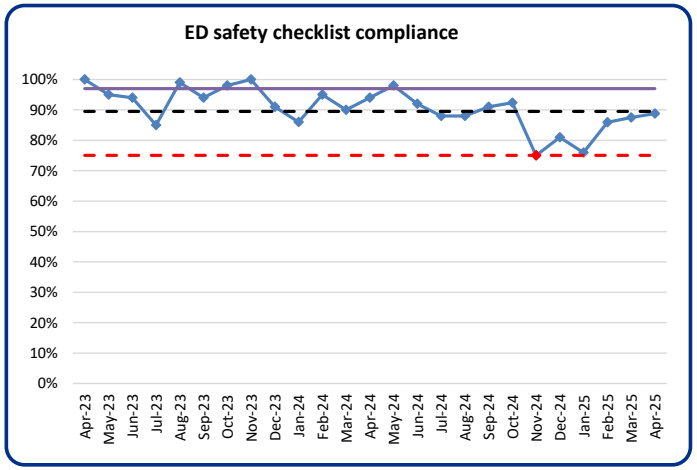
Apr-25
34



Apr-25
15,515

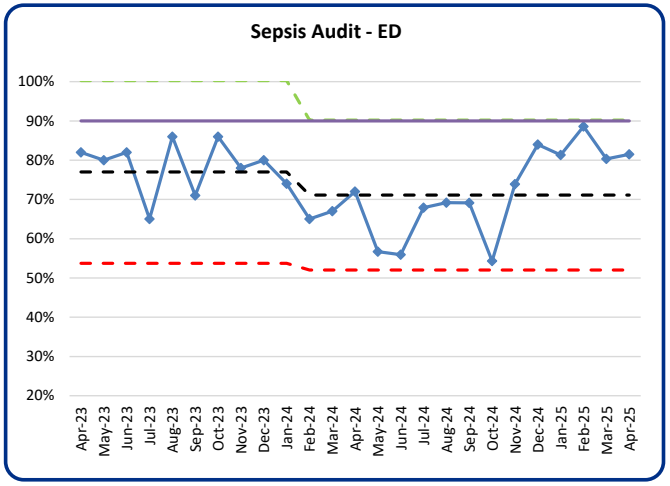


Apr-25	
Patients	1043
Breaches	461

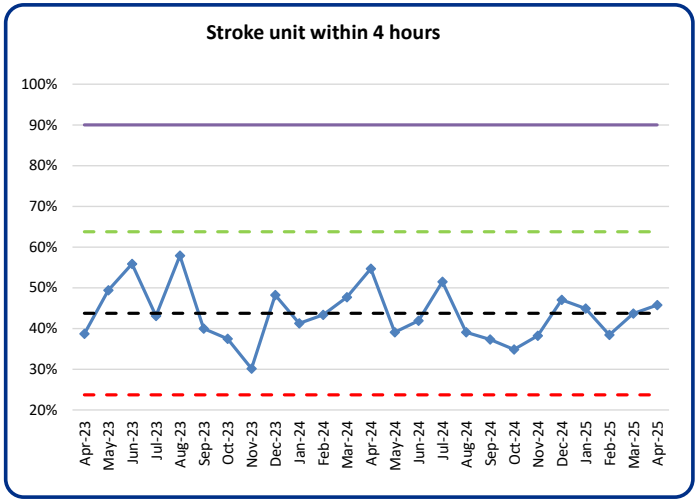


Apr-25
88.80%

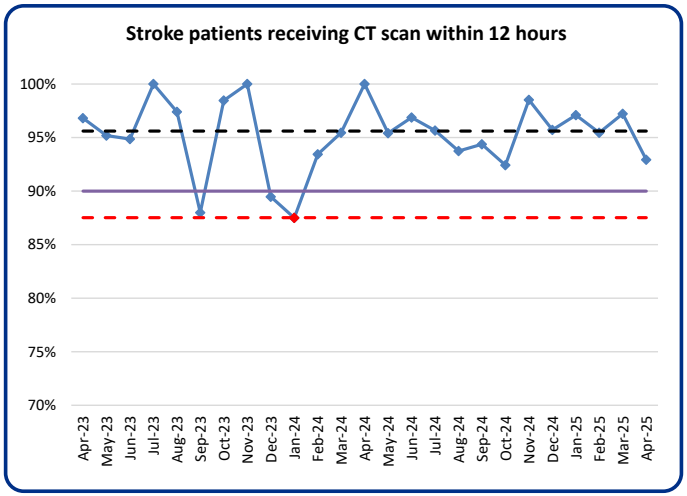
Safe, High Quality Care



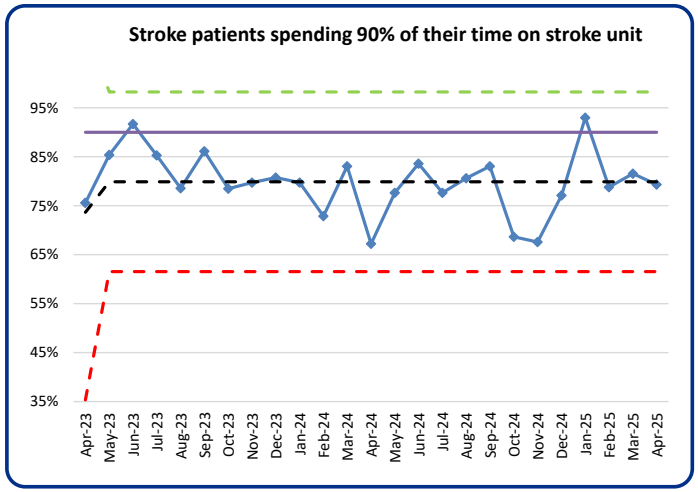
	Apr-25
Antibiotics within 1 hr	81.50%



Apr-25
45.78%

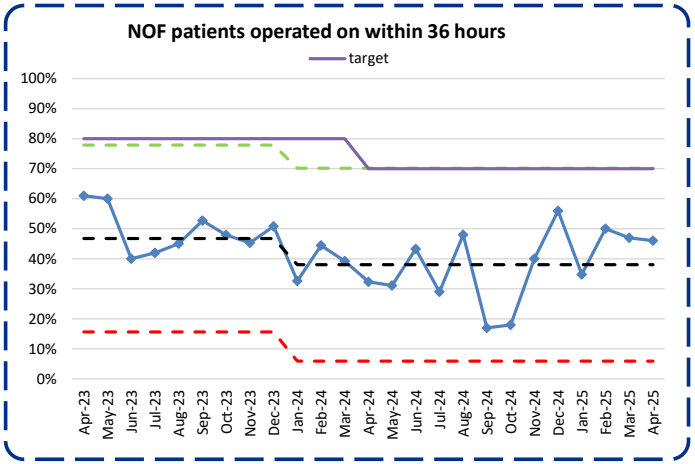


Apr-25
92.94%

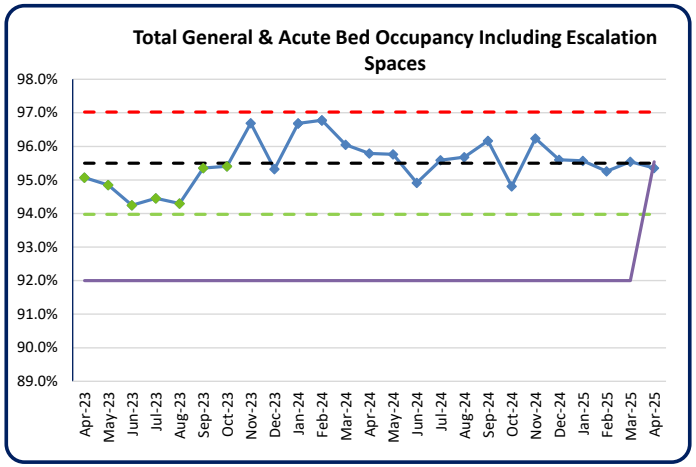


Apr-25
79.31%

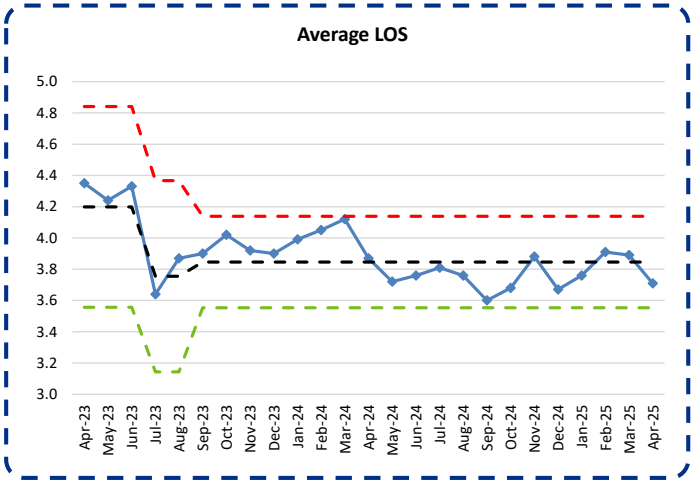
Safe, High Quality Care



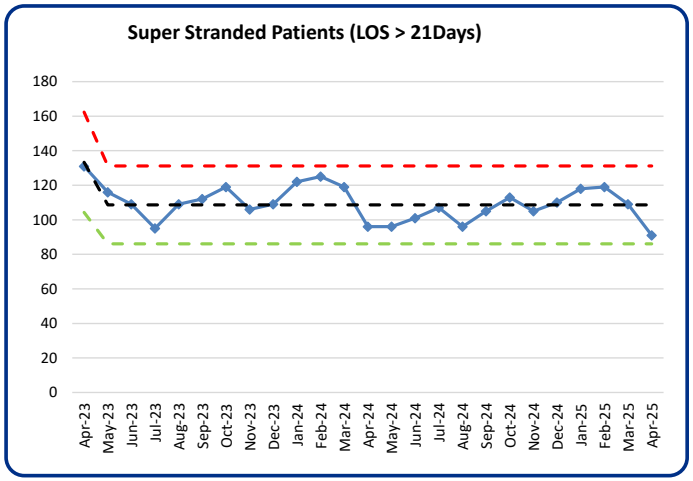
Apr-25
46.00%



Apr-25
95.35%

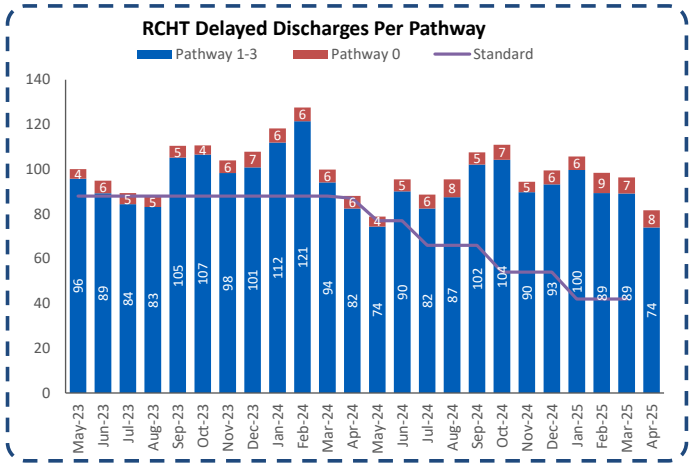


Apr-25
3.71

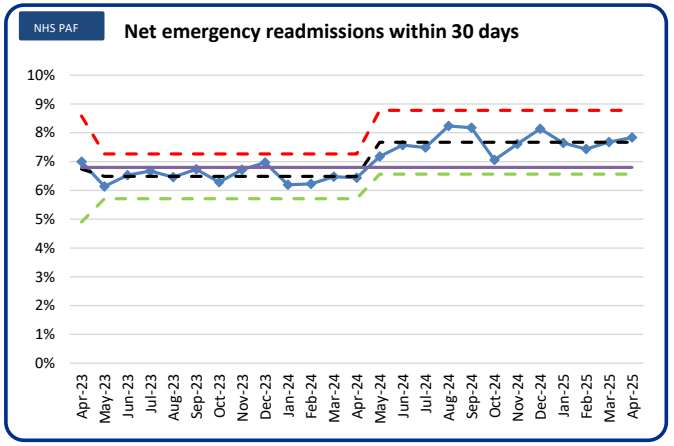


Apr-25
91

Safe, High Quality Care



Apr-25	
Pathway 0	8
Pathway 1-3	74
Total	82



Apr-25
7.84%

Safe, High Quality Care

Planned Care Metric Highlights

Referral to Treatment (RTT) performance reported in the IPR continues to be pre-submission and subject to change (normally improvement) before the final submission. There is expected to be 1 78 week wait in April (Trauma and Orthopaedic) and 13 65 week waits which is expected to improve to 9 cases beyond the snapshot within this report (1 Vascular Surgery, 8 Trauma and Orthop aedics). There were 355 52 week waits in April, though this is expected to improve by 9 cases to 344 (342 in March), with 22 treatment functions reporting these long waits. 36% of 52 week waits were in Trauma and Orthopaedics, with the next highest Gynaecology (13%) and Neurology (9%). Completed RTT pathway activity was 113% compared with 2019/20, equating to 570 per working day. For Trauma & Orthopaedics, completed pathways were 61% compared with 2019/20 – this was entirely within non-admitted pathways stops, which were 47%, admitted pathways were 80%. The outpatient follow up waiting list increased in April to 120,493 (+194). The follow-up waiting list backlog (more than 1 month overdue not booked) increased to 16,288 (+258) - most overdue remains in Cardiology at 33 months. The backlog equates to 14% of the waiting list, specialties most above this were Paediatric Diabetic Medicine (56%), Dermatology (48%), Colorectal Surgery (47%), Clinical Psychology (39%), Vascular Surgery (37%), Speech and Language Th erapy (33%), and Paediatric Clinical Immunology and Allergy (31%).

Diagnostic performance against the 6 week wait standard improved to 91.71% in April, the best performance since November 2024 and triggered as an improvement on statistical process chart (SPC), against a standard of 99%. The number over 13 weeks reduced to 87 (115 in March) with the maximum wait 42 weeks.

28 day re-booking breaches improved to 31 in April from 64 the previous month, however continues to adversely exceed the target of 7, with the highest proportion of breaches for the third consecutive month in oral surgery. There were 75 cancellations in April, 27 less than the previous month. The specialties most affected were oral surgery (14), orthopaedic (10), trauma (9) and ophth almology and urology (both 8). Percentage of cancellations on the same day will be reported one month in arrears, with April data available to report in the IPR report published in June. The Trust continues to perform strongly against Outpatient Transform ation key performance metrics, meeting and exceeding the targets for both percentage of outpatient appointments attended that are non face to face, and patient initiated follow up (PIFU).

Actions and Progress Achieved - Elective Recovery Programme:

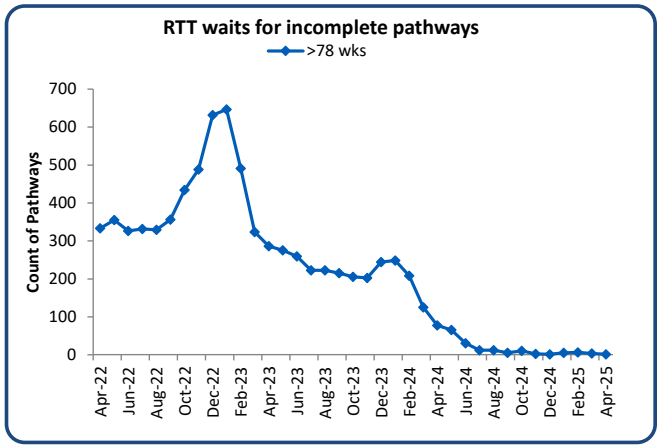
* RCHT has finalised the Operational Plan for 2025/26, as planned, with the aim to deliver 74% RTT performance by the end of March 2026 - in April it was 69.9% an increase of 0.5%. The focus remains on all specialties improving their individual non admitted performance, as well as focusing on the highest challenged areas (Orthopaedics, Neurology, Cardiology, Vascular, General Surg ery, Urology, Dermatology and the Breast pathway).
* Work remains ongoing to complete RCHT's clinically led planned care strategy aiming to deliver planned care in the most eff ective way, recovering back to the national access standards whilst reducing planned care inequalities. This is expected to be finalised by the end of QTR 1.
* Improvement workstreams continue through the outpatient transformation programme, outpatient utilisation project, theatre utilisation, with a theatre template review with agreed plan expected late June. There is a focus on cancellations on the day and withing 48 hours of booked procedures. We are aiming to increase day case rates in conjunction with British Association of Day Surgery and NHSE improvement programme with visits in May, job planning reviews (expected late June) and utilisation of diagnostic capacity to deliver DM01 diagnostic standards, maximize all efficiency, alternative care models, use of existing resources, R CHT CDCs and all funding streams to maximise planned care activity.
* Maximise all opportunities to mitigate the impacts on RTT of E-care preparation and implementation.
* ICB contracted Camborne Redruth CDC is expected to go live in Nov 2025.
* Outpatient transformation metrics continue to be in the upper quartile nationally. Patient engagement portal - digital referral acknowledgement and questionnaires now live under the Waiting Well functionality. Patient specific missed appointment surveys started in targeted clinics. Over 75% engagement rate with electronic notifications. Continued focus on missed appointments, wi th improvements in performance and ranking across South West Region of 5 out of 7 high volume specialties, benchmarked between July 2024 and February 2025. Focus on deep dives in specialties with high DNA rate, in addition to other interventions. Patient s on waiting lists validated to confirm they require their appointment or procedure, with 7,031 patients contacted in April (88% response rate). 4.3% no longer required their appointment/procedure. PIFU (patient initiated follow up) performance improved in month. Cardiology and Rheumatology plans remain work in progress; Ophthalmology reviewing criteria. Clinic template standardisation – focus on 5 key specialties (Cardiology, ENT, Gastroenterology, Respiratory, Urology), plus Gynaecology, in line with NHSE dir ective. Bookwise outpatient system being implemented across all 3 sites to support outpatient space utilisation and enable scheduling process in line with theatre booking.
* 52 Week Wait - The Trust has developed a provisional trajectory for all specialties to have 0 x 52 week wait compliance by th e end March 2026: between March and April 2025 the total number of 52ww increased by 6.
* Additional scrutiny continues of all activity across all elective functions using a range of data sources is underway to id entify increased productivity in support of financial and operational targets, this includes repatriation of higher cost outsourced activity. The Trusts plan is expecting reduced activity in May, with activity expected to recover from June onwards.
* The Echocardiology diagnostic recovery position remains challenged, however an improving picture with urgent Echo's now bei ng booked at 2 weeks and routines down to 7 weeks thanks to insourcing support. Performance improvement has been restricted in April due to significant sickness in the echo team leading to outpatient clinics being cancelled to re-deploy insourced staff to inpatient duties, however RCHT is expecting staff to begin returning to work from the end of May. RCHT will be benefitting from the NHS England International Recruitment Scheme and have an internal development scheme now established as a pipeline for specialty future workforce and vacancy reduction.

Potential Risks/Identified Risks:

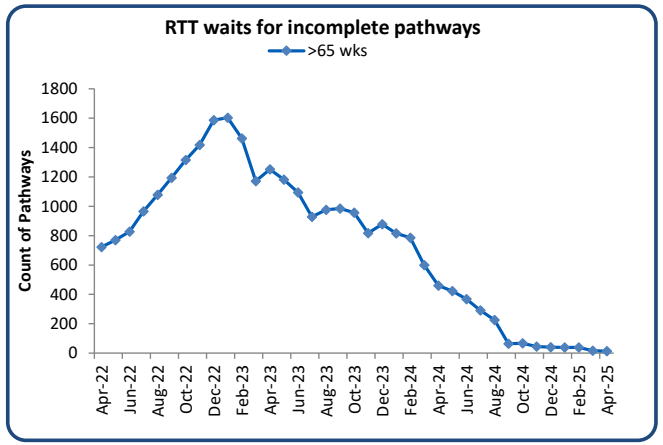
* There is a risk to the Trust's ability to deliver 2024/25 activity levels and maintain pace of improvement and reduction in long waiters in 2025/26 in a financially limited system. RCHT continues to develop plans to meet elective standards, with the overarching aim to reduce long waits for planned care patients.
* There is a risk associated with the implementation of eCare with work continuing to assess the potential impact of eCare on 2025/26 elective care activity and functionality that supports elective care.
* The 2025/26 operational plan assumes 2024/25 completed pathway levels (including premium cost activity levels) which RCHT i s looking to reduce, via delivering operational efficiencies. There is a risk that either the activity levels may not be sufficiently impacted to deliver the required increased activity levels or take longer than anticipated to implement, which could lead to capacity shortfalls for planned care recovery

Safe, High Quality Care

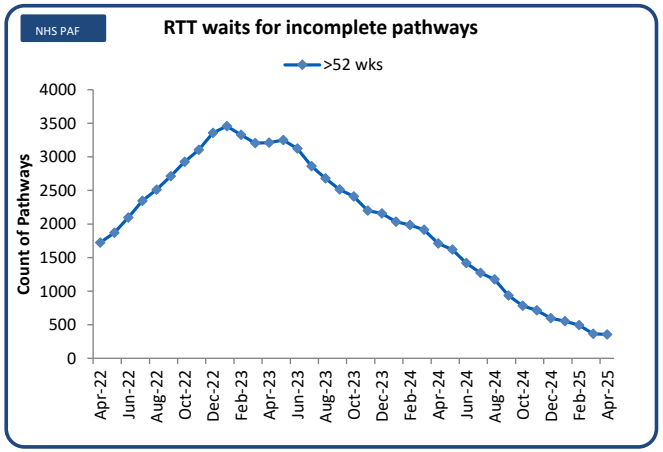
Improving access to elective services. By March 2026: 74% of patients waiting no more than 18 weeks for their elective treatment.



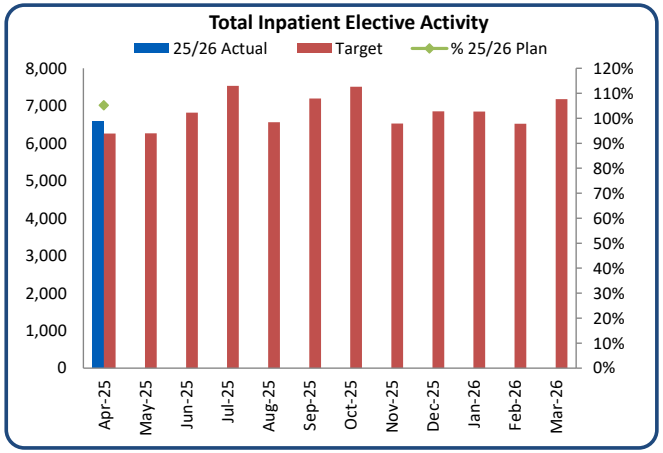
Apr-25	
Over 78 wks	1



Apr-25	
Over 65 wks	13

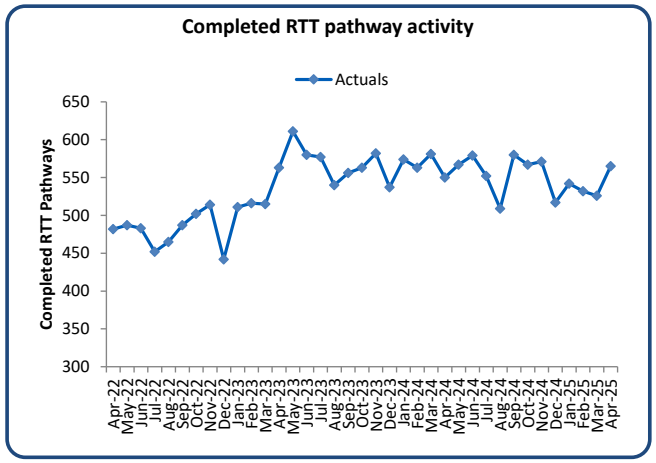


Apr-25	
Over 52 wks	355

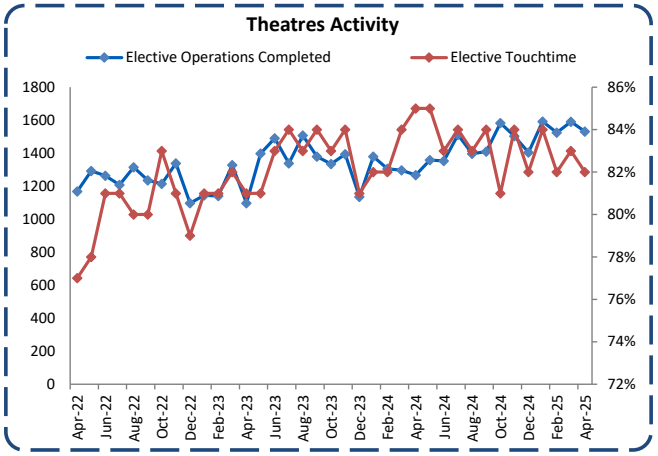


Apr-25	
Target	6259
25/26 Actual	6,585
25/26 Plan %	105%

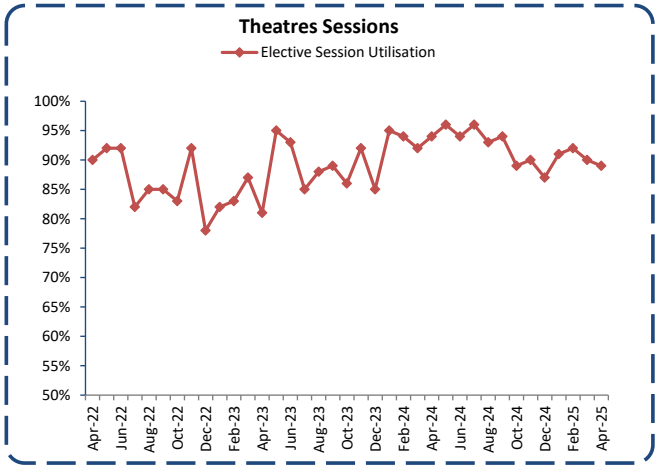
Safe, High Quality Care



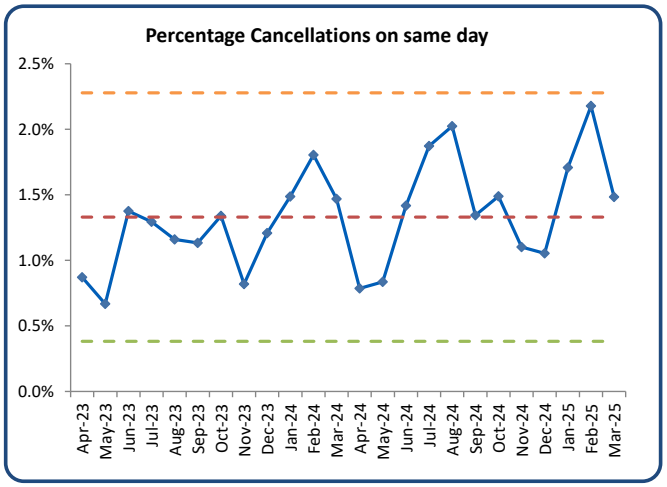
Apr-25
565.00



Apr-25	
Elective Operations	1531
Elective Touchtime	82.00%

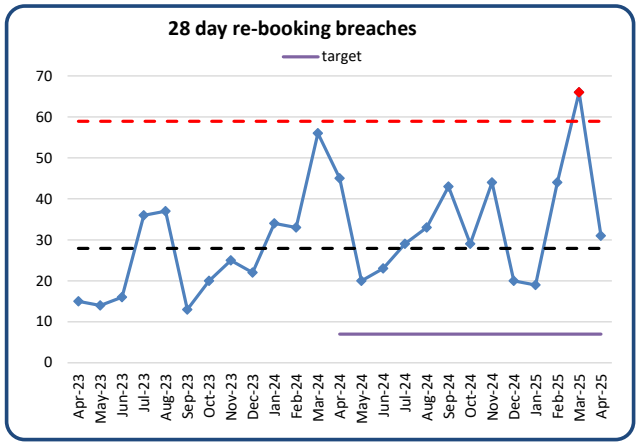


Apr-25	
Elective Session Utilisation	89.00%

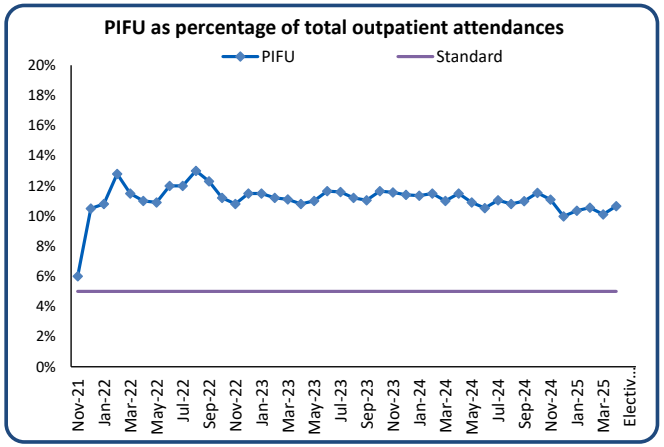


Mar-25
1.48%

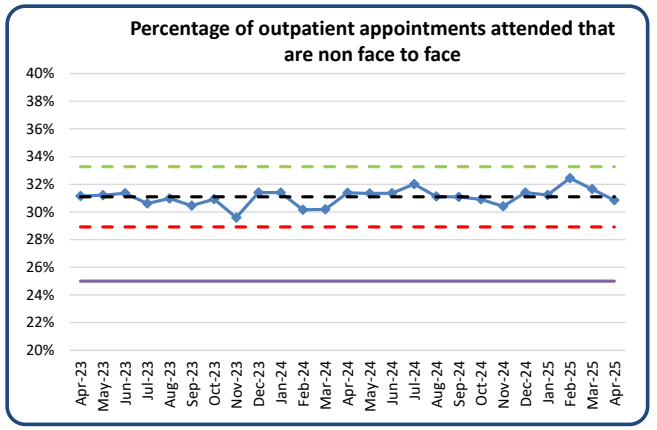
Safe, High Quality Care



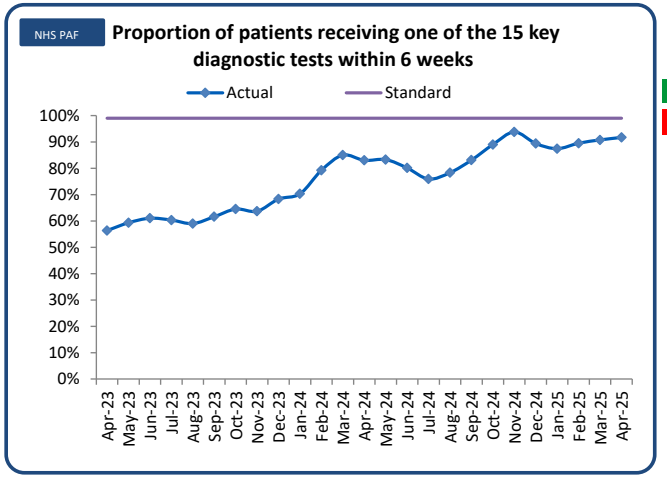
Apr-25
31



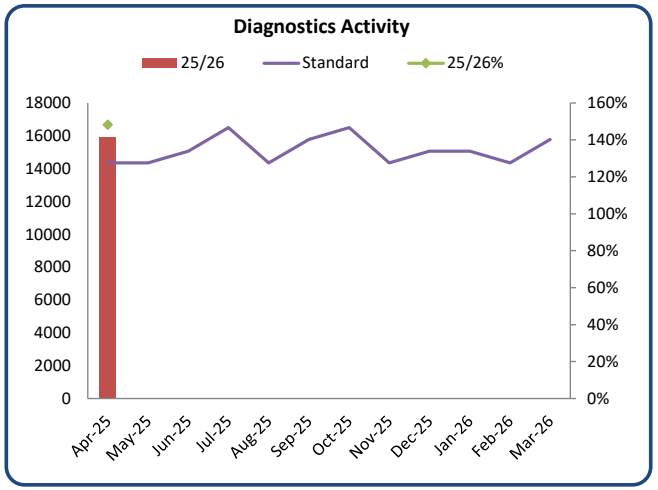
Apr-25
10.65%



Apr-25
30.85%



Apr-25
91.71%



Apr-25	
25/26	15,922
25/26%	148.28%

Cancer

Metric Highlights:
There were 9.5 x 104 day waits in March, up from 5 in February. In March there were: 3x breast breaches, 2.5x lung breaches, 1.5x urology breaches, 1x haematology breach, 1x sarcoma and a shared 0.5 Upper GI breach. These were a mix of complex pathways, diagnostic capacity and outpatient capacity.

Both breast and lung are providing a recovery plan and trajectory to improve pathway steps and performance which will be shared with the ICB and Peninsula Cancer Alliance.
In the combined 62-day target, there were 46 breaches giving a performance of 86.1%. This is above the nationally set interim of 70% but not the actual target of 85%. This compares to an England average of 71.3% putting the Trust 15th in England. Just over a third of the breaches were within breast (16 breaches), a quarter were with urology (12 breaches) and the rest being spread across tumour sites. Breast is the only major tumour site in the Trust not to outperform the England average with 66.7% of patients being treated within 62 days compared to the England average of 76.1%. Although urology reported an increase in breaches, their performance was still significantly above the national average at 80% compared to 63.1% nationally.

Combined 31-day performance remained the same in March as February with performance of 89.8% which is below the England average of 91.4%, and short of achieving the national standard of 96%. The breach numbers again remained static in March having been slowly increasing with an average of 31 per month (April to September 2024). This rose in quarter 3 from 27 to 50 and again in January 2025 to 94 which was predicted post Christmas. They dropped back in February to 67 and remained static with 69 in March. Increases in breaches for first and subsequent surgery along with subsequent radiotherapy have impacted performance.
Workforce shortages in oncology in both consultants and radiotherapy staff have seen breaches rise from one or two per month to over 20 in December and January, 29 in February, and 30 in March. Breast is the major tumour site impacted with 27 of the 30 breaches.

Surgical capacity is also a factor for breast with both breast surgery and skin plastics provided by the breast surgeons. Theatre capacity and named surgeon capacity both combine to put added pressure on patient pathways which have already seen additional cancer diagnoses to their services. This is being reviewed as part of the recovery plan and being supported by external reviewers.
Combined 28-day performance was 81.8% which is above both the external stretch target of 77% and the internal stretch target of 80%. This compares to an England average performance of 78.9%. Overall, the Trust dropped back slightly from 33rd to 46th nationally against around 135 providers.

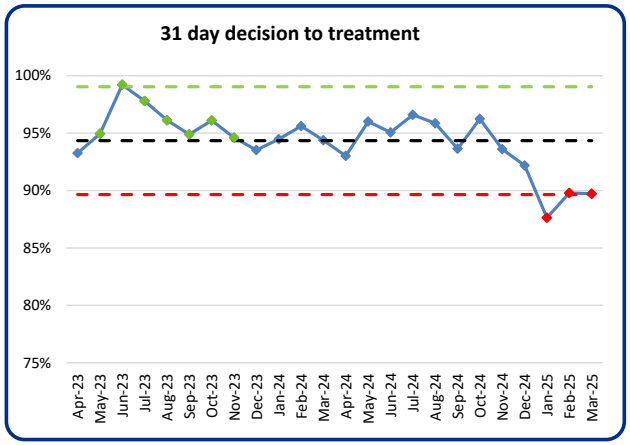
Actions and Progress Achieved

Combined 28 day and Turnaround Time
Histology 10-day turnaround went up to 89.7% in April compared to 81.5% in March, 81.6% in February and 73.4% in January. There was also an increase in numbers reported within 14 days up from 89.3% in March to 93.7% in April. This increase has supported an improvement in 28 day faster diagnosis in some site but other non-diagnostic elements of the pathway limited the benefit.
Cancer services work closely with histology to extract samples to fast-track these through the preparation and reporting on request and the team are utilising outsourcing which has supported more rapid turnaround.
Endoscopy turnaround remained just under 70% at 69.1% for March which has maintained this level of performance for the third month. The average wait was just under 10 days which is a milestone marker at 9.96 as performance has been just over 10 days for quite a while.
In order to achieve and sustain the required performance level, all front-line and supporting teams needs to maintain a booking or processing window of 7 calendar days or less. Teams are working hard to book these within existing capacity and flag up for escalation any shortfall.

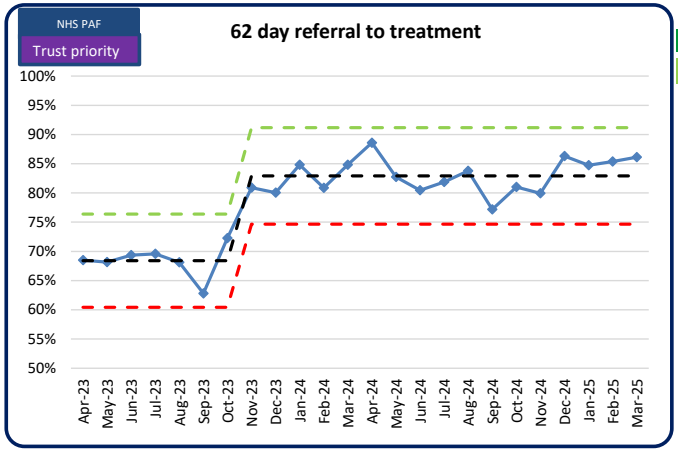
Combined 31 day and 62 days.
Breast surgery performance rose for 31 and 62 day in March but both are still considerably under the national performance and towards the bottom end of the providers. There was slightly more activity in March but with very similar breach numbers which improved performance. The performance between England average and the Trust is showing a consistent gap with rise and fall in performance. There is ongoing work on a recovery plan for breast including radiology, surgery and other supporting teams to review the entire pathway and how performance can be recovered to meet specialty level performance.
Oncology continues to have a high-risk gap in breast oncology with workforce shortages in consultant and radiotherapy. Securing two consultant locums has taken place but current contracts end in June and will need to be extended to support the continuation of breast oncology. The Trust is out to advert for replacements but a national shortage in consultant oncologists means recruitment without incentive is unlikely and use of locum staff will need to continue for the foreseeable future.

Safe, High Quality Care

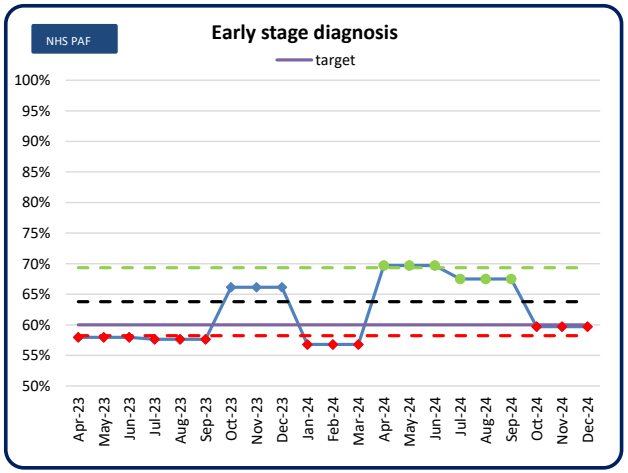
Improving access to elective services. By March 2026: 84.8% patients to receive treatment within 62 days, 83% patients to receive a diagnosis within 28 days



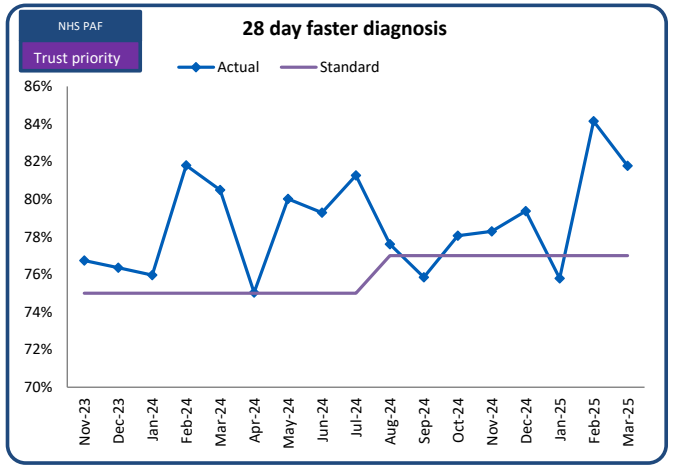
Mar-25
89.72%



Mar-25
86.12%



Dec-24
59.71%



Mar-25	
Faster Diagnosis	81.78%

Safe, High Quality Care

Safety and Quality

Metric Highlights:
All quality and safety metrics remained within control limits in April, demonstrating no special cause variation. Actual vs planned registered nurses (hours) was at the lowest level since April 2024, and close to the lower control limit. Summary hospital-level mortality indicator (SHMI) which is currently reported 3 months in arrears, was the highest since July 2024 and close to the upper control limit.

HSMR (Hospital Standardised Mortality Ratio) and Mortality:
The HSMR (Hospital Standardised Mortality Ratio) (12 months rolling year to January 2025) is 96.35
There are currently 3 HSMR alerts for RCHT:
Fractured neck of femur: 126.59 – a slight increase from 118.92. There are 76 patients in alert.
Deficiency and other anaemia – 121.36 – a slight decrease from 123.59. There are 15 patients in alert
Acute Cerebrovascular Disease (Stroke) – 101.50 – slight increase from 99.21. There are 166 patients in the alert
RCHT takes a standardised approach to analysing such alerts – data coding accuracy, examination of the patient cohort, confirmation of the structure/pathway, and finally individual case analysis, as recommended by the Health and Social Care Benchmarking service, Dr Foster. Workstreams have been further developed with SMART action plans in place and tracked at Executive level as well as monthly at the Mortality Review Oversight Group (MROG): Current controls through the Medical Examiner Service, MROG and the Incident Review & Learning Group. Historic alerts that have reached a significant level, and were high volume, continue to be tracked along with updates being received on their respective improvement programme. The HSMR for each continues to positively reduce: Syncope 0.91, Renal Failure 66, Congestive cardiac failure 66.3, Other Fractures 73 and other Liver disease at 35.

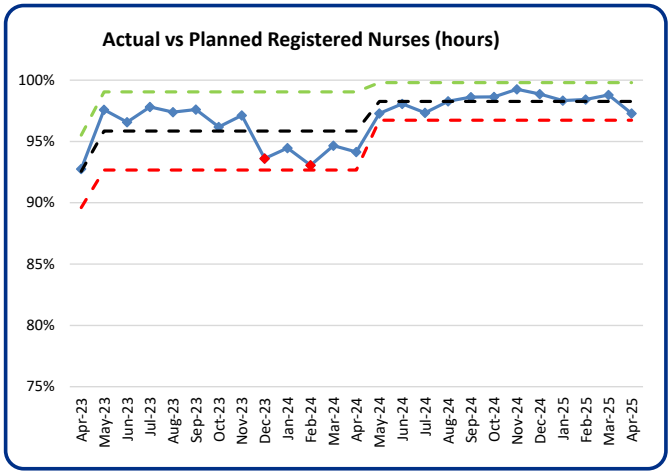
Falls:
In April, there were a total of 104 inpatient falls (including ED and SDSA) which means the Trust did not meet the trust 7.5% reduction (5.32). In April, the Trust achieved 5.39 falls per 1,000 Occupied Bed Day. There was a minor increase in total number of falls reported in April, compared with March. There were four reported patient falls that resulted in moderate or greater harm. Of these incidents, two were classified as moderate and the other two as severe. Despite the number of incidents being reduced by half compared to March, the Trust target of 0.16 was not met (0.21).
From the 19 May 2025, the newly developed Multifactorial Assessment to optimise Safe Activity (MASA), formerly known as MFRAT will go live. This new assessment is designed to identify risk factors for individuals aged 65 and older, as well as those between 50 and 64 who are considered at risk of falling due to one or more identified factors. Once these risk factors are recognised, a personalised falls prevention care plan will be implemented to address each specific risk, aiming to minimise the likelihood of falls for patients during their inpatient stay.
In addition, as of 19 May 2025, as part of the Deconditioning Harm Prevention Programme one of the Heads of Nursing and the Improvement Practitioner for Falls, Dementia and Delirium have appraised the significant link between falls and lower urinary tract symptoms in hospital settings. The decision has been made to provide only decaffeinated beverages as the standard option for patients, with the possibility for patients to request caffeinated drinks if they choose. This is commencing across all ward areas from 19 May 2025. The inpatient wards will be stocked with an adequate supply of decaffeinated beverages to ensure consistency across all locations. By implementing this straightforward change, we anticipate not only an improvement in continence for this demographic but also a reduction in fall incidents within our older patient group.

Infection Control:
The 100,000 bed day rate for MRSA is 0.4 for 2024/25 below the national rate. C.diff cases per 100,000 bed days at RCHT are 45.59, regional rates 34.59 and national rates are 27.62 at the end of Q4. At 2024/25 year end RCHT had 78 HOHA vs a tolerance of 73 and 37 COHA vs a tolerance of 22. At the end of quarter 3 UKHSA provided quarterly epidemiology update and identified that CDI cases were 15.3% higher this year than at the same time in 2023/24. This is so far unexplained. UKHSA has established a 'C.diff Technical Group. Outbreak activity continues at expected rates in April, with three outbreaks of Norovirus, 1 Covid-19 and 1 Influenza A. In previous years Covid-19 levels have tended to increase during the summer period, whilst Norovirus levels tail off. E.coli incidence per 100,000 bed days is 40.83, nationally 34.56 and regionally. MSSA cases are at 9.51 per 100,000 bed days, a further decrease from Q1,2,3 where they were below both the regional and national rate. A local point prevalence study is underway during May. This will review rates of hospital associated infections, for each ward on a particular day, the site of infection, whether an organism has been identified and whether antimicrobial therapy was used. This data can be used to understand themes, and to ensure that the 'as thought' themes are 'as it is' in practice. Following this the antimicrobial pharmacy team will be auditing antibiotic prescribing in those identified as having a hospital-associated infection.

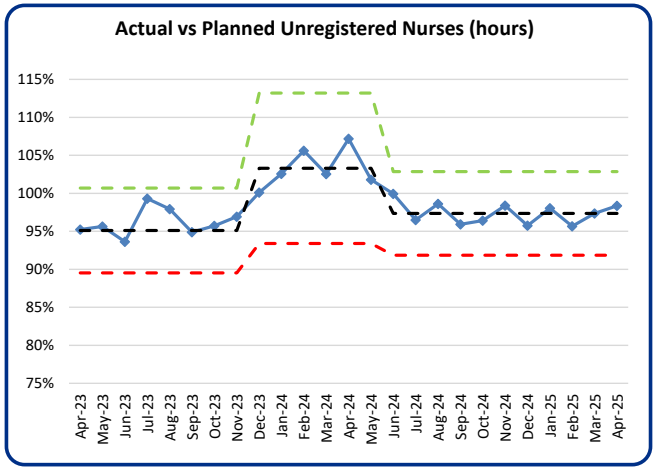
Complaints, DOC, PSII and Never Events:
The complaints response has improved this month through continued work with care groups and early escalation to executives. The work within care groups should be acknowledged also with continued efforts by clinical colleagues.
The duty of candour metric has been amended to report the duty of candour conversations due within the reporting month. This shows an increase in performance this month, but through PSIR&OG we are continuing improvement efforts through the initiation of a QI project.

Pressure Ulcers
The number of reportable pressure ulcers has remained static at 21 incidents this month, the same as March, although still above our reduction target. The incidence rate has fallen slightly from 0.9 to 0.8, however this is not a true reflection as one incident occurred in ED, which is not included in inpatient data. There were 7 incidents at category 3 or above reported this month, 3 of which are confirmed as moderate harms. A thematic review is now in progress looking at the increase in pressure ulcers in the AEM care group. This report is expected to be finished in mid July 2025. Education from the Tissue Viability Team has not yet been restarted, however there are plans for this in the coming weeks.

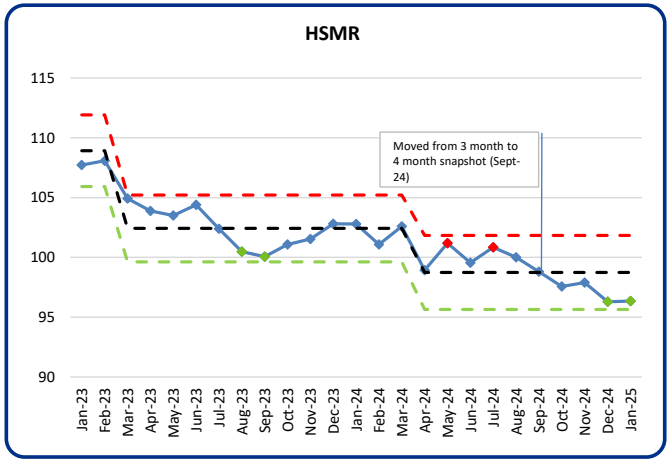
Safe, High Quality Care



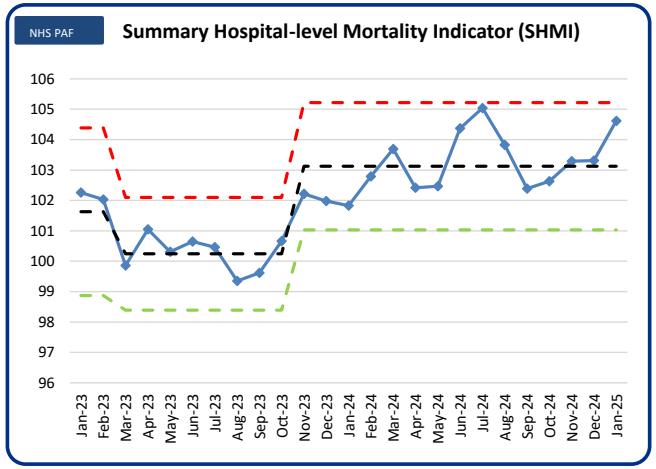
Apr-25	
Actual vs Planned	97.28%



Apr-25	
Actual vs Planned	98.36%

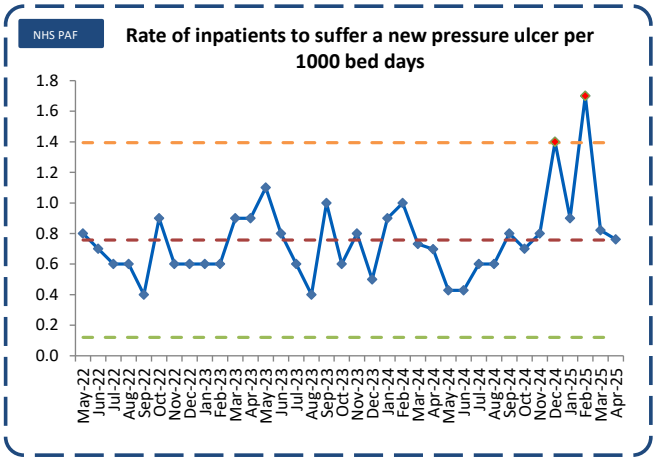


Jan-25	
HSMR	96.35

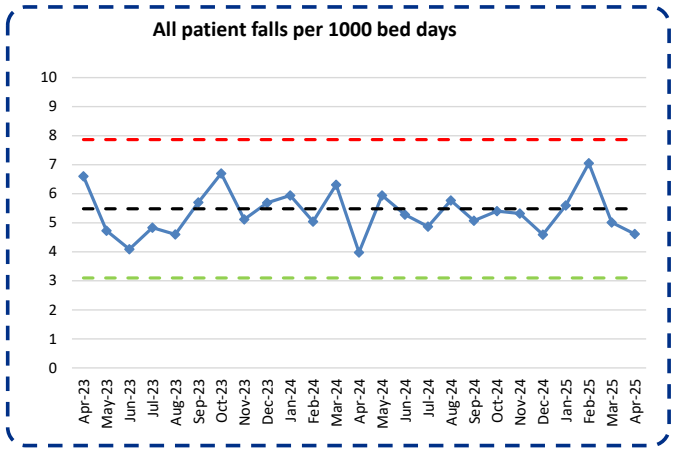


Jan-25
104.62

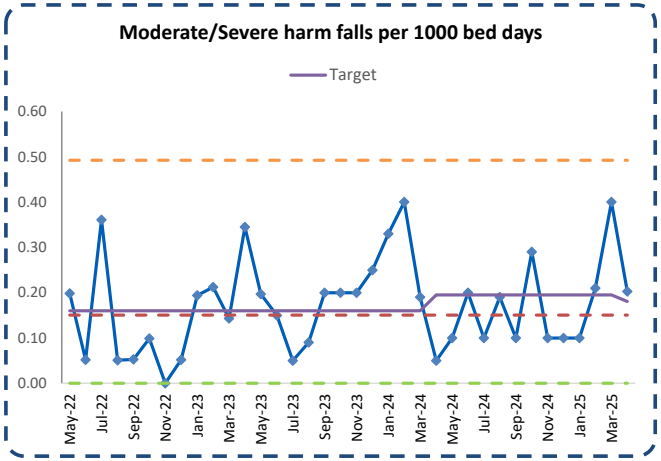
Safe, High Quality Care



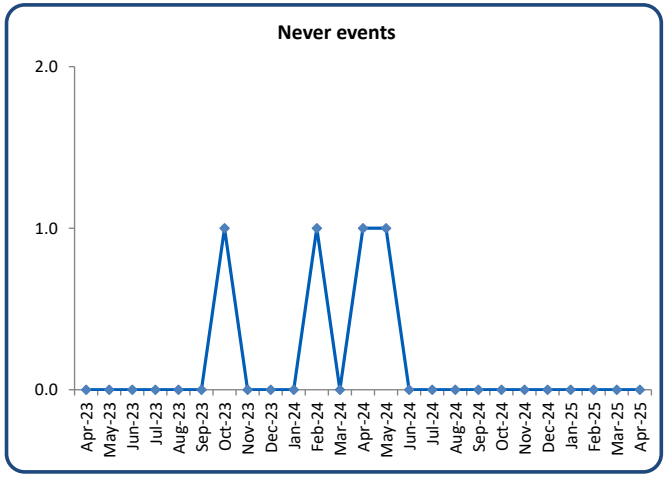
Apr-25
0.76



Apr-25
4.61

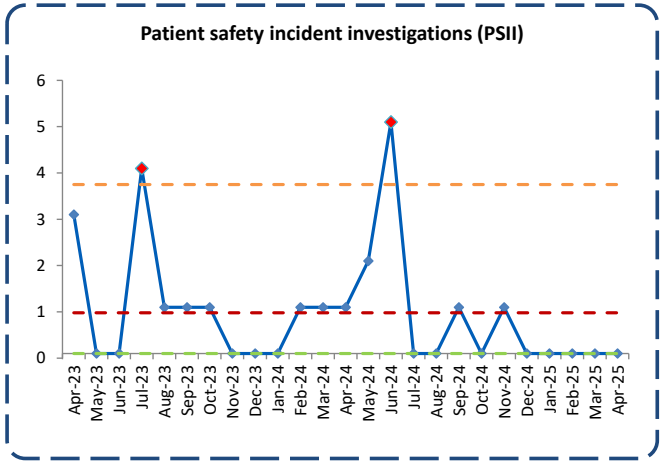


Apr-25
0.20

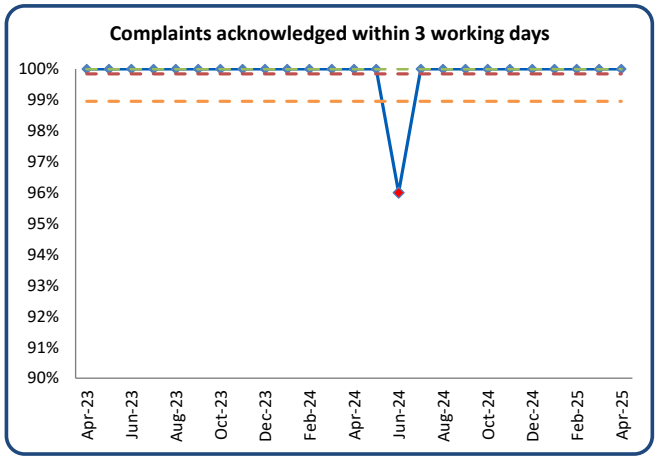


Apr-25
0

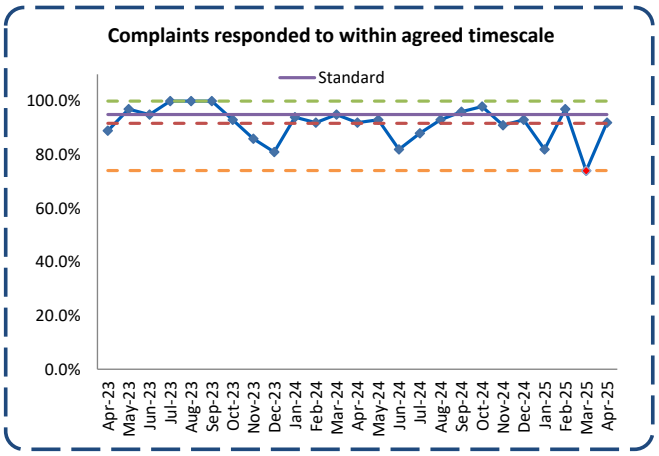
Safe, High Quality Care



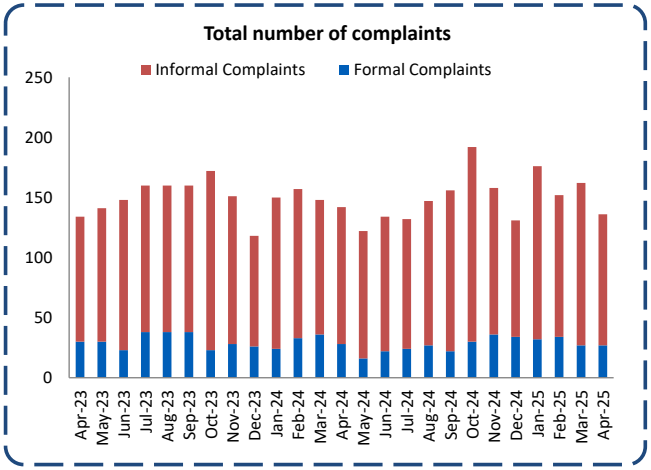
Apr-25
0



Apr-25
100.00%

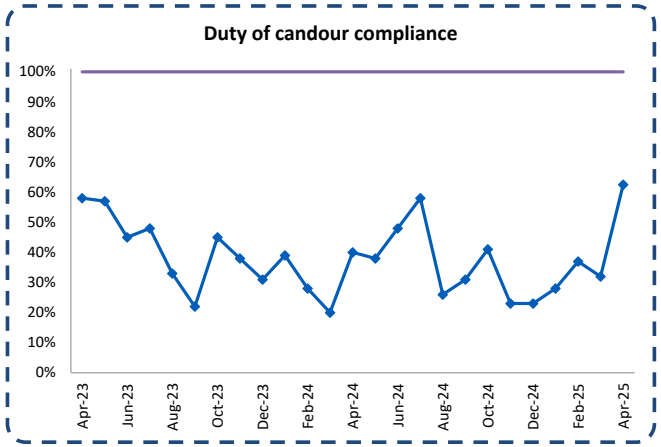


Apr-25
92.00%



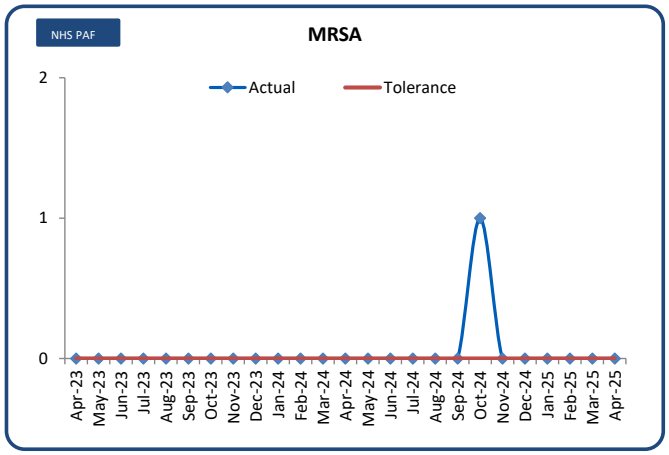
Apr-25	
Formal complaints	27
Informal complaints	109

Safe, High Quality Care

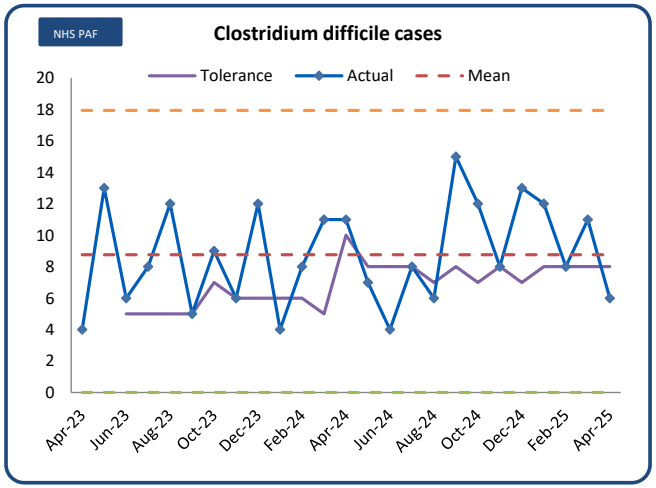


Apr-25
62.50%

Duty of Candour (All Incidents)	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
Incident Graded Moderate or Above	14	16	14	17	28	10
Duty of Candour Complete	14	16	13	12	9	16
% Compliance with Duty of Candour	**23%**	**23%**	**28%**	**37%**	**32%**	**63%**

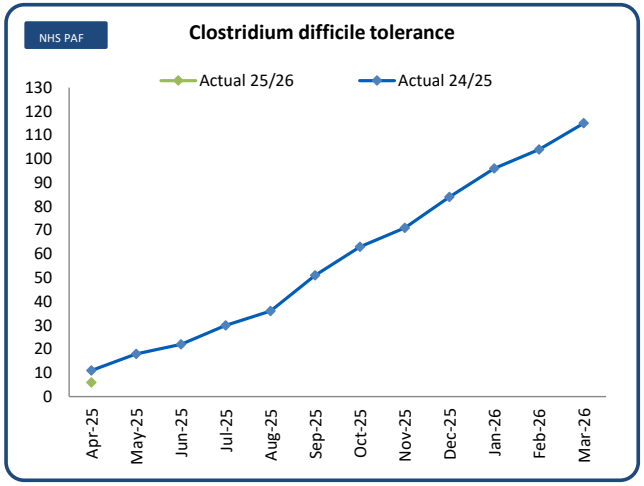


Apr-25
0

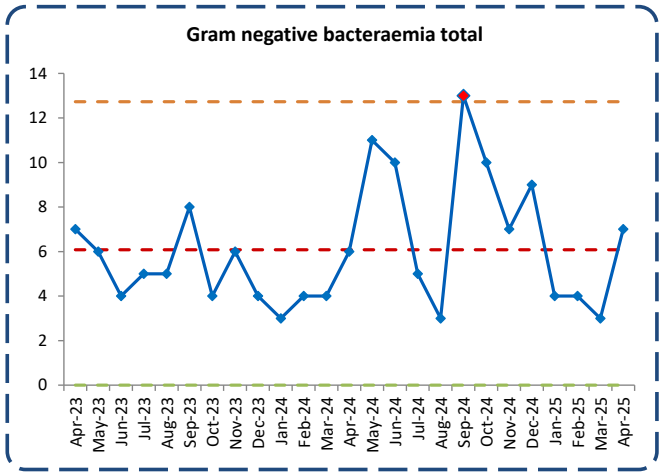


Apr-25	
Cdiff Cases	6
Tolerance	

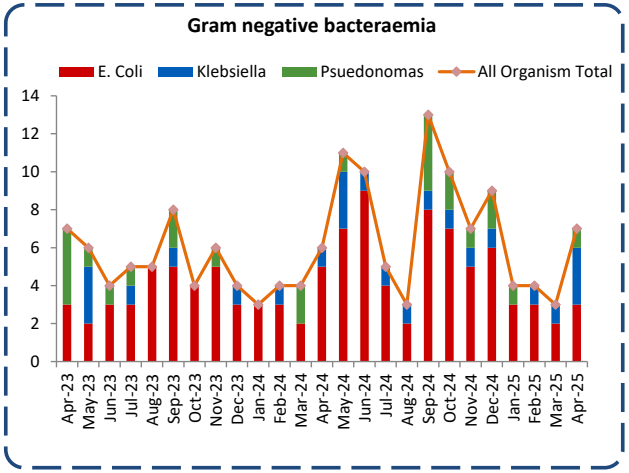
Safe, High Quality Care



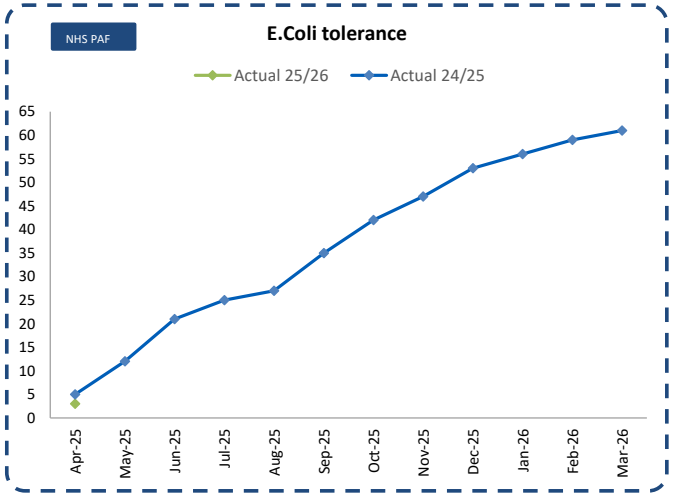
	Apr-25
Cdiff cumulative	6
Tolerance	



Apr-25
7



	Apr-25
E.coli	3
Klebsiella	3
Pseudomonas	1
All Organism Total	7



	Apr-25
E. Coli cumulative	5

Supported and Valued People

People

Metric Highlights:

Stress related absence reduced in April by 2% to 26%, and overall staff sickness reduced for the fourth consecutive month (to 4.44%) and remains at the lowest level since May 2024, close to the lower control limit. Staff turnover has remained stable at 8.5%, and total vacancy rate across the Trust increased to 10.1%. For the second consecutive month appraisal compliance remained at 77% reaching the upper control limit demonstrating improvement, but below the target of 85%. Statutory and Mandatory training compliance remains below the Trust target of 90% and dropped to 78.9%, the lowest since March 2024, reaching the lower control limit and triggering as an exception concern on the statistical process chart (SPC). Staff friends and family survey – recommend the Trust as a place to work, and recommend the Trust as a place to receive care, both triggered as a concern on SPC with the lowest results in 2 years.

Key Exceptions: Performance on statutory and mandatory training and appraisal compliance remains below the Trust target of 90%.

Actions and Progress Achieved

Turnover and vacancy rate: Our total vacancy rate across the trust in April 25 is currently at 10.13% and turnover has remained static at 8.5%. The increased vacancy rate is expected as a result of the current recruitment freeze and review of all posts. This is expected to continue to ensure delivery of the Workforce Plan.

Total Registered Nursing & Midwifery vacancy rate is 9.4% with the vacancy rate for Band 5 RNs has remaining relatively static at 7.93% which equates to 71.43 WTE. Work is currently underway developing detailed trajectories for each Care Group for this staff group together with Heathcare Support Workers to ensure appropriate recruitment is planned to support safe care throughout the financial year.

Medical staff vacancy rate has increased to 7.89%. Consultant and Middle Grade medical vacancies remain the area of highest vacancy rate and specifically within Acute and Emergency Medicine, Peripheral Sites and Clinical Support. This represents areas where there are escalation areas open and hard to fill roles. Targeted support is being given regarding recruitment to hard to fill roles including requesting specialist agencies to support recruitment where some progress is being made and converting agency workers to substantive where possible.

Recruitment: The current default position is no recruitment to vacancies. Where approved, focus continues to appoint substantive to key clinical patient facing roles to reduce demand at source for temporary staffing and demand for any premium workforce spend. The impact of this is seen in the vacancy rates and reducing agency spend.

Variable Pay costs: Agency spend decreased in April to the lowest monthly spend yet at £708k. This is below the planned spend and work will continue to maintain this trajectory. The South West region continues to lead the way in price cap compliance and agency spend reduction.

Sickness Absence The overall annual sickness absence rate has been decreasing since December 24 and is currently at 4.44%

Proportion of days lost for anxiety/stress/depression/other psychiatric is currently 26%. This may reflect the current challenging climate and workforce pressures – support is in place for our staff. Working with the OH team we are promoting proactively the EAP and other support networks such as Workwell.

Appraisal Compliance: The appraisal rate remained relatively static again this month at 77.3%. There is a continued focus on appraisal completion and promotion of the blended approach to appraisal.

Mandatory training: Mandatory training compliance remains below the Trust target of 90%, and has reduced to 78.9% in April 2025. We are undertaking a pilot of face-to-face mandatory days for resident doctors recognising that release for eLearning for this staff group is particularly challenging. We have been participating on the national project to streamline statutory and mandatory training. We are also reviewing all locally mandated training and expect to recommend some reductions in the requirements.

Staff Survey: A paper and presentation have been produced for both ELT and PCC, with an updated version including the newly released national results produced for board. Headline results and priorities were presented to the organisation with the CEO and Deputy CPO, this is being followed up with communications via email, social media and the intranet. A newly developed Power BI dashboard was launched to the organisation's leaders. Support is being given to leaders and teams across the organisation. Action planning guidance and supporting documents have been circulated

Pulse Survey: In April, the updated pulse survey was launched with a total of 294 responses. For Q1 2025/26 49.5% of people would be happy with the standard of care provided If a friend or relative needed treatment. This is down from Q4 2024/25 58.1%. The results will be circulated to the trust and care groups in May.

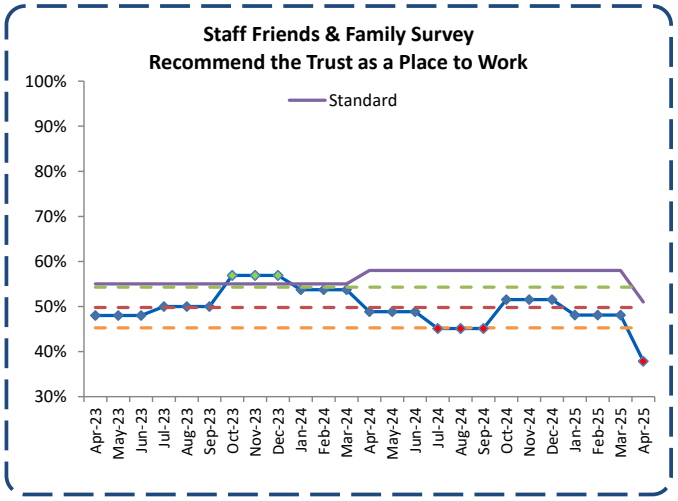
I would recommend the organisation as a place to work: The national and local financial position has impacted performance in this quarter's pulse survey across the board. Staff were waiting for the local financial announcement plus the impact of the overtime conversation Trust. This is supported by the comments coming from the pulse survey. The things within our control which people report prevents them from recommending the Trust as a place to work include acting on and communicating more effectively around:Staffing levels; Staff facilities; Compassionate leadership training; Flow over patient care and risks staff are expected to hold - communicating the 'why'.

The Trust continues to work on the staff survey with all care groups and the Trust forming action plans in response to staff voice. The delivery in May of the Safe and compassionate leadership programme and programmes of work in EDI and Wellbeing.

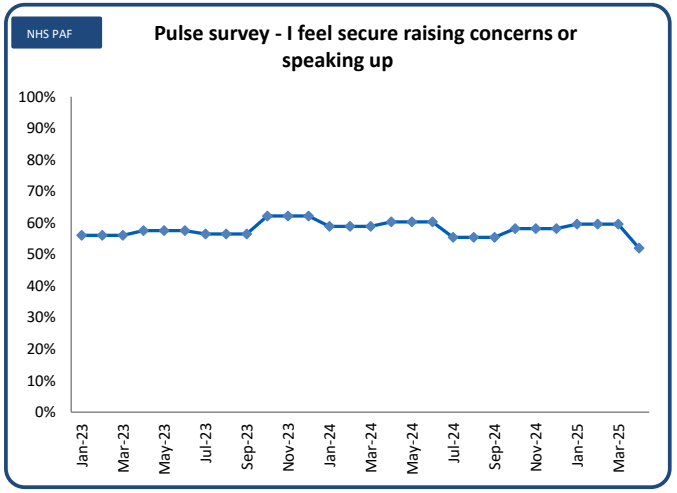
% of people would be happy with the standard of care provided If a friend or relative needed treatment: The national and local financial position has impacted performance in this quarter's pulse survey across the board. Staff were waiting for the local financial announcement plus the impact of the overtime conversation Trust. This is supported by the comments coming from the pulse survey. The things preventing people being happy with the standard of care provided are: Staffing levels; Flow over patient care and risks staff are expected to hold - communicating the 'why'; Slow processes get in the way of implementing changes

Potential Risks/Identified Risks: Key workforce risks are summarised as capacity to support patient care; variable pay costs and impact on overall Trust budget; workforce engagement and wellbeing.

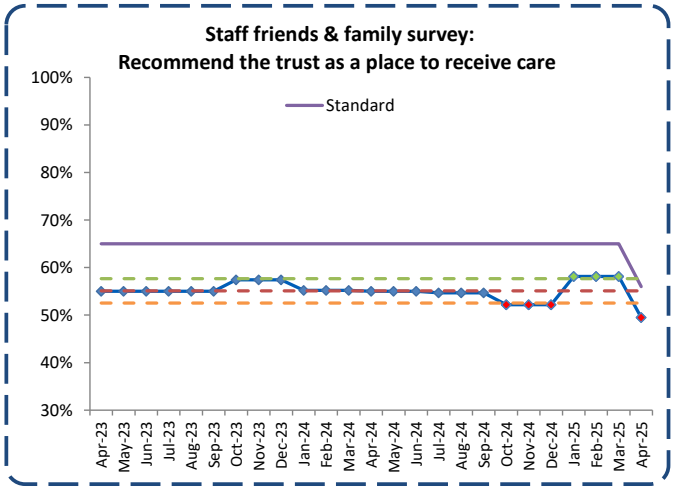
Supported and Valued People



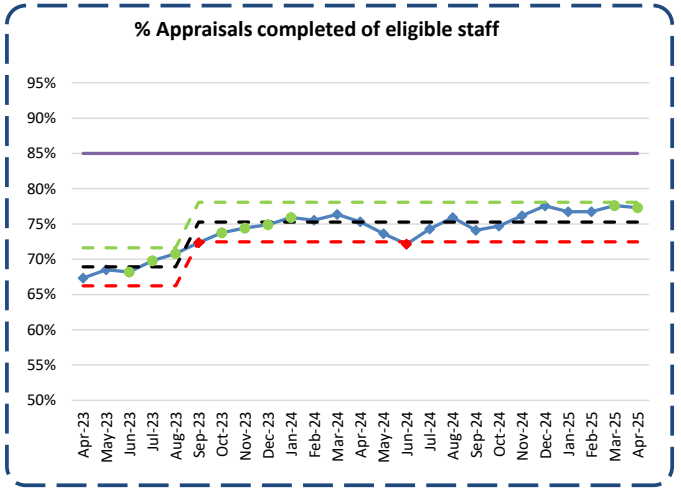
Apr-25
38%



Apr-25
52.04%

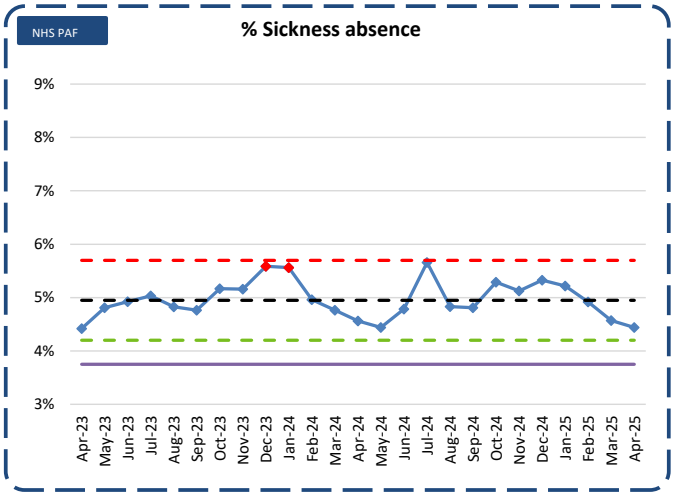


Apr-25
49%

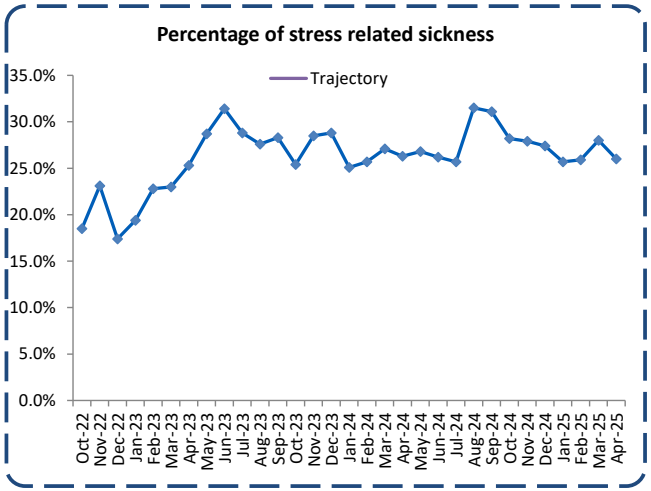


Apr-25
77.3%

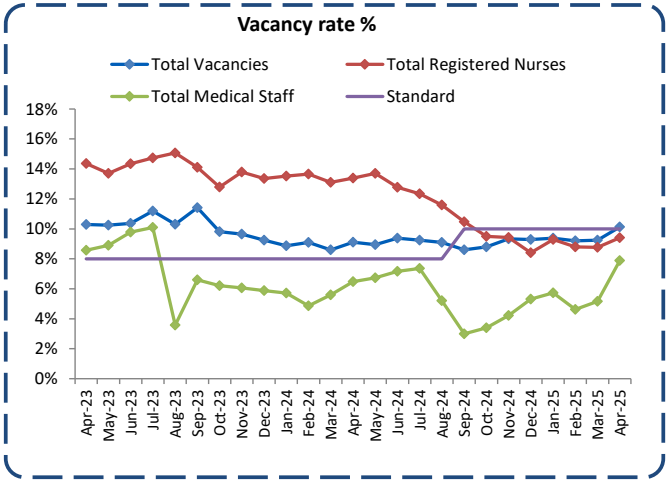
Supported and Valued People



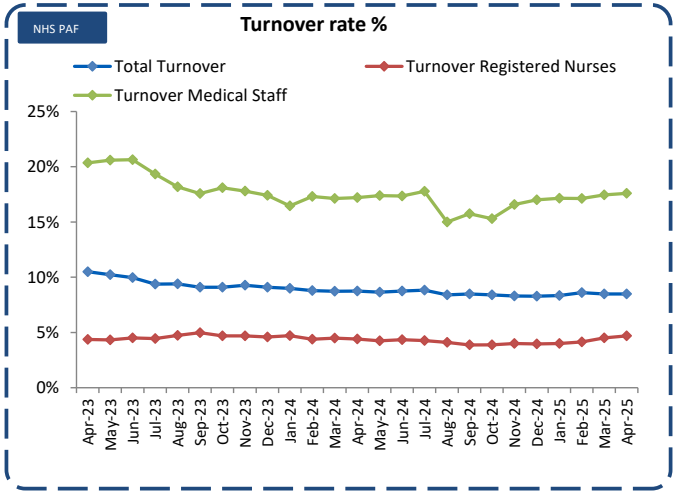
Apr-25
4.44%



Apr-25
26.00%

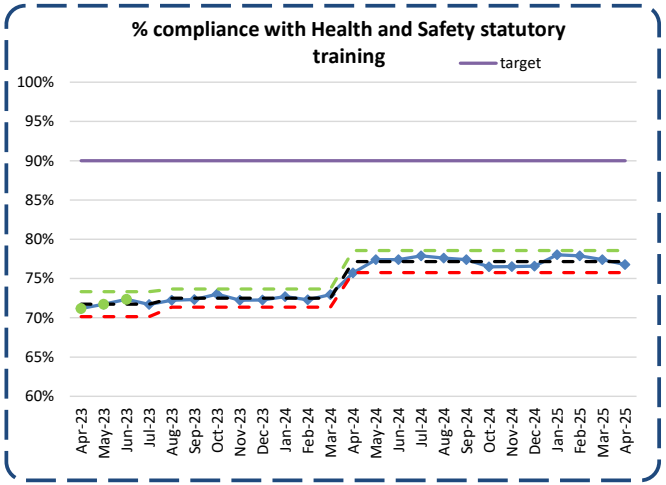


Apr-25	
Total vacancies	10.1%
Total registered nurses	9.4%
Total medical staff	7.9%

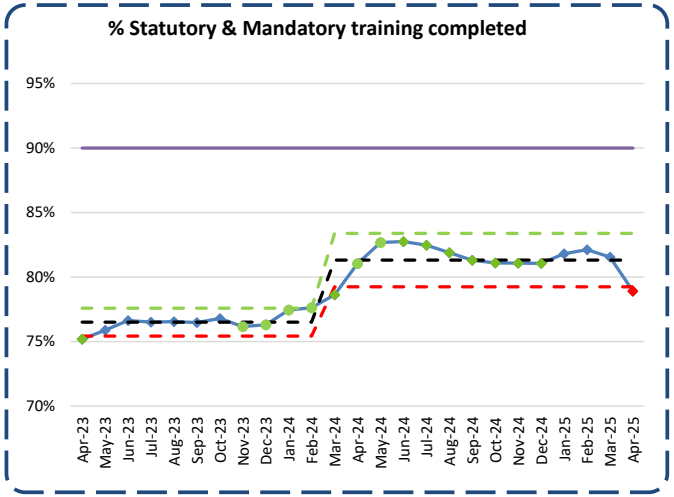


Apr-25	
Total turnover	8.5%
Total registered nurses	4.7%
Total medical staff	17.6%

Supported and Valued People

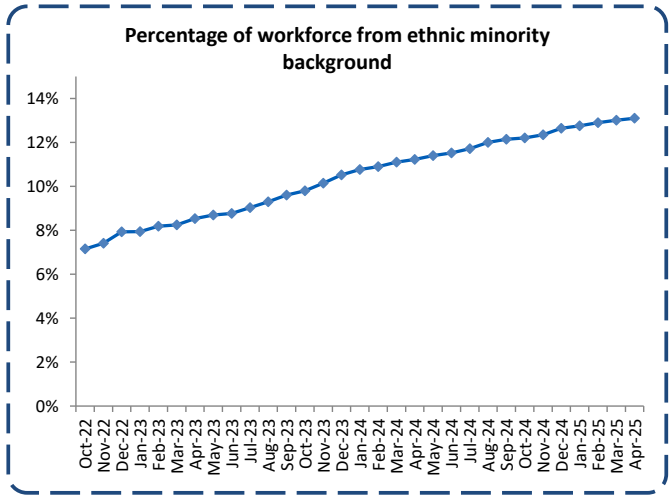


Apr-25
76.77%



Apr-25
78.9%

Apr-25
2.06%



Apr-25
13.10%

Journey of Improvement

Finance

Metric Highlights:
The in-month (April) position was £2.12m deficit, against the planned £2.14m deficit, resulting in a favourable variance to plan of £0.02m.
The surplus was achieved through Care Group and Corporate Departments working to keep their pay to their set control totals through the new CIP programme and support from reserves due to reduced draws.

Subjective Variances (Pay / Non-Pay / Income):
- Pay was over plan with a £0.21m in the first month of 2025/26. The underlying pay after removing one-off and other pay items is £35.75m. This includes the new employer's national insurance rules of a reduced £5k threshold and increase of contributions by 1.2% to 15%. This compared to the average of the 2nd half of 2024/25 of £35.90m (adjusted for NI comparability) is a reduction of c.£0.15m.
- Non-Pay in April was over budget by £0.16m, the underlying non-pay value for April was £9.1m, compared to the average of the 2nd half 2024/25 of £10.43m, (£10.03m plus 4% inflation of £0.40m), is a reduction of £1.3m. The main reduction is clinical supplies and services and a reduction in prosthesis expenditure.
- Income in April was down by £0.22m, reductions in services provided income and delays approvals for research and development studies.

Capital:
Capital expenditure is currently £2.179m behind plan, £500k of this variance is linked to projects which are expected to be funded via external funding that has yet to be received, this has meant that the projects have not been able to start until funds are received.
£800k of the variance is linked to projects that are ahead of plan and as a result more expenditure was incurred during the previous financial year than had been expected when the plan was set.
The remaining variance relates to RCHT's Public Dividend Capital funded projects (Women & Children's Hospital and eCare), both projects are behind plan for the year but are expected to spend their allocations by year-end.

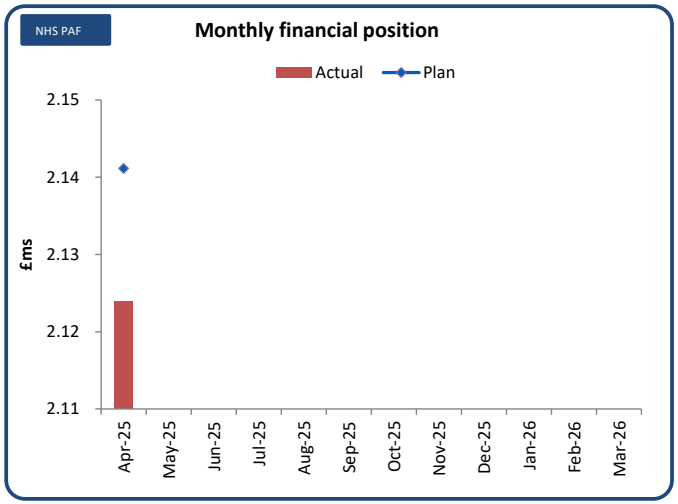
CIP:
The financial plan included a total savings target of £49.3m for 2025/26. Delivery in April was £1.71m, against a £1.88m requirement. The shortfall of £0.16m highlights the risk of delivery when the M1 target is low in comparison to the monthly targets from M5 which are in excess of £4m per month.
Recurrent CIP delivery in M1 was £0.68m (38%) and a full year value of £6.30m.

Cash:
This is a new metric for 2025/26. For April the plan was 22 days the actual was 31 so that is a positive variance of 9 days achieved due to an increase in creditors compared to plan due to higher payment runs in March '25 compared to April.

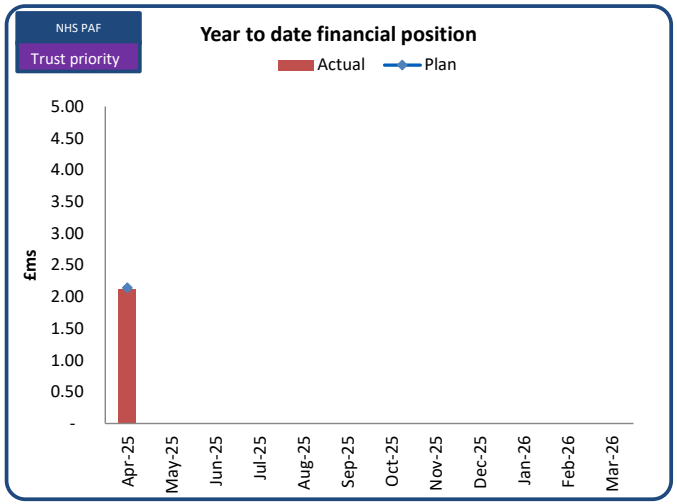
Agency:
Agency spend in April was £0.7m, below plan by c.£0.2m and a significant drop from the average c£1m per month in the second half of 2024/25. The reductions in the main relate to the introduction of the medical model and the transfer of agency consultants over to substantive contracts. The reductions have been evident in both medical and non-medical agency expenditure with c£0.1m under on both.

Journey of Improvement

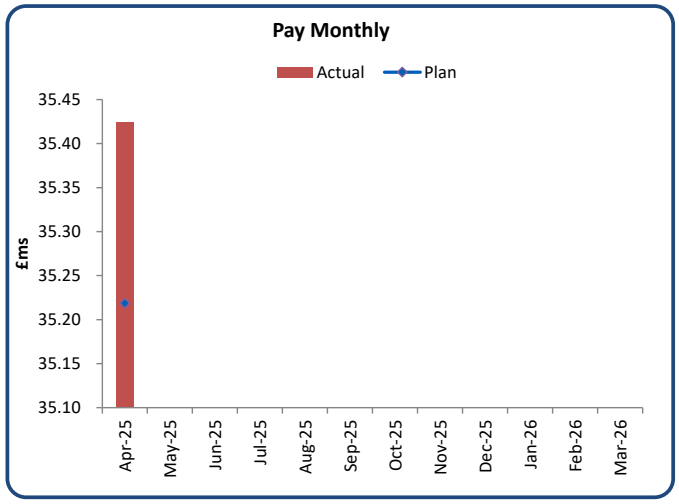
Delivering financial balance, delivering £49m CIP programme, delivering Ecare digital transformation, preparing for the £350m Women and Children's Hospital



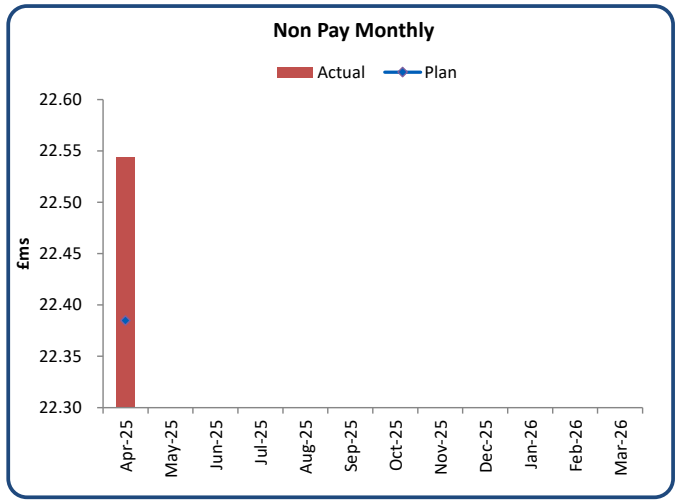
Apr-25
2.12



	Apr-25
Actual	2.12
Variance	-0.02

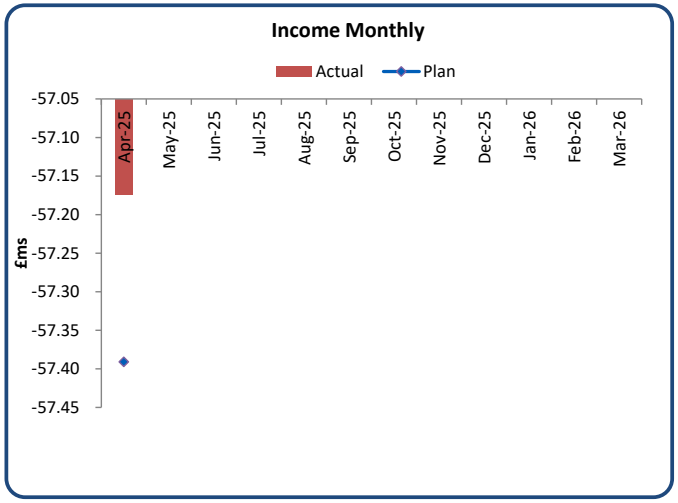


Apr-25
35.42

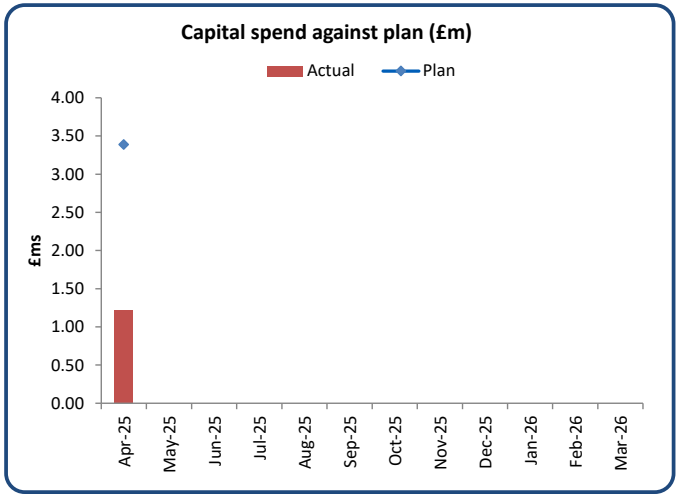


Apr-25
22.54

Journey of Improvement

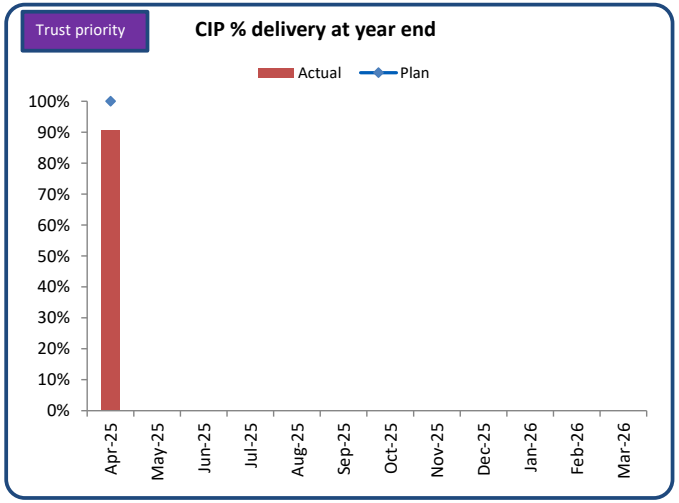


Apr-25
-57.17

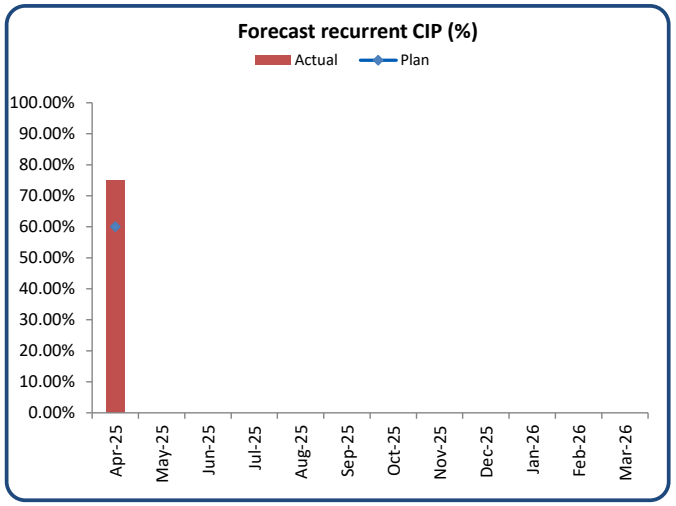


Apr-25
1.21

Trust priority

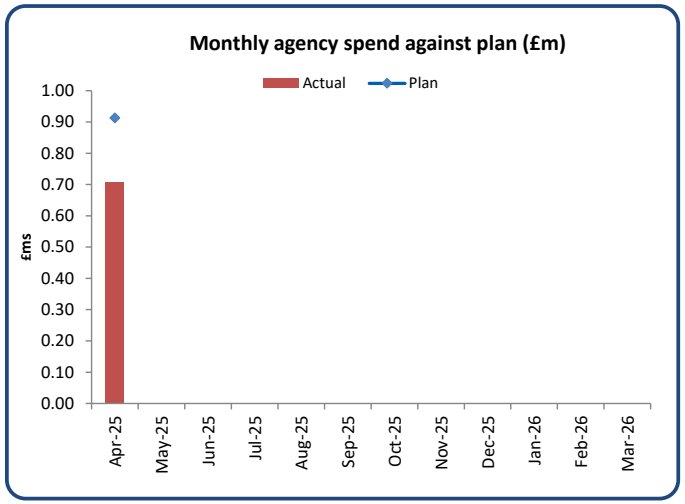


	Apr-25
Delivery %	90.53%
Delivery £	1.70
Plan £	1.88
Variance	- 0.18



Apr-25
75.00%

Journey of Improvement



Apr-25
0.71

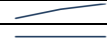
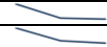
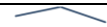
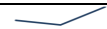
Appendix 1: Safe, High Quality Care Summary Dashboard

Metric	25/26 Target/ Standard	22/23	23/24	Jan-25	Feb-25	Mar-25	Apr-25	Variation	YTD 25/26	Sparkline
Urgent Emergency Care										
Improving urgent and emergency care performance. By March 2026: improve system 4hr performance to 85.8%(ED to 62.9%), reduce ambulance holds to an avg of 27 mins, reduce waits over 12hrs in ED to 5%										
Ambulance delays - % waiting over 15 minutes	20.00%	70.35%	78.44%	89.96%	82.93%	85.00%	90.70%	+5.69%	90.70%	
ED Attendances (TR&WC unplanned)				5987	5765	6629	6767	+138	6767	
ED & MIU attenders - 4 hours arrival to discharge, admission or transfer	78.00%	77.43%	78.21%	76.68%	77.34%	78.05%	79.26%	+1.21%	79.26%	
Treliske ED attenders - 4 hours arrival to discharge, admission or transfer	78.00%	43.34%	43.34%	46.03%	45.98%	47.29%	49.53%	+2.24%	49.53%	
95th percentile, time to initial assessment (mins)	15	58	43	31	28	28	34	+6	34	
ED over 12 hours in department (TR&WC)		13745	12923	1141	766	1013	1043	30	1043	
Aggregated Patient Delay (hours)				17773	11069	14371	15515	+1143	15515	
ED safety checklist	97.00%	87.25%	93.92%	76.00%	85.90%	87.50%	88.80%	+1.30%	88.80%	
Sepsis patients who met the criteria and received antibiotics within an hour - ED	90.00%	66%	76%	81%	89%	80%	82%	+1.20%	82%	
Stroke unit within 4 hours	90.00%	34.88%	44.57%	44.93%	38.46%	43.66%	45.78%	+2.12%	45.78%	
Stroke patients receiving CT scan within 12 hours	90.00%	96.25%	94.68%	97.10%	95.45%	97.22%	92.94%	-4.28%	92.94%	
Stroke patients spending 90% of their time on stroke unit	90.00%	72.81%	81.40%	92.98%	78.79%	81.54%	79.31%	-2.23%	79.31%	
NOF patients operated on within 36 hours	70.00%	44.76%	46.76%	34.78%	50.00%	47.00%	46.00%	-1.00%	46.00%	
Total general and acute (G&A) bed occupancy (%)	95.54%			95.57%	95.26%	95.54%	95.35%	-0.19%	95.35%	

Appendix 1: Safe, High Quality Care Summary Dashboard

Metric	25/26 Target/ Standard	22/23	23/24	Jan-25	Feb-25	Mar-25	Apr-25	Variation	YTD 25/26	Sparkline
Average LOS	3.62	4.17	4.03	3.76	3.91	3.89	3.71	-0.18	3.71	
Super stranded patients (21+ day LOS)	122	134	114	118	119	109	91	-18	91	
RCHT Delayed Patients	42			106	98	96	82	-15	82	
Net emergency readmissions within 30 days	6.80%	6.72%	6.54%	7.65%	7.44%	7.68%	7.84%	+0.16%	7.84%	
Planned Care										
Improving access to elective services. By March 2026: 74% of patients waiting no more than 18 weeks for their elective treatment.										
RTT waits over 52 weeks for incomplete pathways- pre submission		3203	1915	551	493	365	355	-10	355	
Inpatient Elective Activity	100.00%			105.21%	105.18%	108.32%	105.21%	-3.11%	105.21%	
Completed RTT pathway activity growth vs 19/20				542	532	526	565	39	565	
Elective Operations Completed				1592	1524	1590	1531	-59	1531.00	
Elective Touchtime	80.00%			84.00%	82.00%	83.00%	82.00%	-1.00%	82.00%	
Elective Session Utilisation	92.80%			91.00%	92.00%	90.00%	89.00%	-1.00%	89.00%	
Percentage of cancellations on the same day	0.80%	0.91%	1.23%	1.71%	2.18%	1.48%	in arrears		in arrears	
Urgent operations cancelled more than once	0	0	0	0	0	0	0	0	0	
Percentage of outpatient appointments attended that are non F2F	25%	31.14%	30.77%	31.22%	32.44%	31.65%	30.85%	-0.80%	30.85%	
Patient Initiated Follow-up (PIFU)	5.00%			10.35%	10.56%	10.11%	10.65%	0.54%	10.65%	
Proportion of patients receiving one of the 15 key diagnostic tests within 6 weeks	99.00%	53.90%	65.73%	87.44%	89.51%	90.76%	91.71%	+0.95%	91.71%	
Diagnostic activity	110.60%		107.39%	126.96%	109.90%	152.11%	148.28%	-3.83%	148.28%	
Cancer										
Improving access to elective services. By March 2026: 84.8% patients to receive treatment within 62 days, 83% patients to receive a diagnosis within 28 days										
Combined 62 day referral to treament	70.00%			84.72%	85.39%	86.12%	in arrears	+0.74%	in arrears	

Appendix 1: Safe, High Quality Care Summary Dashboard

Metric	25/26 Target/ Standard	22/23	23/24	Jan-25	Feb-25	Mar-25	Apr-25	Variation	YTD 25/26	Sparkline
Combined 31 day decision to treament	96.00%			87.63%	89.79%	89.72%	in arrears	-0.07%	in arrears	
Percentage of cancers diagnosed at stages 1 and 2 (quarterly)	60.00%			in arrears	in arrears	in arrears	in arrears		in arrears	
Percentage of patients meeting the cancer faster diagnosis standard	77.00%			75.79%	84.15%	81.78%	in arrears	-2.37%	in arrears	
Safety and Quality										
Actual vs Planned Registered Nurses (hours)		89.96%	95.71%	98.34%	98.43%	98.80%	97.28%	-1.52%	97.28%	
Actual vs Planned Unregistered Nurses (hours)		84.63%	98.28%	98.03%	95.68%	97.35%	98.36%	+1.01%	98.36%	
Rolling 12 month HSMR		108.59	102.22	96.35	in arrears	in arrears	in arrears		in arrears	
SHMI				104.62	in arrears	in arrears	in arrears		in arrears	
Number of pressure ulcers per 1000 bed days				0.90	1.70	0.82	0.76	-0.06	0.76	
All patient falls per 1000 bed days		5.75		5.60	7.05	5.01	4.61	-0.40	4.61	
Moderate/Severe harm falls per 1000 bed days				0.10	0.21	0.40	0.20	-0.20	0.20	
Never events	0	1	2	0	0	0	0	0	0	
Patient safety incident investigations (PSII)		1	1	0	0	0	0	0	0	
Complaints acknowledged within 3 working days	100.00%			100.00%	100.00%	100.00%	100.00%	0.00%	100.00%	
Complaints responded to within agreed timescale	95.00%	87.17%	93.50%	82.00%	97.00%	74.00%	92.00%	+18.00%	92.00%	
Total number of formal complaints	30	33	31	32	34	27	27	0	27	
Total number of informal complaints		106	119	144	118	135	109	-26	109	
Infection control: MRSA	0	0	0	0	0	0	0	0	0	
Infection control: C-difficile cases		96	98	12	8	11	6	-5	6	
Gram negative bacteraemia total		37	60	4	4	3	7	+4	7	
E.Coli tolerance		23	41	56	59	61	5		5	

Appendix 2: Supported and Valued People Summary Dashboard

Metric	25/26 Target/ Standard	23/24	Jan-25	Feb-25	Mar-25	Apr-25	Variation	YTD 25/26	Sparkline
Recommend the Trust as a Place to Work	51.00%	52.16%	48.13%	48.13%	48.13%	37.88%	-10.25%	37.88%	
Pulse survey – I feel secure raising concerns or speaking up	59.00%	57.66%	59.63%	59.63%	59.63%	52.04%	-7.59%	52.04%	
% Appraisals completed of eligible staff	85.00%	72.32%	76.74%	76.74%	77.61%	77.30%	-0.31%	77.30%	
% Sickness absence	3.75%	5.00%	5.22%	4.92%	4.57%	4.44%	-0.13%	4.44%	
Staff turnover	7-15%	9.38%	8.34%	8.60%	8.48%	8.50%	+0.02%	8.50%	
Staffing FTE: Agency		87	131	132	135	89	-46	89	
Recommend the trust as a place to receive care	56.00%	56%	58.13%	58.13%	58.13%	49.49%	-8.64%	49.49%	
Vacancy rate: Total vacancies	9.00%	9.93%	9.38%	9.20%	9.24%	10.13%	+0.89%	10.13%	
% Statutory and Mandatory training completed	90%	76.68%	81.81%	82.12%	81.55%	78.90%	-2.65%	78.90%	
% compliance with Health and Safety Statutory training	90%	72.25%	78.02%	77.89%	77.39%	76.77%	-0.62%	76.77%	
Percentage of workforce from ethnic minority background			12.76%	12.90%	13.01%	13.10%	+0.09%	13.10%	
Percentage of senior leadership (8c+) from ethnic minority background			2.11%	2.06%	2.11%	2.06%	-0.05%	2.06%	
Percentage of stress related sickness	28.50%		25.70%	25.90%	28.00%	26.00%	-2.00%	26.00%	

Appendix 3: Journey of Improvement Summary Dashboard

Metric	25/26 Target/ Standard	Jan-25	Feb-25	Mar-25	Apr-25	Variation	YTD 25/26	Sparkline
Delivering financial balance, delivering £49m CIP programme, delivering Ecare digital transformation, preparing for the £350m Women and Children's Hospital								
Monthly financial position (£m)		-0.01	-0.02	-0.90	2.12			
Year to date financial position (£m)	-0.33	2.63	0.81	-0.09	2.12			
Pay monthly (£m)		34.38	34.78	68.92	35.42			
Non pay monthly (£m)		23.60	24.54	26.51	22.54			
Income monthly (£m)		-57.97	-61.74	-96.20	-57.17			
Capital spend (£m) (year to date)		27.84	32.62	56.54	1.21			
CIP % delivery at year end (%)	100%	97%	100%	100%	91%			
Forecast recurrent CIP (%)	60%	45%	45%	45%	75%			
Monthly agency spend (£m)		0.98	0.99	0.94	0.71			
Month End Cash balance (number of days operating exp) - Actual					31.00			
Month End Cash balance (number of days operating exp) - Plan					22.00			